



Health Law Alert

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More rest for the weary? Prepare for increased scrutiny and enforcement of resident duty hour limits

By Lindsay Maleson

Do your residency programs have duty hour citations? Do the results of your ACGME Resident Surveys reflect noncompliance with duty hour requirements? Could your program or even the sponsoring institution be at risk for an immediate ACGME site visit? What recommendations did the Institute of Medicine make last week about adjustments to duty hour limits? How has the ACGME responded? Teaching institutions should be asking all of these questions and more as they prepare for increased scrutiny and enforcement of resident duty hour limits.

Last week, the Institute of Medicine (IOM) issued a long-anticipated report on patient safety and medical residents' duty hours that is sure to affect the graduate medical education landscape.¹ "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety" (the "Report") includes a number of recommendations that the IOM believes should be adopted and implemented within 24 months by the Accreditation Council for Graduate Medical Education (ACGME), the organization that accredits 8,500 medical residency programs training approximately 105,000 residents.

Given the speed with which the IOM expects its recommendations to be adopted, as well as the ACGME's recent release of a protocol identifying the serious and swift accreditation consequences of duty hour violations, teaching institutions must be aware of what is at stake and quickly prepare for increased scrutiny and enforcement of resident duty hours. Institutions must also prepare for the potential for additional oversight from the federal Centers for Medicare and Medicaid Services (CMS) and the Joint Commission.

The last time resident duty hours were given such intense attention was 2003, when the ACGME implemented common duty hour standards for all specialties and subspecialties under pressure of impending Congressional intervention. Five years later, Congress is still concerned about resident work hours; indeed, the IOM study was commissioned by

¹ See <http://www.nationalacademies.org/morenews/20081202.html>.

the House Committee on Energy and Commerce and sponsored by the Agency for Healthcare Research and Quality.

In a public briefing held on December 2, 2008, Dr. Michael M.E. Johns, the chair of the IOM committee that was responsible for the Report, the Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety (the “Committee”), explained that the “overarching conclusion [of the Committee] is that the science clearly shows that fatigue increases the chances of errors, and residents often work long hours without rest and regular time off.”²

The IOM’s recommended adjustments to duty hour rules

The ACGME’s current rules limit resident work hours to 80 hours per week (averaged over a 4-week period); require training programs to provide one day off every seven days (averaged over a 4-week period); limit continuous on-call periods to 30 hours; limit call to every third night (averaged over a 4-week period); and require a 10-hour rest period between shifts. Some states, including New York, have implemented their own duty hour requirements that differ slightly from the ACGME standards; ACGME-accredited programs in those states must follow the more stringent of the two sets of rules.

While the IOM does not recommend a decrease in the total number of hours residents may work per week as some expected it would, it *does recommend a number of significant adjustments to the current duty hour rules*. Highlights include:

- *Continuous duty limit.* The Committee recommends limiting long shifts to 16 hours. Shifts may extend up to 30 hours if an uninterrupted, 5-hour sleep break between 10 p.m. and 8 a.m. is provided. The sleep break would be counted toward the 80-hour limit, and residents would only be permitted to admit patients for up to 16 hours.
- *Time off between shifts.* The Committee recommends enhancing the amount of time off between shifts to give 10 hours off after a day shift, and 12 hours off after a night shift. A 14-hour break would be given after a 30-hour shift, with the resident not returning until 6 a.m. of the next day.
- *On-call frequency.* The Committee’s recommendations maintain the current every-third-night rule, but would not permit averaging over a 4-week period, which the ACGME currently allows.
- *Frequency of night shifts.* The frequency of in-house night shifts (night float) has not been addressed by ACGME standards. The Committee recommends that after 3 or 4 nights of consecutive duty (night float), a resident should be given 48 hours off.

² The Opening Statement by Michael M.E. Johns, M.D., is available at <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=12022008a>.

- *Days off.* The Committee recommends 5 days off per month, with a guaranteed one day off in every week and one 48-hour period off per month.

Supervision, patient caps, & handoffs

The IOM Report makes clear that the Committee does not believe that adjusting duty hours alone is sufficient to improve patient safety. Thus, the Report also recommends *increased supervision of residents, limits on resident patient loads (i.e., patient caps), and more structured and effective handoffs of patients at shift changes.* In addition, the Committee recommends that resident moonlighting be restricted and that moonlighting hours, whether inside or outside the resident's training institution, be counted toward all duty hour limits.

Enforcement plans

In his statement at last week's public briefing, Dr. Johns said that the Committee had heard from "many sources" that violations of current duty hour limits are "frequent" and "underreported," so the Committee "call[ed] for the [ACGME] to *strengthen its monitoring efforts by making more frequent duty hour audits and making these visits unannounced.*"³

The Committee also called for increased protection for whistleblowers and *oversight of the ACGME's enforcement efforts by CMS and the Joint Commission.* The Report suggests that CMS could perform evaluations of adherence to resident duty hours, the effectiveness of the ACGME in its monitoring role, and the acceptability of program rationales for variances in duty hour limits. The Report suggests that the Joint Commission "should seek to ensure that duty hour monitoring is linked to broader activities to improve patient safety in hospitals, including the use of ACGME's adherence data as part of the Joint Commission's hospital surveys and accreditation actions."

ACGME response to the IOM report & recently released protocol

In its statement on the IOM Report, the ACGME announced that in early March of 2009, it will convene a duty hours symposium during which conference participants "will carefully review the IOM report as part of discussions on possible refinements to the duty hour standards."⁴

Before the release of the IOM Report, the ACGME had already announced a protocol allowing it to perform accelerated site visits and to take expansive accreditation action with respect to potential duty hour violations apparent in programs' Resident Survey results.⁵ The Resident Survey is an anonymous, electronic survey administered by the

³ Emphasis supplied.

⁴ See [ACGME statement on IOM resident duty hours report](http://www.acgme.org) (12/02/08), available at www.acgme.org.

⁵ The ACGME protocol was approved by the ACGME Board of Directors at its September 2008 meeting and released on September 18, 2008, in the form of a "Special Message from the Chief Executive Officer to All Program Directors, Designated Institutional Officials, and Residents" entitled "Standard Approach to Programs Across All Specialties with Potential Duty Hour Violations Identified in the Resident Survey." It is available at <http://www.acgme.org>.

ACGME to all residents and fellows every other year.⁶ According to the protocol, when a program's Resident Survey results demonstrate that it has met the ACGME's threshold for "potential duty hour violations," it will receive a letter of warning, and the Resident Survey will be repeated the next year. If violations are evident in the results of the next Resident Survey, the program's *accreditation cycle will be shortened to no more than 9 months*, and the ACGME's Institutional Review Committee, which governs the sponsoring institution's accreditation, could take action based on the deficiencies and the results of the program's accelerated site visit. For programs receiving repeated (three in a row) noncompliant results on Resident Surveys, there could be an *immediate full site visit of the program with a simultaneous institutional review focusing on institutional oversight of duty hours*.

Conclusion

Regardless of whether the ACGME implements the recommendations of the IOM, it is clear that teaching institutions should expect increased scrutiny and enforcement of duty hour limits, as well as the likelihood of unprecedented enforcement, oversight, and monitoring by CMS and the Joint Commission. Further, enforcement protocols now being used by the ACGME could place programs and institutions in accreditation jeopardy swiftly, with serious consequences for an entire teaching institution.

Institutions or programs with Resident Survey or state survey results indicating potential noncompliance with duty hour rules should address such violations immediately and proactively and are advised to seek outside assistance when necessary. When a letter of warning or a letter advising a program or an institution of an accelerated site visit is received, an institution should recognize that the relevant program's accreditation is at risk as well as the institution's accreditation.

To discuss duty hour violations or other graduate medical education and accreditation issues, contact Nixon Peabody attorneys Lindsay Maleson at lmaleson@nixonpeabody.com or 516-832-7627; or Richard F. Minicucci at rminicucci@nixonpeabody.com or 516-832-7527, who have particular skill and experience in addressing and resolving these matters.

⁶ According to the ACGME protocol released in September, failure to ensure that 70% of program residents complete the Survey may result in a letter of warning. Repeated failure to reach the 70% threshold for completion of the Survey may result in administrative withdrawal of the program.