

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401  
(November 2020)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee D

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1 Whereas, AMA Policy H-15.958, “Fatigue, Sleep Disorders, and Motor Vehicle Crashes,” notes  
2 the risks associated with sleep deprivation and actions physicians can take to help protect  
3 patients; and  
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5 Whereas, About 20-30 percent of shift workers experience prominent insomnia symptoms and  
6 excessive daytime sleepiness consistent with circadian rhythm sleep disorder, also known as  
7 shift work disorder;<sup>5</sup> and  
8

9 Whereas, Drowsy driving causes almost 1,000 estimated fatal motor vehicle crashes in the  
10 United States (2.5 percent of all fatal crashes), 37,000 injury crashes, and 45,000 property  
11 damage-only crashes;<sup>2</sup> and  
12

13 Whereas, Physicians have a higher likelihood of dying from accidents than from other causes  
14 relative to the general populations;<sup>4</sup> and  
15

16 Whereas, Physicians’ risk of crashing while driving after working extended shifts (≥24 hours)  
17 was 2.3 times greater and the risk for a “near miss” crash was 5.9 times greater, compared to a  
18 non-extended shift. The estimated risk of a crash rose by 9.1 percent for every additional  
19 extended work shift hour;<sup>3</sup> and  
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21 Whereas, Forty-one percent (41%) of physicians report falling asleep at the wheel after a night  
22 shift;<sup>6</sup> and  
23

24 Whereas, A simulation study demonstrated that being awake for 18 hours, which is common for  
25 physicians working a swing shift (i.e., from 6 p.m. to 2 a.m.), produced an impairment equal to a  
26 blood alcohol concentration (BAC) of 0.05 and rose to equal 0.10 after 24 hours without  
27 sleep;<sup>7</sup> and  
28

29 Whereas, Driving simulator studies show driving home from the night shift is associated with two  
30 to eight times the incidents of off track veering, decreased time to first accident, increased eye  
31 closure duration, and increased subjective sleepiness. Night-shift work increases driver  
32 drowsiness, degrading driving performance and increasing the risk of near-crash drive  
33 events;<sup>8</sup> and  
34

35 Whereas, Actual driving studies post-night shift versus post-sleep night showed eleven near-  
36 crashes occurred in 6 of 16 post night-shift drives (37.5 percent), and 7 of 16 post night-shift  
37 drives (43.8 percent) were terminated early for safety reasons, compared with zero near-  
38 crashes or early drive terminations during 16 post-sleep drives;<sup>9</sup> and

1 Whereas, Institutional support for self-care and fatigue mitigation can help protect physician  
2 well-being and model appropriate behaviors for physicians in training; therefore be it  
3

4 RESOLVED, That our American Medical Association advocate for legislation and policies that  
5 support fatigue mitigation programs, which include, but are not limited to, a quiet place to rest or  
6 funding for alternative transport and return to work for vehicle recovery at a later time for all  
7 medical staff who feel unsafe driving due to fatigue after working overnight or extended shifts.  
8 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 09/30/20

References:

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3. Barger LK, Cade BE, Ayas NT, Cronin JW, Rosner B, Speizer FE, et al. Extended work shifts and the risk of motor vehicle crashes among interns. *N Engl J Med*. 2005;352(2):125–34.
4. Frank, E, Biola, H, Burnett, CA. Mortality rates and causes among U.S. physicians. *Am J Prev Med* 2000; 19: 155–9.
5. Booker LA, Magee M, Rajaratnam SMW, Sletten TL, Howard ME. Individual vulnerability to insomnia, excessive sleepiness and shift work disorder amongst healthcare shift workers. A systematic review. *Sleep Med Rev*. 2018;41:220–33. <https://www.bbc.com/news/uk-england-suffolk-36767868>
6. Williamson AM, Feyer AM. Moderate sleep deprivation produces impairments in cognitive and motor performance equivalent to legally prescribed levels of alcohol intoxication. *Occup Environ Med*. 2000;57(10):649–655. doi:10.1136/oem.57.10.649.
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## RELEVANT AMA POLICY

### Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
  - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
  - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
  - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
  - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:

- a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
- b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
- c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
- d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.

7. Our AMA supports the following statements related to clinical and educational work hours:

- a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
- b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
- c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
- f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
- g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
- h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
- i) Scheduled time providing patient care services of limited or no educational value should be minimized.
- j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
- k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
- l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
- m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18

### **Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958**

Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups.

(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.

(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.

(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.

(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.

(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.

(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.

(8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.

(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19