Cutting Resident Hours Would Cost $1.6 Billion

BY MARY ANN MOON

Implementing the Institute of Medicine's four main recommendations for taming excessive resident work hours would cost an estimated $1.6 billion each year just to substitute other providers to perform the residents' work, according to a new report.

Alternatively, hiring enough additional residents to take up the slack—rather than distributing this work among nurses, physician assistants, attending physicians, and others—would cost an estimated $1.7 billion annually, according to Dr. Teryl K. Nuckols of the University of California, Los Angeles, and her associates.

The four key IOM recommendations are that residents work no more than 80 hours per week, be ensured of an uninterrupted 5-hour nap during extended (21-hour) shifts, work no more than 16 hours at a time without such a nap, and have a generally reduced workload.

For each major teaching hospital, costs would be an estimated $3.2 million every year for substitute providers or $990,000-$3.5 million every year for additional residents.

This is more expensive than implementing other patient safety systems, including computerized physician order entry ($3.3 million to $11.8 million over a period of 10 years) and medication bar-coding systems ($2.2 million over a period of 5 years).

Even after monetary outlays of this magnitude, "it remains unknown whether implementing the IOM's recommendations would reduce preventable adverse events" because research has not yet demonstrated such an effect. A single randomized trial suggested that shorter work shifts could reduce residents' errors in the ICU by 25%, but such errors rarely cause patient injury, and the results could differ in other clinical settings, the researchers wrote (N. Engl. J. Med. 2009;360;2202-15).

Moreover, the additional patient care handoffs necessitated by these changes could increase preventable adverse events, Dr. Nuckols and her colleagues wrote in their IOM-supported report.

They arrived at these conclusions after constructing a probability model based on estimated labor costs at 1,206 hospitals accredited by the Accreditation Council for Graduate Medical Education and estimated costs at major teaching hosptials. The model simulated hypothetical changes in preventable adverse events when residents' workweek, duration and frequency of extended shifts, and time on inpatient rotations vary.

The investigators found that if the recommended changes prove to be very effective at reducing medical errors, they would be cost effective for society at large but very expensive for hospitals.

"Possible strategies that teaching hospitals could use to manage the additional costs include reducing residents' salaries, increasing the workload of faculty physicians without increasing compensation, increasing charges to patients, allowing profitability to decrease, reducing clinical services, allowing quality of care to decline, improving efficiency, and securing subsidies—or not implementing the recommendations," Dr. Nuckols and her associates wrote.

To date, surveys of residents have found widespread nonadherence to the recommendations, which were implemented by ACGME in 2003 but are not enforced.

In an editorial comment accompanying this report, Dr. Melvin S. Blanchard and Dr. Kenneth S. Polonsky of Washington University, St. Louis, and Dr. David Meltzer of the University of Chicago urged that the IOM recommendations not be implemented at this time.

"Such a major policy change should be based not only on the recommendations of an expert committee but also on careful studies and evidence that improvements in both patient and educational outcomes will result. To date, the necessary research has not been done and the evidence of benefit is lacking," they noted (N. Engl. J. Med. 2009;360:2242-4).

Dr. Blanchard reported receiving grant support from Pfizer. No other potential conflicts of interest were reported. ■

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