



## Vacation as a Duty Hour Policy Lever

With rising rates of physician burnout, much of the debate on work-life balance has focused on weekly duty hours. And for good reason. Today's residents routinely work 80 hours per week—the equivalent of two full-time jobs. Assuming residents get the recommended 8 hours of sleep per night, live 15 minutes from the hospital, and have their required 1 day off per week, this amounts to 2 hours per day at home before bed to do everything. From cooking to cleaning to laundry and, lest we forget, spending time with family and friends.

The majority of residents are also required to work at least 48 weeks per year each year of their residency by their respective medical board. If the Accreditation Council on Graduate Medical Education (ACGME) were to liberalize vacation policy to require all specialties to allow up to 6 weeks of vacation, vacation time could be increased 50% while only reducing clinical exposure 4%. And there are ways to do so without increasing health care spending.

Recent attempts to reduce weekly duty hours have been met with strong criticism. Despite the majority of peer countries successfully limiting duty hours to less than 60,<sup>1</sup> strong evidence suggesting harms of longer work hours<sup>2</sup> and the safety of shorter work hours,<sup>3</sup> critics have argued that reducing duty hours to less than 80 would harm patients by increasing handoffs, hurt resident education by reducing didactic time, and pose an insurmountable logistical challenge. We've heard all of these arguments before, and none hold water. Nonetheless, since the ACGME passed its 80-hour limit in 2003, most debate instead has focused on 24-hour call rather than further reductions in weekly hours.

Lost in this debate is the fact that physicians-in-training work significantly more weeks per year than they will at *any* other point in their careers, especially on demanding inpatient services. Three-fourths of full-time hospitalists work shifts of alternating 7-days on, 7-days off.<sup>4</sup> This amounts to 26 weeks per year. Academic physicians,

specialists, and those with outpatient practices typically work more weeks per year but spend significantly less time on inpatient services. In contrast, residents in internal medicine, family medicine, pediatrics, general surgery, and anesthesiology must work at least 48 weeks per year and are not allotted additional time for illness, parental leave, or family leave. The only exception is internal medicine, which, since 2018, has allowed program directors to excuse up to 4 additional weeks off for exceptional circumstances. Although many programs do offer 4 weeks of vacation, not all do, and some programs continue to only offer 2 weeks.

Allowing all residency programs to offer 6 weeks of vacation is a modest change that has already been adopted by several of the more "lifestyle-friendly" fields, including dermatology, ophthalmology, and emergency medicine. Currently, internal medicine residents work 144 out of 156 weeks during their residency. Increasing vacation to 6 weeks per year would only reduce clinical time to 138 weeks, or a 4% reduction. If this is unfeasible, programs could opt to offer only 5 weeks for a 2% reduction or only offer 6 weeks to interns for a 1.5% reduction. These marginal reductions would be coupled with better-rested and happier residents, for whom numerous studies have demonstrated increased performance and educational retention.<sup>5</sup>

Liberalizing vacation policy would have several additional benefits. First, residents would have significantly greater time and flexibility to attend major life events. Rather than having 1 week off every 3 months, they would be able to take 1 week off every 2 months. This would allow residents to attend weddings, travel, and spend time with family. Second, this would empower residents to pursue their own wellness activities. Most importantly, this represents a simple solution to reduce work hours without risking additional handoffs or making changes to the existing call schedule that might increase patient risks.

The major barrier might be cost. Although residency programs undeniably devote significant resources to educating their trainees, the labor that residents perform is incredibly valuable. Without residents, academic centers would grind to a halt. This at times contradictory balance between education and service contributes to today's exceptionally high duty hours. Regardless how we got here, there are 3 options to provide residents with more vacation time, all at a reasonable price.

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First, programs could simply hire more residents. Bringing 1 additional resident on board in a class of 23 would allow every resident to have 6 rather than 4 weeks off each year. Hiring 2 would double the amount of vacation time residents enjoy.

In 2018, there were 517 internal medicine residency programs offering 7542 positions, for an average class size of 14.6. If every program were to immediately hire 1 additional resident, the cost would be ~\$60 million per year. However, with growing demand for primary care providers, the number of internal medicine residency spots has increased every year since 2005 anyway and is projected to continue to grow 2.2% per year.<sup>6</sup> At this rate, it would only take 2 years for every program to be able to offer 6 weeks without increasing costs any more than is needed to fit national demand.

Practically speaking, there are 2 major barriers. First, although the majority of hospitals earn money for each resident they train, not all do. Hospitals receive on average \$112,642 per resident as part of Direct and Indirect Medical Education (GME) payments<sup>7</sup> and only pay residents on average \$54,107 in their first year. However, the range of payments is enormous—from \$63,000 to more than \$150,000 per resident, depending on state—and those at the lower end have a strong case for losing money. Second, since 1997 hospitals have been capped at the number of residency positions they receive funding for. For programs who are at their resident cap, they would not receive any additional GME payments for training more residents. Reform is needed for both. GME payments should be more evenly distributed between states, and residency programs must be granted greater flexibility to increase their resident cap.

Alternatively, hospitals could increase vacation time immediately by hiring hospitalists or nurse practitioners. The average academic hospitalist earns \$173,000 per year, whereas nurse practitioners average \$91,000 per year. Programs would only need to hire an average of 1 additional person to provide an additional 2 weeks off. Given an average residency of 15, hiring 1 additional hospitalist or nurse practitioner would only represent 10%-20% of the surplus \$878,025 in GME payments (minus resident salary) they receive.

If neither of these options is feasible, a final option would be to allow interns to start residency early. During

the fourth year of medical school, most medical students have significant amounts of free time and little, if anything meaningful to do. Allowing interns to start 2 or 4 weeks early would allow them to have more vacation during their intern year without changing the hospitals' or the health system's bottom line.

To break the path we're on, we need to reform resident work hours. Superficial changes and wellness programs are not enough. The core driver—overworking residents—can no longer be ignored, and true reform is needed. As further reducing weekly duty hours has hit a wall, it's time to look at vacation as a policy lever to reduce resident burnout.

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## References

1. Temple J. Resident duty hours around the globe: where are we now? *BMC Med Educ* 2014;14(suppl 1):S8.
2. Landrigan CP, Rothschild JM, Cronin JW, et al. Effect of reducing interns' work hours on serious medical errors in intensive care units. *N Engl J Med* 2004;351(18):1838–48.
3. Patel MS, Volpp KG, Small DS, et al. Association of the 2011 ACGME resident duty hour reforms with mortality and readmissions among hospitalized Medicare patients. *JAMA* 2014;312(22):2364–73.
4. Ma E. The scourge of seven on/seven off. *ACP Hospitalist*. <https://acphospitalist.org/archives/2011/05/perspectives.htm>. 2011. Accessed March 1, 2019.
5. Philibert I. Sleep loss and performance in residents and nonphysicians: a meta-analytic examination. *Sleep* 2005;28(11):1392–402.
6. Hayek S, Lane S, Fluck M, Hunsinger M, Blansfield J, Shabahang M. Ten year projections for us residency positions: will there be enough positions to accommodate the growing number of U.S. medical school graduates? *J Surg Educ* 2018;75(3):546–51.
7. Mullan F, Chen C, Steinmetz E. The geography of graduate medical education: imbalances signal need for new distribution policies. *Health Aff (Millwood)* 2013;32(11):1914–21.