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Chief Executive Officer  
Accreditation Council for Graduate Medical Education  
515 North State Street, Suite 2000  
Chicago, IL 60654

RE: CoPS Response to the Institute of Medicine Report on Resident Duty Hours

Dear Dr. Nasca:

We thank you for the opportunity to provide the ACGME with a formal position paper in response to the Institute of Medicine (IOM) Report on Resident Duty Hours that was issued in December of 2008. This position paper reflects the consensus opinion of the Council of Pediatric Specialties (CoPS). CoPS represents more than 14,000 pediatric subspecialists in the United States, including Program Directors and Division Directors who supervise the training of subspecialty fellows.

We support the basic principles of the IOM report regarding patient safety, resident supervision, resident safety, and the importance of effective “hand-offs”. We believe that the ACGME must view this as a unique opportunity to carefully examine the policies that guide postgraduate medical education in the United States. The following material summarizes the main points of our position regarding the IOM report. In the attached document we respond point-by-point to key IOM recommendations.

**Position Statement**

1. *Restricting resident duty hours further will have a significant impact on the preparation of residents for pediatric fellowships and on the competency of fellows.* Training program directors, especially those in pediatric critical care specialties (Neonatology and Critical Care), indicate that beginning fellows currently lack sufficient clinical and technical skills to perform at expected levels. Reductions in resident and fellow duty hours will adversely impact the competence of fellows in training and will likely lengthen the duration of training required to achieve the clinical competence necessary to care for children with complex medical conditions.

**Executive Director**

Laura Degnon, CAE

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2. *Restricting duty hours further will be costly to implement, especially for small programs.* There is insufficient GME support currently to recruit the trainees necessary to support an increased duration of training or to fill the clinical needs created by additional reductions in duty hours. Current estimates indicate that at least 25% more trainees will be needed if the IOM recommendations for resident duty hours are implemented. If resident duty hours are restricted, more aspects of the care of subspecialty patients will be shifted from pediatric residencies to subspecialty services. There are currently insufficient numbers of fellows or subspecialists to assume all of the anticipated teaching and clinical responsibilities. Based on data from the American Board of Pediatrics, indicating that there are more than 3400 fellows in training in pediatric specialties, we estimate that up to 1000 more fellow trainees will be needed if the IOM recommendations, especially the revised 30 hour day, are implemented. Given that the *direct* costs of training one fellow for three years are currently \$200,000, *at least* an additional \$200 million in GME support will be needed to provide an adequate fellow workforce if the IOM recommendations are implemented. This cost is *in addition to* the \$1.7 billion estimated in IOM report. There are insufficient numbers of applicants, especially US medical graduates, to fill current fellowship positions, let alone the numbers necessary if the IOM recommendations are implemented as written.
3. *There is a workforce shortage in pediatric subspecialties.* It will be extremely difficult for pediatric subspecialists to assume additional clinical duties should fellow and resident duty hours be reduced further. The average age of pediatric subspecialists ranges from 48.4 years (emergency medicine) to 55.7 years (nephrology) (*data from The American Board of Pediatrics, 2008-2009*). The costs of hiring additional subspecialists for training environments are prohibitive and the supplemental workforce, whether aging subspecialists or mid-level providers, is not currently available to provide adequate access to subspecialty care in US children's hospitals, let alone in community hospitals.
4. *Fellows must be viewed differently than residents.* The "one size fits all" approach to the policies and regulations for residencies and fellows does not fit the current educational needs of fellowship training. Fellows, especially in their final years of training, function like junior faculty members. They require autonomy and must engage in scholarly activities, especially if they anticipate academic careers.
5. *Changes in the educational and duty hour requirements for fellows must be data-driven.* We encourage the ACGME to propose studies that will be initiated now and continued through the implementation of any changes in the structure of postgraduate training. We must have high quality data to guide the future directions of fellow education. At the present time, data supporting substantial changes from the current duty hour structure are modest, at best.

We applaud the ACGME's desire to receive opinions from its constituents. We sincerely hope that the responses and the recommendations provided by organizations such as CoPS will be considered carefully by the ACGME and used to create policies that will ensure training excellence and safe, effective patient care. We look forward to the opportunity for representatives of CoPS to participate in the Duty Hour Congress scheduled for June and to represent the opinions of the Program Directors and Division Directors of pediatric subspecialties.

Sincerely,

The Executive Committee of the Council of Pediatric Specialties  
Victoria Norwood, MD, Chair  
James Bale, Jr., MD, Vice-Chair  
Daniel Coury, MD  
Paul Darden, MD  
Richard Mink, MD  
Christopher Kennedy, MD

## Summary of Council of Pediatric Specialties Opinions Regarding the Key IOM Recommendations

### IOM Recommendations

### CoPS Opinion

80 hour rule

*CoPS believes that non-patient care related activities of fellows, e.g., research time, manuscript preparation, etc., should be exempt from the 80 hour rule.*

30 hour shift but rest after 16 hours of work; 5 hours of rest; no new patients after 16 hours

*CoPS opposes this recommendation. It is costly to implement (at least 25% more trainees will be needed) and will be extremely difficult for programs to implement without changing to an all shift, day-float, night-float system. Fellows must function like faculty physicians, especially in their senior years. More data are needed to determine the optimum length of continuous duty hours to achieve this goal, especially in critical care specialties.*

Maximum 4 nights of work in succession

*CoPS opposes this recommendation, if it will be applied to call from home. Fellowship programs, especially small programs, have insufficient fellow or faculty workforce to implement this currently.*

Mandatory 5 days off per month

*CoPS agrees with this recommendation.*

External moonlighting should count toward the 80 hour rule

*CoPS agrees with this recommendation, but the IOM and ACGME must recognize that educational debt is a major burden for graduating medical students and a major factor influencing career choices. As many as one-half of the fellows in many programs moonlight to pay their debts. Educational loan repayment programs should be available to all fellows, including those entering clinical careers. Any reduction in resident or fellow duty hours must be linked to mechanisms to reduce the burden of educational debt.*

Enhanced night time supervision

*CoPS agrees with this recommendation.* However, CoPS also recognizes that fellows require sufficient opportunities for autonomy, especially in their senior years, when they function like junior attendings. Recommendations for increased supervision by faculty, especially if “in-house” must take into account the *severe* workforce shortages that current affect virtually all pediatric subspecialties.

Defined elements in the effective transfer of care

*CoPS agrees with this recommendation.* We will work with our partnering organizations to implement analysis of “hand-offs” or “sign-outs” to understand the necessary and sufficient elements of this critical aspect of patient care. Patient safety and medical error are influenced by several factors, including physician fatigue and sleep deprivation. It is unknown, however, if the errors avoided by providing opportunities for rest will be off-set by the errors that are perceived to be inherent in the more frequent hand-offs necessitated by shortened duty hours or shift work. The ACGME must encourage the performance of well-designed studies to critically examine these issues.