From the Desk of the Residency Program Director

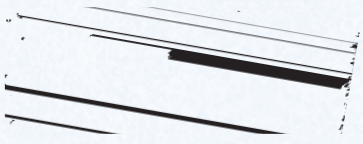
In September 2010, the ACGME Board of Directors voted to implement work rules which would among other things limit intern shifts to 16 hours effective July 2011. At Jefferson, our leadership team began working on our program's process and specific plans in attempting to rapidly adapt to the new ACGME mandates even before they were formally adopted. Together with our Chief Residents, Drs. Doug Guggenheim, Dina Halegoua, and Emily Stewart, we planned a retreat for October 22, 2010. It was held at the Union League with assembled residents from all three levels, senior administrators, and faculty that we forged our plan and response. Our goal was not only to comply, but to enhance the educational environment at Jefferson at the same time.

During a preliminary Town Hall Meeting with the Interns- before we even went on retreat — we presented the new ACGME directive for informational purposes including the rationale behind the new rules. Several Interns voiced concerns about preserving education in the new work hours environment. Some asked whether the hours changes would apply to just interns or interns and residents. There was a broad discussion about the affects of a lack of sleep on errors and fatigue and the concern over car crashes post–call. As a result of this meeting we pledged to aim for 16 hour compliance for not just Interns (as the new ACGME work rules mandated), but also for Residents as well (the new rules do permit them to work 24 plus 4 hour shifts).

In considering this revolutionary change, you may have several questions regarding details of our rationale. Over the past decade, a series of studies have emerged indicating that residents' traditional 24-hr work shifts pose hazards to their patients and to themselves. Elimination of 24-hour shifts has been shown in a randomized trial and other studies to reduce overall error rates. Landrigan et al, showed that houseofficers made substantially more serous errors when they worked shifts of 24 hours or more than when they worked shorter shifts (136 vs. 100 per 1000 patient days, $P<0.001$). While reassignment of personnel needed to support shorter work hours undoubtedly carries an up front cost (in this circumstance pulling housestaff from the BMT), a decrease in medical errors would more than pay for these costs.

Beyond patient safety, housestaff safety and education are also important. In a series of remarkable conversations I have had with many physicians who trained in the era of no hours limits, I have been amazed by the stories of near car crashes and actual car wrecks that occur driving home post call. Several well conducted studies have validated this important risk. This issue demands bold action to protect the well-being of our residents and unsuspecting motorists.

The imperative for 16 hours comes through the ACGME, I realize, but the imperative should have come from us as leaders in medical education. Whatever the case, we must answer the call and meet not only the letter of the law, but the spirit of the law as well.



Gregory C. Kane MD, FACP, FCCP
Professor of Medicine
Residency Program Director and Vice-Chairman
Interim Chief, Division of Pulmonary and Critical Care
Department of Medicine