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Duty hours and guaiacs

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There have always been 'days of the giants' stories about medical training. Back when I was a house officer, the book *The House of God* by Samuel Shem served as a manual of operations for interns and residents, emphasizing the roles and responsibilities of trainees, albeit from a farcical standpoint. Our training included being on call every third night, reliance on 'primary data', and 'ownership' of our patients, who we followed throughout their hospitalization. Such intense and comprehensive training developed us as young physicians, inspired collegiality amongst the house staff, and provided us with an attitude of 'see one, do one, teach one' with regard to our patients.

While I was a medical resident, I was impressed by a surgical resident who was on call every other night and his complaint that the schedule forced him to "miss half of the cases". For every admission, we were expected to perform a peripheral blood smear, spin urine specimens for microscopic analysis, Gram-stain sputum or cerebrospinal fluid and perform acid-fast bacilli staining for suspected tuberculosis, perform our own electrocardiograms and analysis, and describe chest X-ray findings. We were outraged if a 'covering' physician 'messed' with our patient and were often present at the bedside of an unstable patient through the night and following day. We handled phone calls at any hour, thrived on the intensity of patient care, and rarely, if ever, made medical errors related to fatigue. I will bet 'dollars for doughnuts' that medical errors will be increased by the transfers between covering house officers who do not have the same ownership of their primary patients.

Skip to the present. We have just been informed that, because of government regulations, stool guaiacs cannot be performed without maintaining a clinic log. This requires documentation in the chart with 'stickers' that need to be transferred to a central log in the clinic and then individual charges claimed for each test. Essentially, this hassle factor now discourages us from performing tests for blood in the stool because analysis of these samples, along with blood counts, urinalyses, sputum examinations, and electrocardiograms, must be performed in central ('quality controlled') laboratories or settings. Not only do these regulations add to the cost of and cause delays in care, but they take the physician further and further away from primary data that assist in patient assessment and treatment planning. There is also an impact on the quality of care. I frequently see hospitalized patients started on antibiotics for urinary tract infections on the basis of elevated bacterial counts in urine: a direct correlate to how long the sample waits before being analyzed.

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One weekend in November, I made rounds on a dozen patients along with a gastroenterology fellow. Although there were house staff assigned to the patients, I never saw an intern or resident (although I spoke to one intern on the phone). They were doing rounds with their primary team and could not 'break' to review or discuss our patients, having to finish rounds and leave at the end of their shift, as specified by government policy.

It seems to me that medical education and the training of young physicians has been eroded by unsubstantiated and reactive government policies, such that the profession has been taken further afield from the ideals and benefits related to continuity of patient-oriented care.

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