IOM Committee Charged to Fix Resident Hours

BY CHRISTINE KILGORE
Contributing Writer

WASHINGTON — Five years after the establishment of across-specialty rules to limit resident work hours, the issue of trainee schedules in teaching hospitals is again under the microscope as a continuing threat to patient safety—and this time an Institute of Medicine committee has been forewarned that specific "workable" solutions are needed.

The schedules in teaching hospitals "belie virtually all the tenets of providing good health care. How can we profess to provide the best possible quality of care when we know we have staff members who are operating at levels of sleep deprivation so severe that they are similar to someone driving under the influence of alcohol?" Dr. Carolyn Clancy, director of the federal Agency for Health Care Research and Quality, asked at a meeting sponsored by the Institute of Medicine.

"If we don't give members of Congress some workable solutions, they'll come up with their own," she told members of the IOM's Committee on Optimizing Graduate Medical Trainee Hours and Work Schedules.

The committee, which held the first of four workshops in December, was formed at the request of Rep. John D. Dingell (D-Mich.) and colleagues on the House Committee on Energy and Commerce as part of an investigation into preventable medical errors. The IOM will publish a report including strategies and actions for implementing safe work schedules in February 2009.

The issue of resident works hours received relatively little attention in the IOM's landmark 1999 report on medical errors, experts said at the workshop, despite several decades of research on the effects of sleep deprivation on human performance and research more specifically showing an impaired ability of interns to read EKGs after long shifts.

Since then—and especially within the past several years—various studies have demonstrated the effects of sleep deprivation in medical residents and have shown that reductions in work hours can reduce errors, physicians told the committee.

A prospective, national survey of more than 2,700 interns, for instance, showed that residents were seven times more likely to report a harmful fatigue-related error when they worked five or more 24-hour shifts in a month than when they worked no 24-hour shifts. They were four times more likely to report a fatal error.

In a randomized trial, residents had twice as many EEG-documented attention failures at night when working the traditional schedule of 24- to 30-hour shifts than when working an "intervention" schedule of a 16-hour maximum. Both studies were led by researchers at Harvard University.

Dr. Christopher P. Landrigan, who directs the Sleep and Patient Safety Program at Brigham and Women's Hospital, Boston, said the Harvard research has also shown that residents working 24- to 30-hour shifts make five times as many serious diagnostic errors as do those scheduled to work 16 hours or less. They're also twice as likely to crash their cars, and they suffer 61% more needlestick injuries, he told the IOM committee.

Limits instituted by the American Council on Graduate Medical Education in 2003 mark shifts of 24-30 hours as acceptable. The council's "common duty hour standards" call for a 24-hour limit on continuous duty, with an additional 6 hours allowed for continuity and the transfer of care, as well as an 80-hour weekly limit averaged over 4 weeks. Programs can request an increase of up to 8 hours a week and can apply for further exemptions.

Residents must also have a minimum rest period of 10 hours between duty periods, 1 in 7 days free from patient care responsibilities, and in-house call no more than every third night, averaged over a 4-week period, the standards say.

The American Council on Graduate Medical Education says it has issued citations to individual programs for duty hour violations and has done resident surveys that demonstrate a compliance rate of 94%.

Others argue that enforcement is inadequate and that an independent body is needed to ensure compliance. Culture and tradition are so entrenched, they say, that too little has changed and that residents routinely underreport hours for fear of retaliation.

"I'm a resident who said one thing on a survey and did another thing in real life," Dr. Sunny Ramchandani, past chair of the AMA Residents and Fellows Section, told the IOM committee. "I'd have a 30-hour shift, work at least 34 hours, and report 16."

Residents' workloads tend to remain the same even when shifts are shortened. Surveys of faculty and program directors taken by the American College of Physicians indicate that, even under the current rules, there is often less time for both formal and informal education.

"Changing duty hours means changing everything," from work flow and coverage strategies to transfer-of-care techniques and the "very fundamentals of how patients are treated" and what residents are responsible for, said Dr. Ethan Fried, director of graduate medical education at St. Luke's–Roosevelt Hospital Center in New York.

Hospitals in New York state have been dealing with work hour limits and supervision requirements since 1988, several years after the death of Libby Zion in a teaching hospital spurred the state to take action.

Changes made at Dr. Fried's hospital mean that a patient may be admitted by one team of residents, treated by another, and discharged by yet another. "It's up to educators to help residents integrate these experiences," he said. "I don't know whether I can." ■

Health Care Stakeholders Bullish on Grants

BY ALICIA AULT
Associate Editor, Practice Trends

Participants in several hospital and physician-related quality organizations are sanguine that almost $16 million in grants from the Robert Wood Johnson Foundation will hasten development of national cost and quality measures, as well as acceptance of those measures.

Last fall, the foundation awarded $8.7 million to the Engelberg Center for Health Care Reform at the Washington-based Brookings Institution, $4.2 million to the America's Health Insurance Plans (AHIP) Foundation, and another $3 million to various other groups to identify potential cost measures.

The project will be coordinated by Dr. Mark McClellan, the former commissioner of the Food and Drug Administration and former administrator of the Centers for Medicare and Medicaid Services, who now directs the Engelberg Center.

The grants will help "fill in the gaps" of the work being done by the Quality Alliance Steering Committee (QASC), said Susan Pisano, a spokeswoman for the AHIP Foundation. The Steering Committee is an amalgam of the Hospital Quality Alliance and the AQA, bringing together hospital and physician concerns.

"By bringing all stakeholders in the health care system together, this new project is an important step in accelerating the current slow pace of improvement in health care quality," said Dr. Carolyn Clancy, director of the Agency for Health Care Research and Quality, and cochair of the QASC, in a statement.

The RWJ Foundation's backing also serves as recognition that the Steering Committee's efforts are worthwhile, said Dr. Frank Opelka, vice chancellor of clinical affairs at the Louisiana State University Health Sciences Center, and the American College of Surgeons' representative on the QASC.

Established in 2006, the Steering Committee's principal members include: the RWJ Foundation, the American Medical Association, the American College of Physicians, the Association of American Medical Colleges, the Federation of American Hospitals, Blue Cross/Blue Shield, the American Hospital Association, the Society of Thoracic Surgeons, AHIP, the AFL-CIO, the National Partnership for Women and Families, the National Business Coalition on Health, the Pacific Business Group on Health, General Motors, Honeywell, Boeing, Exxon Mobil, the Joint Commission, the AHRQ, the Centers for Medicare and Medicaid Services, the National Quality Forum (NQF), and the National Committee for Quality Assurance.

The group will use performance measures that have been developed and endorsed by the NQF and AQA, but will use them in conjunction with a new database being developed by AHIP. The data will be collected from private plans and Medicare—all from claims—and aggregated into a practice-wide and a nationwide picture, said Ms. Pisano. The database means that reports back to physicians will "provide a more comprehensive view of their practices," she said. Instead of getting a report from one plan on all that plan's patients, and another from another plan, it will be a report that cuts across all insurers.

The bigger picture is important because it will give physicians the information they need to evaluate their performance across an entire practice, not just a single encounter, said Dr. John Tooker, executive vice president and CEO of the American College of Physicians.

It also will make for more accurate reporting, he said, noting that with a larger sample, there should be fewer outlier patients to skew a physician's rating.

The RWJ Foundation grants will also support the development of cost measures that will look at how physicians and hospitals use resources and compare them with national data. Initially, measures will be developed for 20 common conditions.

Both the quality and cost data will also eventually be shared with consumers.

"Tracking performance by adherence to quality standards tells patients only part of what they need to know in order to make informed decisions about health care services," said Dr. McClellan, in a statement. "They also need to know how the cost for these services compares." ■

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