

## Resident Duty Hours

An article in the January issue of the *Journal of the American College of Radiology* (2010;7:56–60) outlines the current status of Accreditation Council for Graduate Medical Education (ACGME) requirements for residency duty hour limits, an Institute of Medicine (IOM) report recommending additional duty hour restrictions and other actions to reduce residency fatigue, and the general response to these requirements and recommendations from the diagnostic imaging community.

In 2003, the ACGME set duty hour limits across all medical specialties nationally to promote safe patient care and resident well-being. “Compliance with the current ACGME duty hour requirements is assessed by an anonymous annual resident survey in addition to periodic site visits,” said Martha B. Mainiero, MD, lead author of the article. “When a survey indicates that a significant number of residents work beyond duty hour limits, the ACGME will perform an immediate site visit of the program as well as a focused review of the institution.” Data from resident surveys since the institution of the common duty hour requirements suggest that each year fewer residents report working beyond duty hour limits.

The new IOM recommendations focus more on reducing fatigue-related errors by assuring that residents get regular opportunities for sleep each day than by reducing the maximum weekly work hours. The current ACGME duty hour requirements state that residents must not work more than 80 h/wk averaged over 4 wk and must be provided 1 in 7 d free from all educational and clinical responsibilities, averaged over 4 wk. “The radiology community supports the current ACGME requirements but recognizes that there has been inadequate study of the outcomes of the current duty hour regulations and that there continue to be issues with compliance with those regulations. Therefore,

we feel these issues should be addressed with more rigorous monitoring of duty hours before implementing new duty hour requirements,” said Mainiero. “The ACGME is currently reviewing the IOM’s recommendations but will have little choice but to take further action in this area.”

*Journal of the American College of Radiology*

## AAPM Statement on Radiation Dose

A panel of experts at the American Association of Physicists in Medicine (AAPM) issued a statement on December 21 calling for an open discussion of the facts about radiation hazards from CT scanning after a series of alarming news reports and published medical studies about radiation dose. The AAPM statement warned of “several misleading statements made with respect to radiation hazards from CT scanning” after a recent U.S. Food and Drug Administration (FDA) alert, as well as 2 articles in a leading medical journal, called public attention to the safety of CT scans. The Science Council and Executive Committee of the AAPM issued the statement “out of concern that incomplete or incorrect information may lead some people to forgo necessary scans.”

In November the FDA issued an alert after 206 people undergoing diagnosis and treatment of stroke were exposed to high doses of radiation at a hospital in southern California. Similar incidents have since been identified at other hospitals, including 2 additional ones in southern California. The AAPM statement noted: “There is no excuse for such radiation overexposures. Improved training as well as new machine interface features may be needed to prevent future occurrences.” The statement made a clear distinction between these types of overexposures, resulting from misapplication of technology, and those related to potential cumulative negative effects from routine medical imaging, as outlined

in December in the *Archives of Internal Medicine*. These articles projected, based on a number of assumptions, that the use of diagnostic CT in 2007 alone (the most recent year for which data were available) could lead to thousands of future deaths from cancer in the United States. The AAPM took issue with the assumptions used to calculate these risks. It also noted the difficulty in determining whether radiation or some other factor causes any instance of cancer, contrasting this speculative data with that from less equivocal and ambiguous events, such as fatalities in automobile accidents.

“Because radiation-induced cancers present the same clinically as normally occurring cancers, there is no way to know who died from a radiation-induced cancer and who died from a naturally occurring cancer,” the statement read. “This issue is compounded by the fact that the number of theoretically predicted radiation-induced cancers is tiny compared to the very large cancer incidence rate in humans (~25%–30%), making the impact of radiation on cancer rate very hard to measure.”

The statement recognized the need for conservative imaging and provided a list of recommendations for practitioners and patients. AAPM also announced plans to host an interdisciplinary CT Dose Summit on April 29 and 30 to provide education to the imaging community. More details will be available in the coming months at [www.aapm.org](http://www.aapm.org). The full statement is available at: [www.aapm.org/publicgeneral/CTDoseResponse.asp](http://www.aapm.org/publicgeneral/CTDoseResponse.asp).

*American Association of Physicists in Medicine*

## NCRP: Radiation Benefits and Risks in Decision Making

The focus of this year’s National Council on Radiation Protection and

Measurements (NCRP) annual meeting, to be held in Bethesda, MD, March 8 and 9, will be effective communication about the benefits and risks of radiation. Topics to be featured at the meeting include: (1) concepts and examples of effective risk communication today and in historical perspective; (2) the role of new tools and media as efficient vehicles for radiation risk communication; (3) communication issues and challenges posed by potential acts of nuclear and radiological terrorism and radiation emergencies; (4) communicating benefits and risks of medical applications of radiation for the diagnosis and treatment of disease; and (5) mechanisms and examples of effective communications in decision making related to protection of human health and the environment. Central to the theme of the meeting will be the engagement of relevant stakeholders in the process of reaching decisions involving radiation protection, which is essential for achieving sustainability of decisions.

The meeting will also feature the seventh annual Warren K. Sinclair Keynote Address, by Vincent Covello, PhD, on “Effective Risk Communication Before, During, and After a Radiological Emergency: Challenges, Guidelines, Strategies, and Tools.” The 34th annual Lauriston S. Taylor Lecture will be presented by Charles Land, PhD, on “Radiation Protection in an Uncertain World.”

The final program for the meeting will be posted at <http://NCRPonline.org>. No fee will be charged for registration. For additional information

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*National Council on Radiation Protection and Measurements*

### Short-Term SGR Fix in Place

On December 23, 2009, President Obama signed a defense spending bill that would freeze the Sustainable Growth Rate (SGR) conversion factor—for 2 mo—at the 2009 rate for physicians, which will avoid a 21% pay cut facing doctors in 2010. At the same time, the Centers for Medicare & Medicaid Services (CMS) issued updated information about holding of claims for services paid under the 2010 Medicare Physician Fee Schedule (MPFS). CMS instructed its contractors to hold claims for services paid under the MPFS for up to the first 10 business days of January (January 1 through January 15) for 2010 dates of service. According to a CMS statement, the holding of claims would allow Medicare contractors time to receive the new, updated payment files and perform necessary testing before paying claims at the new rates. CMS instructed contractors to begin processing claims at the new rates no later than January 19.

Although the freeze was welcomed by medical professional societies, many observers called for more attention to long-term solutions to address this perennial problem. “We urge Congress to take action now to implement a long-term formula that adequately addresses the level of demand—and actual cost—of providing these ser-

vices,” said Michael M. Graham, PhD, MD, president of SNM. “This is a critical issue facing the medical community, and we need to continue to work together to protect the patients we serve.”

On December 16, the U.S. House of Representatives passed H.R. 3326, which delayed cuts to physician reimbursement rates that would affect nearly one-third of the American public eligible for coverage through Medicare or Medicaid, if implemented. The Senate approved the measure on December 19. Significant cuts in the reimbursement rates for physicians will be postponed until March 1. In the short-term, the fix to the SGR will protect cuts to medical care. If a long-term fix is not approved, Medicare funding could be cut by more than 21% next year.

“At this time, the term ‘SGR fix’ is really a misnomer,” said Graham. “A 2-mo patch is not a resolution to an ongoing issue that has been affecting patients and the medical community. While this is a good temporary measure, we hope that the Senate will take swift action to establish a permanent solution.” After the temporary fix expires, physicians would once again face severe cuts in the level of reimbursement they receive for caring for Medicare patients. Previously, Congress has failed to approve a permanent fix to the SGR, instead passing a series of 1-y patches to prevent proposed cuts.

*Centers for Medicare & Medicaid Services  
SNM*