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**Testimony  
Committee of Interns and Residents/SEIU Healthcare  
ACGME Duty Hours Congress  
June 11-12, 2009  
Chicago, IL**

Good day. CIR President Dr. Luella Toni Lewis was not able to be here today, so I am representing the Committee of Interns and Residents/SEIU Healthcare.

My name is Dr. Nailah Thompson. I completed my Internal Medicine residency at Alameda County Medical Center in Oakland CA in 2007 and was chief resident in 2007-2008. I am currently doing a Preventive Medicine fellowship at Columbia University and serve as national vice-president of the Committee of Interns and Residents/SEIU Healthcare.

CIR represents 13,000 interns, residents and fellows training in more than 60 public and private teaching hospitals across the country.

Since its inception in 1957, CIR has been involved in one way or another in the effort to limit unsafe work hours for residents and the patients we care for. Most notably:

- A New York City-wide action by 3000 residents in 1975 successfully replaced every other night on-call – which, at that time was commonplace for all specialties – with every third night on call.
- In the late 1980s, CIR supported the New York State Bell Commission recommendations and lobbied for the Public Health regulation and state funding which ultimately led to improved attending supervision and a limit on the duration of on-call shifts to no more than 24 consecutive hours.
- In 1998, a CIR member died in a post-call car crash.
- From 1999 to 2002, we joined with medical student and consumer safety organizations to file an OSHA petition and support federal legislation aimed at reducing hours. Our efforts contributed to the ACGME's decision to implement the first ever hours limits across all medical specialties in 2003 – a reduction from 36 consecutive hours on-call to 24+ 6 hours.

It is safe to say that the medical community greeted each small step towards reform with widespread and vociferous objections. The historical record reveals the all too familiar arguments – arguments that we have heard for 35 years:

1. Medical education will be irrevocably damaged;
2. Residents trained under the new system will be unsafe and unable to pass their boards;
3. Training, especially in the surgical specialties will have to be extended;
4. Residents are lazy, unwilling to work and will develop a “shift work” mentality;
5. Professionalism and dedication to patient care will be lost forever – and finally, the all purpose:
6. “Change is simply impossible.”

And yet, change did occur, slowly but surely. Remarkably, the physicians trained during these last 35 years are as knowledgeable, professional and committed as their colleagues of earlier generations.

Today we find ourselves at another pivotal moment in “resident hours history” – but with an important difference. At the behest of Congress and the Agency for Healthcare Research and Quality,<sup>1</sup> the Institute of Medicine spent twelve months in 2007 – 2008 reviewing the overwhelming body of evidence produced over decades on the link between fatigue and human performance -- in multiple industries, including our own.<sup>2</sup>

The IOM’s recommendations for broad reforms in medical education have been released for all to see and it is the reason we are assembled for this ACGME Congress. The 428-page report was produced by a panel of experts in their fields and vetted in a rigorous peer review process. It creates, in effect, a new and very public community standard for what constitutes safe patient care – and that is not care provided by a resident who has worked without sleep for 30 consecutive hours.

CIR’s goals in this new period of reform are remarkably similar to those we have embraced throughout our history:

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<sup>1</sup> Dingell JD, et al, Agency for Healthcare Research and Quality. Washington DC:U.S. House of Representatives, Committee on Energy and Commerce, March 29, 2007.

<sup>2</sup> Institute of Medicine. Resident duty hours: enhancing sleep, supervision and safety. Committee on Optimizing Graduate medical trainee (Resident) Hours and Work Schedules to Improve Patient Safety. Washington DC: National Academies Press, 2008.

- We want to learn and practice evidence-based medicine and to champion what is best for patient care and safety.
- We expect to work hard throughout our medical training, but we do not want that training to put us in danger – by exposing us to an increased risk of car crashes and needlestick injuries.
- We want to find a healthy balance in our personal lives – time for training, for education and also for family and friends – because we believe we will be better physicians if we also care for ourselves;

For all these reasons, CIR supports implementation of the Institute of Medicine recommendations – with the following specific caveats:

1. The 30 hour shift, with a mandatory five hour nap should be abandoned. It is unworkable and unenforceable. Only a maximum shift of no more than 16 hours is supported by the evidence.
2. Some flexibility in the IOM's limit of 4 consecutive night shifts would be highly preferable. Currently 5 consecutive nights is a common schedule (usually Sunday – Thursday) and a successful addition to many training programs looking to reduce hours. While a 4 consecutive night

maximum is preferable, it will be hard to implement in many programs and the differences in resident fatigue between a 4 and a 5 night schedule have not been demonstrated when a program is in compliance with all of the other IOM time off recommendations.

3. Scheduling is most successful when it provides sufficient overlap for the transfer of patient information. Medical educators and hospital administrators should put renewed emphasis on standardized, state of the art hand-overs to address continuity of care concerns.
4. There should be an additional recommendation and a limitation on home call during those rotations when the number of calls results in frequent night-time disruptions, even in those cases in which the resident is not required to come into the hospital.

When it comes to implementing the IOM recommendations, however, we hear most often from our members (particularly those training in safety net hospitals) that they cannot conceive of having the funding in place to actually do it!

We know that the IOM is clear and unequivocal on this subject. The report states: “To avoid having residents bear the burden of implementing the duty hour recommendations by increasing their work load again and

increasing the risk to patient safety, additional funds are needed from all existing as well as new sources<sup>3</sup>.

The authors report that although the additional funding required may be significant -- at least \$1.7 billion -- that figure is actually only 0.4% of the entire Medicare budget.<sup>4</sup> Should preventable adverse events drop by just 7% as a result of reducing resident work hours to safer limits, the IOM suggests the savings to the system would offset the costs.

CIR and SEIU -- our 2 million-member national affiliate -- are committed to lobbying for that additional funding in the months and years to come. That effort is what we believe the ACGME and the greater medical community should also be engaged in -- *not* the promotion of hastily assembled RFPs for additional data as to whether or not 30 hour shifts are harming patients, nor questioning whether the allocation of additional resources is “worth it” when weighed against the number of adverse events that could be prevented.

These are debates that the medical community is having with itself.

The general public, patients and consumers of health care, and Congress are far more rooted in the real world understanding of the relationship between fatigue and errors. They understand that fatigued pilots

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<sup>3</sup> IOM 2008. Resident duty hours, S-15.

<sup>4</sup> IOM 2008. Resident duty hours. 9-19.

are the cause of accidents, like the well-publicized February 2009 crash outside Buffalo that killed all on board. They are aware that other industries entrusted with the public's safety – industries like aviation, trucking and nuclear power – have had regulation in place for decades to limit work hours to safe levels.

That 'common sense' notion -- that staying up for 24 hours impairs performance -- holds for medicine as well. In a 2004 Kaiser Family Foundation Nationwide survey of public opinion on the causes of medical errors, for example, 74% of respondents listed "overwork, stress or fatigue of health professionals as a "very important cause of medical errors" and 66% felt "reducing the work hours of doctors in training to avoid fatigue" would be "very effective" in reducing preventable errors."<sup>5</sup>

We look to the ACGME for leadership in addressing the evidence and public concern over unsafe work hours, because if medicine does not take up this task, it is only a matter of time before the public – through its representatives in Congress – will.

CIR is confident that, just as in 1975 and 1989 and 2003, medical education can and will adapt, because "necessity is the mother of invention." We already have many examples of innovative scheduling changes in place in

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<sup>5</sup> Causes of Medical Errors: Public Opinions, Kaiser Family Foundation Nationwide Survey 2004.

residency programs across the country and with additional funding more will come. Residents must be at the center of any effort to redesign how patient care and education are organized.

Finally, an important paradigm shift must take place in how we define what it means to be a professional. The IOM report stresses that developing a health care team philosophy and structure is essential to providing quality care in the 21<sup>st</sup> century hospital. The IOM calls for a transformation in the culture of care to one that “allows residents to tone down expectations of superhuman resistance to long hours and continuous care and give in to the flexibility of team systems.”<sup>6</sup>

The report also states that “Professionalism should not just mean staying long hours. Educational leaders, hospital administrators and residents themselves should recognize that ensuring adequate sleep for residents is part of responsible behavior to promote safe conditions for both residents and patients.”<sup>7</sup>

We want to be part of re-defining what it means to be professionals devoted to our patients – professionals who are part of a health care team and who understand that robust hand-overs and rested physicians are key to

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<sup>6</sup> IOM 2008. Resident duty hours, 8-16

<sup>7</sup> IOM 2008. Resident duty hours, 2-29.

patient safety. Those teamwork and communication skills and experience are what we need to learn and master during residency.

Fatigue and performance deficits have been the subject of numerous studies financed by the Agency for Healthcare Research and Quality. In her opening statement to the IOM committee on December 3, 2007, Dr. Carolyn Clancy, AHRQ Director, was direct:

“How can we profess to provide the best possible quality when we know we have staff members who are operating at levels of sleep deprivation so severe that they are similar to those of someone who is driving under the influence of alcohol?”<sup>8</sup>

The opportunity for important change is before us. Legislation has already been filed in Congress to increase the number of GME-funded residency slots in primary care and general surgery.<sup>9</sup> Shortages of these specialties -- and the legislation to correct it -- are just one concrete way to also begin funding the necessary change in medical training recommended by the IOM.

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<sup>8</sup> Carolyn Clancy, AHRQ Director in testimony before the IOM 12/3/07 ([www.cirseiu.org](http://www.cirseiu.org))

<sup>9</sup> HR 2350, Preserving Patient Access to Primary Care Act of 2009.

CIR urges the ACGME to take up the IOM's challenge to bring medical training into the 21<sup>st</sup> century. We will work tirelessly with you to secure the necessary funding and spark the innovation.

Thank you for this opportunity to present our views.