antibiotics alters the course of a disease that has typically been present for days, or alternatively that patients who have delays in receiving antibiotics are substantially different with respect to important comorbid illnesses.

While administering antibiotics promptly is desirable, the real key to improving outcomes lies in understanding why patients who have a delay in antibiotic therapy are more likely to die. Although an enforceable time limit satisfies the need of administrators to claim they are meeting standards of care, better patient outcomes are more likely to be linked to recognizing key comorbid conditions (eg, heart failure and diabetes) and instituting appropriate therapy for them as early as possible.

Arguing that the large Medicare database studies\(^1,2\) controlled for the factors we identified is misleading. Confusion is known to be poorly recognized and documented in emergency departments.\(^3,4\) The accuracy of qualitative assessments like the presence of confusion in the Medicare studies is therefore markedly inferior to the detailed individual assessment by an experienced physician, as occurred in our study. Assessment of other diagnoses requiring detailed clinical evaluation (eg, mild chronic organ disease) may also be suspect.

We sympathize with the desire for simple quality measures to meet administrative goals. However, these targets must actually improve patient outcomes. Prospective studies of improving the delivery of antibiotics within 4 h have not documented a mortality benefit. A 4-h rule for antibiotic therapy in community-acquired pneumonia is not supported by current data.

Grant W. Waterer, MD, FCCP
School of Medicine and Pharmacology
University of Western Australia
Perth, WA, Australia
Richard G. Wunderink, MD, FCCP
Northwestern University Feinberg School of Medicine
Chicago, IL

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Effect of Work Hour Restrictions on Fellows

To the Editor:

In 2003, the Accreditation Council for Graduate Medical Education began enforcing the 80-h work week for residents. While work hour restrictions (WHR) have had beneficial effects on resident well-being and fatigue, unintended effects of these changes are beginning to emerge.\(^1,2\) The effects on fellow trainees has not been evaluated.

We sent an anonymous Internet-based survey via e-mail to fellowship directors identified on the American Thoracic Society Web page. The directors were asked to forward the survey link to their fellows. A total of 125 responses were received.

Most fellows reported no impact or a negative impact of WHR on fellow quality of life (58%), personal life (57%), and sleep (59%). Fellows report doing more resident-level duties (58%) and procedures (49%), with less time to teach residents and students (43%). Strikingly, 26% report a negative impact of WHR on fellow education.

These data suggest that WHR have significant effects on pulmonary and critical care fellow training. In contrast to other studies\(^3,5\) that have demonstrated a substantial improvement in quality of life of residents after WHR, this does not appear to be the case for fellows. The lack of improvement may be due to a shift in duties traditionally performed by residents to fellows. Previous reports\(^6,5\) of resident dissatisfaction with WHR have been related to decreased interactions with attending physicians, decreased educational opportunities, and an increase in more junior trainee-level responsibility. It may be that this shift in resident duties to fellows that is a significant factor for the negative view of WHR among fellows. These preliminary data argue for further large-scale studies of the impact of WHR on fellow education and patient care outcomes, as current approaches to fellowship training may need to be adjusted due to WHR.

Maria Lucarelli, MD, MS
John Mastronarde, MD
Division of Pulmonary, Allergy, Critical Care, and Sleep Medicine
Gary Phillips, MS
Center for Biostatistics
Catherine Lucey, MD
Department of Internal Medicine
Ohio State University Medical Center
Columbus, OH

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Correspondence