The Bell Commission:

Ethical Implications for the Training of Physicians

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Abstract

In 1989, the New York State Legislature enacted New York State Code 405 in response to the death of a patient in a New York City hospital. Code 405 was the culmination of a report (the Bell Commission Report) that implicated the training of residents as part of the problem leading to that tragic death. This paper explores the consequences of the regulatory changes in physician training.

The sleep deprivation of house officers was considered a major issue requiring correction. There is little evidence to support the claim that sleep deprivation is a serious cause of medical misadventures. Nevertheless, the changes in house officers' working hours and responsibilities have profound implications. Changes in the time allotted to teaching, the ability to learn from patients admitted after a shift is over, and the increasing loss of continuity, all may have a negative impact on physician training. It is not clear that trainees are being realistically prepared for the actual practice of medicine — physicians often work extended hours.

The most serious concern that has been raised is the loss of professionalism by physicians. Residents are now viewing themselves as hourly workers, and the State has intervened in an area of training formerly left to the profession to manage. We are now training doctors in New York State who will be comfortable working in an hourly wage setting, but not in the traditional practice of medicine as it has been in the United States during this century. We are concerned that this may sever the bond between doctor and patient — a bond that has been the bedrock of our conception of a physician.
Key Words: Bell Commission, residents, training, bioethics, professionalism.

In 1989, the New York State Legislature enacted New York State Code 405 in response to the tragic death of Libby Zion at New York Hospital. The enactment was the end result of a wide-ranging investigation by the State Department of Health, the Bell Commission, the court system, and the newspapers, leading to the conclusion that the manner of training residents was somehow part of the problem. Besides an immediate flurry of publications in the popular press, some attention was given to these new rules in the academic literature, both medical and bioethical. In this paper, we wish to explore what we view as the profoundly troubling consequences of these changes.

One of the major issues considered by the Bell Commission was the deleterious effect on patients of house officers' sleep deprivation. Although it was not clear that sleep deprivation was a major cause of medical misadventures generally, the members of the Bell Commission saw this as an opportunity to correct what they perceived to be a problem in the training of physicians. Among their mandates was the stipulation that physician house staff must not work more than 24 consecutive hours, must have no less than 8 non-working hours between shifts, and must not work more than 80 hours per week. These recommendations are not conclusively supported, however, by evidence in the sleep literature. While a meta-analysis of nineteen studies has demonstrated both decreased performance on standard tests of cognitive function and altered mood with sleep-deprivation (1), Storer and col-

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leagues (2), using board examination questions to test cognition and patient care tasks to test coordination, demonstrated no deleterious effects of sleep-deprivation in pediatric residents.

Issues of proper supervision by attending physicians were also raised in the Bell Commission deliberations, and rules about the availability of attending staff were mandated. These were far less proscriptive. To our knowledge, nothing has been written concerning the impact of the changes in attending physician supervision, and we have chosen, in this paper, to focus primarily on the resident physician rules.

In order to examine the short- and long-term implications of the Bell Commission, we need to examine the goals of house officer training from the point of view of the teacher. Then we can determine whether the Bell Commission regulations allow us to realize them. We must then also examine whether the resident physician rules substantially change the doctors who are trained under them, and if these new doctors can be effective in providing health care that meets the goals of their training. This assessment involves two interrelated facets. The first relates to the bottom line, i.e., will we have competent physicians to care for patients? The second relates to the broader issue of professionalism. We shall deal with both facets in this paper.

Let us begin with some generalizations about the nature and purpose of training interns and residents. First and foremost, we should want to maximize learning. In medical training, learning derives from many activities: reading, lectures, hands-on experience, observing, etc. Bell Commission guidelines were initially interpreted as allowing trainees to attend teaching sessions after the 24-hour limit, but recent audits of New York City programs have thrown this aspect of the regulations into a state of confusion. If it is acceptable to go to lectures after the 24-hour limit, then the message being sent to residents is that didactic learning is of less importance than patient-centered learning. We have seen no evidence to suggest that the Bell Commission has improved learning by residents — if anything, we submit that there has been a negative effect.

In a medical setting, maximizing learning requires, in a limited time, exposing our trainees to as many patients and diseases as possible. There is no question that the most skilled physicians are those who have been exposed to and cared for the widest range of patients. Learning from lectures and texts will never replace the reality of the patient encounter. In some cases, a trainee may have seen a wide enough range of patients with a particular problem to be competent in their management; in other cases, there are truly enough variations and permutations to make critical more clinical exposure. Should the trainee never go home? Obviously that is not a practical solution. But decisions about when to leave the hospital or clinic should be left to the individual, who is probably in the best situation to judge.

Learning clinical medicine involves more than single or multiple exposures to diseases. It requires exposure to the continuity of individual patients' care, through illnesses and life experiences. The more of this we see, the more we learn. While the Bell Commission opines that patient care would be improved with discontinuous care, the literature is more ambiguous on this issue. Residents have reported concerns about developing a shift-work mentality and an inability to provide continuity of care (3, 4). Studies of the effects of post-call transfer of resident responsibility have demonstrated deleterious effects on length of stay and test ordering, and an increase in medical complications (5, 6). Gottlieb, however, developed a scheduling model designed to reduce sleep-deprivation and improve continuity, and demonstrated decrease in lab test ordering and length of stay (7).

An additional goal for graduate medical education should be to adequately prepare trainees for the careers they will enter. Fifty-seven percent of 1998 graduates of New York State Medical training programs reported a plan to enter patient care/clinical practice (8). Yedidia (9) has argued that the Bell Commission regulations foster shared decision making and collective responsibility, which may conflict with the autonomy and individual responsibility that were traditionally taught and that remain integral to the life of an attending physician. In addition, the new regulations were among several factors that promoted an expansion of training positions in New York State (10). Our teaching goals should include preparing residents for the current job market, and we are concerned that 43% of those responding to the above exit survey reported difficulty finding a job with which they were satisfied; 44% reported few, very few or no jobs within fifty miles of their training site.

An essential component of all medical school teaching is the apprenticeship role of the trainee. Interns and residents learn from their mentors. They watch, assist, and interact with senior physicians caring for patients. For excellence in medical education, the supervisor is the teacher, the model, the ideal to which the trainee aspires. The

more we make this a reality, the more successful training will be. The Bell Commission regulations seem to recognize the importance of this apprenticeship when they mandate increased supervision. For the Bell Commission, however, the supervisor is there primarily to prevent mistakes. While these two functions are not at all mutually exclusive, too little thought and effort have occurred to meld them into one.

We are also concerned that the Bell Commission regulations are part of a disturbing movement accelerating the loss of the professionalism of physicians. James Gustafson speaks of professions as "callings" — they involve motivation (including moral motives) and a vision of the ends to be served (11). For the trainee, the motivation must be to learn how to become the best physician possible. Part of the learning is through caring for patients, part is through didactic learning. At no previous time in the history of physician training was there a concept of the trainee as an hourly worker. A resident aspired to train at the best program for learning, not the one with the easiest call schedule or fewest admissions at night. At the end of internship, the physician felt (and generally was) remarkably knowledgeable, proud of an ability to manage most illnesses that most patients were likely to have. While we all knew there was still much to learn, it was certainly true that we had acquired a tremendous amount of knowledge and skill.

While professions traditionally controlled training of new members, now the "State" has become a significant force in this training. In a not too subtle way, the Bell Commission rules tell house officers that they are members of the workforce, and that they should think of their labor contract in terms of hours, wages, vacations, and protocols. Instead of choosing obligation over self-interest (another definition of professionalism), our trainees are taught to reverse these priorities. We quantify their work and put twenty-four hour limits in place.

In effect, this revises the very concept of intern and resident. Never before did the educators (the medical school faculty and clinical attending physicians) openly plan for a way to care for patients without interns and residents. It is common now for faculty to sit in meetings, nodding their heads knowingly, when it is said that the house staff are of little value to the clinical service. To make matters worse, managed care companies and state and federal reimbursement programs pay only the most minimal lip-service to the value of training new physicians.

While the Association of American Medical Colleges has endorsed the 80-hour limit as consistent with the goals of graduate medical education (12), we propose that the Bell Commission Regulations are part of a fundamental change in our training, and that its implicit transformation of the concept of who and what a physician is has significant ethical implications. By interfering with optimal training as we have defined it, these regulations place patients at as great a risk from lack of professional commitment as any perceived risk from sleepy interns. This is not an immediate risk, but clearly a risk for the future. We are assuring that only rare physicians will recognize their fiduciary role as the professional who is always there for the patient. The State has said, "Go home. Someone else can do it." We have now institutionally sanctioned behavior that used to arouse guilt and remorse. We have said that it's fine to leave a sick patient. Someone else will deliver care. Even if that was always, as least in part, the reality, it was not our ethos. The interns and residents still feel wrong about leaving. A few stay way past the scheduled hour, but many do not. Some say their own personal lives are more important. Maybe that is true. But this represents a very serious change in the professional attitude doctors have traditionally expounded.

The proponents of the Bell Commission Regulations have answers to these criticisms. They say we can train people in other ways. Work around the time problem. Hire others to care for most of the patients. They are missing the point. No one would argue that we need more senior physicians around. That could only improve education as we have defined it. But that is not really the issue. The loss of the relationship between the trainee and the direct, continuous learning from patients presents the most serious attack on the traditions of medicine. If we look at the training of physicians using the framework of raising our children, we can reach the same conclusions that Erik Erikson reached in his seminal publication (13). He stated that "small differences in child training are of lasting and sometimes fatal significance in differentiating a people's image of the world, their sense of decency, and their sense of identity." We are now training doctors in New York State who will be comfortable working in the hourly-wage setting but not in the traditional practice of medicine as it has been performed in the United States up to now. We are laying the groundwork for severing the bonds between doctor and patient.

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