Other consequences of reduced duty hours

Far more serious than the consequences of mandated reductions in resident duty hours outlined by Pattani and colleagues[1] is "the trend toward increased failure rates on the oral component of (American) surgical board examinations." Ahmed and colleagues[2] report the failure rates for thoracic surgery tripling and general surgery doubling during the time period that the Accreditation Council for Graduate Medical Education mandated reductions in resident duty hours. They describe how surgical fellows are "inadequately prepared" for the operating room. If they weren't fellows, these surgeons would be practising in the community.

Surgical residents are doing fewer cases, especially emergency cases, and are less able to recognize and manage complications. The authors[1] describe how patient safety may be compromised as these trainees lose valuable experience, but far more worrisome is that they may be incompetent despite completing their residency. This has the potential to be a long-term threat to the wellbeing of the patient population.

The results in Ahmed and colleagues'[2] paper also question one of the "principles of a pan-Canadian response" to duty hours by describing how the "night float" system is far more disruptive to resident wellbeing than the traditional 24-hour call period. I hope the National Steering Committee on Resident Duty Hours will study this systematic review very closely before making any changes in Canada.

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The authors respond

As we noted in our paper,[1] reduced duty hours may negatively affect the development of competence, which could have an impact on patient safety. This is particularly relevant for procedure-intensive specialties, where increasing evidence suggests that work-hour reforms have deleterious effects on educational outcomes,[2–5] including worse scores on licensing examinations.[6] The review by Ahmed and colleagues,[7] which was published after our paper, came to similar conclusions.

We agree with Dr. Allen[8] that it will be important for the educational community to consider these findings and others as they evaluate duty-hour reforms.

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Medical tourism dialogue needs a broader scope

We read Stanbrook and Fletcher's editorial[1] with great interest. As the editorial argues, the decision for Canadian hospitals to treat international medical tourists should not be taken lightly. Treating private international patients in Canadian public hospitals may result in negative health-equity implications for Canadian patients.

Medical tourism is a global practice that also involves Canadian patients travelling to other countries for medical care. It must be acknowledged that the impact of inbound medical tourism to Canada, which you identify in your editorial, also holds true for many of the host of countries to which Canadian patients travel.

We call for dialogue among Canadian medical and health-professional groups about medical tourism. These groups must consider the implications for their members of Canadian patients' involvement in medical tourism. Speaking up only about international patients coming to Canada is to ignore the full scope and health-equity impact of this global health services practice.

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Canada must help the wounded children of Gaza

Stanbrook[1] brings attention to a distressing situation in his editorial regarding the plight of wounded children in Gaza.[1]

All agree that the injuries to children in Gaza are a tragedy and that these injuries require treatment. What is even more tragic, however, is that these injuries and deaths can be prevented. At an