Hospital Extended Shifts: A Patient Safety Crisis

Opinion by Bill Smith © all rights reserved. January 2025

After experiencing a devastating personal loss due to a preventable medical error, my journey to improve healthcare safety began. This experience led me to develop an innovative approach that combines legal requirements, patient rights, and healthcare worker safety in a groundbreaking way. With over 250,000 lives lost annually to preventable medical errors [Source: BMJ Medicine, 2024], this initiative offers an immediate path to saving lives starting today.

The Core Issue: Hospitals traditionally implement 12+ hour shifts, primarily for financial reasons, despite clear research showing:

- 25-30% decline in cognitive function by hour 8 [Source: Lockley, S.W., et al. "Effects of Health Care Provider Work Hours and Sleep Deprivation on Safety and Performance" Joint Commission Journal on Patient Safety, 2024]
- 40-50% decline during hours 10-12 [Source: Rogers, A.E., et al. "The Working Hours Of Hospital Staff Nurses And Patient Safety" Health Affairs, 2024]
- 300% increase in medical errors after 12.5 hours [Source: Journal of Occupational Health, 2024]

Supporting Research - Recent studies confirm the dangers:

- Medication errors increase by 250% after 8 hours [Source: American Journal of Critical Care, 2024]
- Decision-making capability decreases by 35% during extended shifts [Source: BMJ Quality & Safety, 2024]
- Patient mortality increases by 6% for every hour after 8-hour shifts [Source: JAMA Internal Medicine, 2024]

Legal Framework: Similar to tobacco warning requirements [Philip Morris USA v. Williams, 549 U.S. 346 (2007)], hospitals should be required to disclose known risks to patients. Current practice violates informed consent principles by:

- Failing to warn of documented risks
- Creating known dangerous conditions
- Prioritizing profits over patient safety
- Showing deliberate indifference to patient safety

The pages that follow reveal, in clear and accessible language, a compelling path toward eliminating preventable medical errors. This straightforward solution offers immediate impact because every life saved matters. As the father of a son who lost his life at just 20 years old due to medical error, I am passionate about preventing other families from experiencing this devastating, lifelong grief. The evidence is compelling, the implementation is practical, and the opportunity to save lives begins now.

I invite you to explore these next pages and join me in this vital mission to transform patient safety. Your engagement could help ensure no other parent has to endure what our family has experienced.

Hospital Extended Shifts: A Patient Safety Crisis

I am an advocate for improved healthcare following the tragic loss of my son, Zander, to medical malpractice. Through Zander's memorial website, I provide valuable information to help others navigate the complex healthcare while honoring his memory.

A recent analysis led me to explore a novel legal approach regarding hospital liability for extended shifts and patient safety. This concept could revolutionize healthcare safety standards through a simple yet powerful change: mandatory informed consent about the known risks of extended shifts.

The Hidden Danger

Hospitals traditionally implement 12+ hour shifts, primarily for financial reasons, despite clear research showing:

- 25-30% decline in cognitive function by hour 8 [Source: Lockley, S.W., et al. "Effects of Health Care Provider Work Hours and Sleep Deprivation on Safety and Performance" *Joint Commission Journal on Patient Safety*, 2024]
- 40-50% decline during hours 10-12 [Source: Rogers, A.E., et al. "The Working Hours Of Hospital Staff Nurses And Patient Safety" *Health Affairs*, 2024]
- 300% increase in medical errors after 12.5 hours [Source: Journal of Occupational Health, 2024]

Supporting Research

Recent studies confirm the dangers:

- Medication errors increase by 250% after 8 hours [Source: American Journal of Critical Care, 2024]
- Decision-making capability decreases by 35% during extended shifts [Source: BMJ Quality & Safety, 2024]
- Patient mortality increases by 6% for every hour after 8-hour shifts [Source: JAMA Internal Medicine, 2024]

A Call for Change

The degraded performance caused by long work shifts has no place in hospitals. Even one error is too many and often leads to death or permanent harm. While "preventable errors" has become a catchphrase, here's an opportunity for meaningful change through two simple steps: raising awareness and empowering patients with information.

Proposed Warning Requirement

⚠ **PATIENT SAFETY NOTICE**

You are receiving care during an extended shift period.
Research shows:
Healthcare worker performance declines up to 50% after 8 hours
Error rates increase significantly during extended shifts
Decision-making capability is measurably impaired
(For details click: AT A GLANCE)

As a patient, you have the right to:
1. Know your provider's shift duration
2. Request care during early shift hours
3. Delay non-emergency procedures until next shift·

Please contact the on duty Hospital Administrator if you wish to make a change according to this notice.

Take Action Now

Your support can help make healthcare safer for everyone. Here's how you can help:

1. **Stay Informed**

- Join our mailing list for updates on this initiative [mailto:Admin@YesGFA.org/Mail_list]
- Follow our progress as we work to implement these safety measures
- Learn about hospitals adopting these warnings

2. **Spread Awareness**

- Share this article with friends and family
- Discuss these safety concerns with your healthcare providers
- Post about this initiative on social media using #ZandersLaw

3. **Make Your Voice Heard**

- Ask your local hospitals about their shift policies
- Request this warning during admission procedures
- Support hospitals that prioritize patient safety
- Send us feedback about hospitals' responses
- Share your own healthcare safety stories

Sample Email to Your Local Hospital:

> **Subject: Patient Safety - Extended Shift Warning Implementation**
>
> **Dear [Hospital Administrator],**
>
> **As a concerned community member, I'm writing to inquire about your hospital's policies regarding extended shifts and patient safety warnings. Research shows significant increases in medical errors during extended shifts. Would your facility consider implementing patient safety warnings about these known risks?**
>
> **I look forward to your response regarding this important patient safety initiative.**
>
> **Best regards,**
> **[Your name]**

4. **Join the Broader Patient Safety Movement** As a Champion Member of **Patients For Patient Safety (PFPS-US)**, the US action arm of The **World Health Organization** (WHO), I've witnessed their significant contributions to patient safety. PFPS-US continues to make important progress in healthcare safety across the US and globally. I encourage you to join and support their efforts, including participation in events like Patient Safety Day in Washington, DC, which honors those who have lost their lives to medical errors. Your involvement in their various healthcare improvement projects would be invaluable.

Together, we can create meaningful change in healthcare safety while honoring Zander's memory. Send us an email to stay updated on our progress and learn how you can contribute to this important cause.

Please read Zander's Justice

AT A GLANCE

NURSING ERRORS DURING EXTENDED SHIFTS

1. **Cognitive Function Decline**

- Baseline (first 4 hours): Normal cognitive function
- Hours 4-6: 10-15% decline
- By hour 8: 25-30% decline
- Hours 10-12: 40-50% decline

- After 12.5 hours: 300% increase in errors [Source: Journal of Occupational Health, "Cognitive Performance Curves in Healthcare Settings" 2024]

2. **Documentation Errors**

- Baseline: 1% error rate in manual data entry
- After 8 hours: 2.5% error rate (150% increase)
- Types: Missing information, incorrect data entry, wrong patient records [Source: Journal of Healthcare Quality, 2024]

3. **Medication Administration**

- Baseline: 2.3 errors per 1000 doses
- After 8 hours: 5.75 errors per 1000 doses (250% increase)
- Types: Wrong dose, wrong timing, wrong patient [Source: American Journal of Critical Care, 2024]

4. **Clinical Decision Making**

- Baseline: 95% accuracy rate
- After 8 hours: Decreases by 35%
- Types: Delayed responses, incorrect prioritization, missed protocols [Source: BMJ Quality & Safety, 2024]

5. **Clinical Assessment Errors**

- 40% slower response times to patient deterioration
- 55% increase in missed vital sign changes
- 70% increase in delayed interventions [Source: Journal of Patient Safety, 2024]

PHYSICIAN ERRORS DURING EXTENDED SHIFTS

1. **Cognitive Function Decline**

- Baseline (first 4 hours): Normal cognitive function
- Hours 4-6: 15-20% decline
- By hour 8: 30-35% decline
- Hours 10-12: 45-55% decline
- After 12.5 hours: 300% increase in errors [Source: New England Journal of Medicine, "Physician Performance During Extended Shifts," 2024]

2. **Diagnostic Errors**

- Baseline: 4% error rate in first 8 hours
- After 8 hours: 12% error rate (200% increase)
- Types: Missed diagnoses, delayed diagnoses, incorrect interpretations [Source: JAMA Internal Medicine, "Diagnostic Accuracy in Extended Shifts," 2024]

3. **Procedural Errors**

- Baseline: 1.2 errors per 100 procedures
- After 8 hours: 3.6 errors per 100 procedures (200% increase)
- Types: Technical errors, wrong-site procedures, equipment misuse [Source: Journal of Surgery, "Impact of Fatigue on Surgical Performance," 2024]

4. **Clinical Decision Making**

- Baseline: 97% accuracy rate
- After 8 hours: Decreases by 35%
- Types: Treatment plan errors, medication ordering errors, test interpretation errors [Source: BMJ Quality & Safety, 2024]

5. **Critical Thinking/Judgment**

- 45% increase in risk assessment errors
- 60% increase in complex decision-making errors
- 75% increase in emergency response errors [Source: Journal of Patient Safety, "Physician Cognitive Performance," 2024]

Note 1: The Joint Commission Journal on Patient Safety (2024) reports approximately 5**0% of medical errors go unreported,** suggesting actual error rates may be significantly higher.

Note 2: Patient **mortality increases by 6% for every hour after 8-hour** shifts [Source: JAMA Internal Medicine, 2024]

BE INFORMED – STUDIES, AND CITED DATA

Do most hospitals in America operate on 12 hour work schedules?

In most hospitals in the United States, **12-hour work shifts** are quite common, especially in certain departments such as **emergency rooms**, **intensive care units (ICUs)**, and **surgical teams**. However, this can vary depending on the hospital, its policies, and the specific department or role. Here's a breakdown of how this scheduling works in various hospital settings:

Common Use of 12-Hour Shifts:

- **Nurses**: Many hospitals offer **12-hour shifts** for nurses, with shifts typically running either **7 AM to 7 PM** or **7 PM to 7 AM**. This allows nurses to have more days off, typically working **3-4 days a week**, but it can be exhausting due to the long hours.
- **Emergency Room (ER)**: In busy ERs, 12-hour shifts for doctors, nurses, and staff are common to ensure continuous coverage without overburdening individuals with too many hours on a single shift.
- **Intensive Care Units (ICU)**: Critical care units often rely on 12-hour shifts for physicians and nursing staff to maintain high levels of care and ensure that staff are well-rested between shifts.

- **Surgical Teams**: In some settings, surgical teams might also work 12-hour shifts, especially for highly complex or scheduled surgeries, although this can depend on the type of surgery and the hospital's scheduling preferences.

Reasons for 12-Hour Shifts:

- **Continuity of Care**: Longer shifts can offer continuity in patient care, reducing the number of handoffs between staff.
- **Reduced Days Worked**: Healthcare providers who work 12-hour shifts typically work fewer days in a week, which can improve work-life balance.
- **Cost Efficiency**: Hospitals may find it more cost-effective to have fewer shift changes and maintain continuous coverage by having staff work longer hours.

Alternatives to 12-Hour Shifts:

Not all hospitals adopt the 12-hour shift model. Some hospitals prefer shorter shifts, such as:

2. **8-hour shifts**: This is more common in certain departments like outpatient services, clinics, and administrative areas.
3. **Flexible schedules**: Some hospitals also offer flexible or part-time schedules to accommodate staff needs.

Challenges of 12-Hour Shifts:

- **Fatigue**: Long shifts can contribute to physical and mental fatigue, which might increase the risk of errors, especially in high-stakes environments like surgery or ICU care.
- **Staffing Shortages**: Hospitals may face challenges in maintaining appropriate staffing levels, which can impact the ability to sustain long shifts.

Conclusion:

While **12-hour work schedules** are common in many U.S. hospitals, especially in high-demand areas such as the ER, ICU, and surgical teams, there are also hospitals that operate on shorter shifts (like 8-hour shifts). The adoption of 12-hour shifts depends on the hospital's needs, the department, and overall staffing policies.

Issues

The issue of **12-hour hospital shifts** and their potential impact on the **quality of care** has been the subject of several studies, and opinions are mixed. While some evidence suggests that longer shifts can have benefits in terms of continuity of care and cost efficiency, there is also substantial research indicating that these long hours may detrimentally affect both **healthcare worker performance** and **patient outcomes**.

Negative Impacts of 12-Hour Shifts on Healthcare Quality:

3. **Fatigue and Performance Degradation:** A significant concern with 12-hour shifts is the **fatigue** that workers experience, particularly during the latter part of the shift. Studies have shown that fatigue can lead to:

1. **Increased errors**: Fatigue has been linked to **increased cognitive impairment**, reduced attention, slower reaction times, and higher likelihood of making mistakes. In healthcare, this translates to **medication errors**, **surgical mistakes**, and **missed diagnoses**, all of which directly impact patient safety.
2. **Decreased vigilance**: Research has shown that healthcare workers' ability to remain vigilant declines over time during long shifts, which is especially dangerous in **ICU settings** or **emergency rooms**, where quick decision-making is critical.

A study published in the **Journal of the American Medical Association (JAMA)** (2014) found that residents working extended shifts (including 12-hour shifts or longer) were more prone to making mistakes compared to those on shorter shifts. The **longer the shift**, the higher the risk of **patient safety incidents**.

4. **Diminished Decision-Making and Clinical Judgment:** Another concern is that **decision-making** quality deteriorates as shifts progress. When healthcare professionals are fatigued, they might struggle to make accurate clinical judgments. This can lead to:

    1. **Delayed treatments or interventions**: Fatigued staff may be more likely to overlook key signs or symptoms, leading to delayed interventions.
    2. **Suboptimal communication**: As workers become more tired, communication between staff members can suffer, potentially leading to **misunderstandings** and **poor handoffs** during shift changes, further compromising patient care.

A 2019 review in the **British Medical Journal (BMJ)** noted that prolonged working hours could cause **impaired memory and decision-making** among healthcare providers, increasing the likelihood of medical errors and resulting in poorer patient outcomes.

5. **Impact on Health Worker Well-Being:** 12-hour shifts can also take a toll on the **well-being** of healthcare workers themselves:

    1. **Physical and mental health consequences**: Prolonged shifts can lead to burnout, **mental health issues** (such as depression and anxiety), and physical health problems (such as cardiovascular issues). These health issues can contribute to more frequent sick days, decreased job satisfaction, and even higher turnover rates, all of which impact patient care indirectly.
    2. **Sleep deprivation**: Continuous 12-hour shifts, particularly when combined with night shifts, can lead to chronic **sleep deprivation**, which has been shown to impair both cognitive function and mood, further worsening performance during shifts.

Studies on healthcare workers have repeatedly demonstrated that long shifts are linked to **increased fatigue** and **stress**, both of which compromise performance and overall job satisfaction.

Benefits or Arguments in Favor of 12-Hour Shifts:

While the negative impacts are well-documented, there are also studies that suggest potential benefits to 12-hour shifts. Some of the arguments in favor of extended shifts include:

- **Improved Continuity of Care:** 12-hour shifts allow healthcare workers, particularly **nurses** and **surgeons**, to follow patients throughout the entire course of their care, ensuring that there is

less disruption between staff changes. This **continuity** can lead to better communication and smoother transitions, reducing the risk of **errors during shift handoffs**.

A study published in **Nursing Economics (2016)** found that longer shifts can help reduce the **number of shift changes** and ensure a more cohesive approach to patient care. For example, patients in critical care settings may benefit from having the same nurse for a longer period of time, reducing the likelihood of being handed off to a new nurse who may not be fully aware of their specific needs.

- **Work-Life Balance:** For many healthcare workers, especially in hospitals with 24/7 operations, the **schedule flexibility** of 12-hour shifts can provide more **days off**. This can lead to better **work-life balance** and decreased burnout in the long term, as workers are not subjected to the daily grind of shorter shifts. For some, working longer hours in fewer days can help manage family and personal commitments.
- **Cost-Effectiveness for Hospitals:** From a **hospital's perspective**, 12-hour shifts may help reduce labor costs by having fewer shift changes and requiring fewer staff to cover the same number of hours. This can be particularly important in **high-demand specialties** like ICU care or emergency medicine, where continuous staffing is critical.

A study published in the **American Journal of Infection Control (2017)** showed that **cost-efficiency** was one of the main reasons why 12-hour shifts are popular in many hospitals, despite the health risks involved.

Conclusion and Opinion:

While **12-hour shifts** may offer certain benefits, such as improved **continuity of care** and **cost efficiency**, the **negative impact on quality of care**—particularly with regard to **fatigue**, **errors**, and **staff well-being**—cannot be ignored. **Fatigue-related errors** are a real concern, especially in high-risk environments like the **ICU** or **emergency departments**, where quick decision-making is crucial.

Healthcare quality should always be prioritized over cost savings or convenience. Given the evidence linking fatigue to poorer outcomes, hospitals should reassess their reliance on 12-hour shifts and consider implementing measures to mitigate their risks. These could include:

4. Reducing the number of consecutive 12-hour shifts.
5. **Incorporating mandatory rest periods** for staff.
6. Providing **more comprehensive shift rotations** to minimize exhaustion.
7. Ensuring that **staffing levels** are sufficient to handle patient needs without overburdening workers.

In conclusion, while 12-hour shifts might be more convenient for some workers and offer certain operational advantages, the **detrimental effects on both patient safety and healthcare workers** must be carefully considered. Hospitals should strive for a balance that ensures optimal patient care while also supporting the health and well-being of their staff.

Weighted Measurements

While there is considerable research on the impact of **12-hour shifts** versus **8-hour shifts** on various aspects of healthcare, there are very few studies that directly assign a specific **weight** to each attribute

(like fatigue, errors, staffing levels, and continuity of care) in relation to **patient outcomes**. However, many studies provide **qualitative insights** or **quantitative data** that can indirectly inform us about the relative importance of these factors. Below are some of the key attributes and how they have been studied in relation to **12-hour shifts**, along with the potential impact on **patient outcomes**:

1. Fatigue and Cognitive Performance

- **Studies and Findings**: Fatigue is one of the most frequently cited negative consequences of extended shifts. A study in **JAMA Surgery (2015)** found that surgical residents working longer shifts showed a higher likelihood of **cognitive errors**, particularly during the later hours of a shift. Fatigue can impair **attention, decision-making**, and **reaction times**, all of which directly affect patient safety and outcomes. The **American College of Surgeons** has cited fatigue as a critical factor in **preventable medical errors**.
- **Weight on Patient Outcomes**: Fatigue-related errors (e.g., medication mistakes, missed diagnoses) are likely one of the most important factors affecting patient outcomes, particularly during **12-hour shifts**. A study in **BMJ Quality & Safety (2016)** attributed **fatigue** as a major cause of **adverse events** and noted that fatigued workers tend to exhibit a higher **rate of medical errors**, directly affecting patient outcomes.
- **Relative Weight**: Based on the studies, fatigue likely plays a **high-impact role** in the context of **12-hour shifts**, especially in high-stakes environments (e.g., surgery, ICU). The cognitive decline toward the end of a 12-hour shift increases the risk of errors, making fatigue an attribute that weighs heavily on **patient outcomes**.

2. Clinical Judgment and Decision-Making

5. **Studies and Findings**: A study published in the **Journal of Patient Safety (2015)** found that longer shifts were correlated with **poorer clinical judgment**, especially in the **critical decision-making moments** during treatment. The research suggested that longer shifts negatively impacted the **ability to make timely and accurate decisions**, which could delay treatment and result in worse outcomes for patients.
6. **Weight on Patient Outcomes**: The ability to make quick, informed decisions is crucial for **patient safety**, especially in fast-paced areas like the **ER** or **surgery**. The deterioration of clinical judgment can significantly affect patient care, making it a major factor in **patient outcomes** when working extended shifts. **12-hour shifts** contribute to **decision fatigue**, which can make healthcare workers more prone to **oversights** or delayed interventions.
7. **Relative Weight**: Like fatigue, **clinical judgment** and decision-making are highly significant. In the context of **patient outcomes**, this factor could be considered as a **high-impact** attribute when comparing **12-hour** and **8-hour shifts**.

3. Staffing Levels and Team Coordination

Studies and Findings: Longer shifts can help **ensure continuity** of care, particularly in **ICU settings**, where complex patient needs require sustained attention. However, there is evidence from studies like those in **Critical Care Medicine (2017)** showing that **inadequate staffing levels** and the **fatigue** of long shifts can lead to issues with **team coordination**, particularly toward the end of the shift, which could **compromise patient care**.

Weight on Patient Outcomes: Adequate staffing levels are essential to prevent **staff burnout** and ensure effective **teamwork**. Poor coordination due to fatigue or understaffing can result in miscommunication, which is a major cause of medical errors and **delayed treatments**. Hospitals with **better staffing ratios** and **rotation schedules** (to avoid fatigue) likely see better patient outcomes, suggesting that staffing levels and team dynamics weigh heavily on the quality of care.

Relative Weight: While **staffing** is a key factor, **team coordination** may be slightly less impactful than **fatigue** in terms of directly affecting **individual clinical decisions**. Still, in high-pressure environments like surgery or ICU care, its impact is **substantial**.

4. Infection Control and Clinical Safety

- **Studies and Findings**: There is also research focused on how longer shifts may impact the risk of **surgical site infections** or other **infections** in hospitalized patients. For instance, a study in the **Journal of the American Medical Association (JAMA, 2016)** suggested that surgical teams working extended shifts may show a slight increase in the **rate of infections**. The fatigue and mental strain involved in longer shifts could affect the **attention to sterility protocols** and the **efficiency of infection control procedures**.
- **Weight on Patient Outcomes**: **Infection control** is paramount in determining surgical outcomes and preventing complications. Long shifts can lead to lapses in adherence to **sterility protocols** and **infection prevention measures**, resulting in increased patient morbidity. While infection rates are generally low in well-staffed and well-monitored hospital settings, extended shifts can slightly increase infection risk.
- **Relative Weight**: **Infection control** is a high-stakes factor for patient outcomes, and fatigue-related lapses in protocol adherence can be quite impactful. However, infection risk is somewhat less frequent than other outcomes like decision-making errors, making it a **moderate** but **important factor**.

5. Physical and Mental Health of Healthcare Workers

- **Studies and Findings**: A study in **Nursing Outlook (2019)** found that prolonged 12-hour shifts led to higher levels of **burnout** and **physical health problems** (like back pain, sleep disturbances, and increased stress). The negative health impacts on healthcare workers can affect their performance and, consequently, patient care. Healthcare workers suffering from **burnout** are more likely to make errors, miss important clinical signs, and experience a general decline in their ability to provide high-quality care.
- **Weight on Patient Outcomes**: The mental and physical health of healthcare workers directly affects their **attentiveness**, **work capacity**, and **decision-making ability**, all of which are integral to **patient safety** and **care quality**. **Burnout** and **stress** have been shown to increase the likelihood of errors, which in turn can lead to **patient harm**.
- **Relative Weight**: While the physical and mental health of workers is important, **fatigue** and its direct impact on **clinical performance** tend to have a more **immediate and measurable effect** on patient outcomes.

Conclusion: Relative Weights of Each Attribute

While it's difficult to assign a precise numerical weight to each of these factors without specific studies that directly compare the impact of each on **patient outcomes**, we can approximate the relative significance based on existing research:

1. **Fatigue (High Impact)**: Fatigue is arguably the most significant factor in determining patient outcomes, particularly for errors related to cognitive performance and decision-making.
2. **Clinical Judgment (High Impact)**: As decision-making is crucial for timely, appropriate interventions, fatigue-induced degradation in clinical judgment is a critical issue.
3. **Team Coordination and Staffing (Moderate to High Impact)**: Effective teamwork and adequate staffing are essential for reducing errors, but their impact is often secondary to individual cognitive errors arising from fatigue.
4. **Infection Control (Moderate Impact)**: Lapses in sterility and infection control protocols due to fatigue can lead to complications, but the overall risk of infection remains relatively low in well-managed settings.
5. **Healthcare Worker Health (Moderate Impact)**: The physical and mental health of healthcare workers is crucial for long-term performance, but its immediate impact on patient care is often overshadowed by more immediate issues like fatigue and clinical errors.

In summary, **fatigue** and **clinical judgment** are likely the **highest-weighted factors** affecting **patient outcomes** in the context of **12-hour shifts**, with **staffing levels** and **infection control** following as important but somewhat secondary considerations.

Known, or should be know in the Healthcare environments.

1. Is the Negative Impact of 12-Hour Shifts on Patient Outcomes Common Knowledge in Healthcare?

The **negative effects of 12-hour shifts** on healthcare workers' **fatigue**, **clinical judgment**, and **performance** are widely acknowledged within **academic circles** and among **medical professionals**, particularly those working in critical care settings like **surgery, emergency rooms (ER), and intensive care units (ICUs)**. Numerous studies have highlighted the increased risk of **errors**, **mistakes**, and **poor decision-making** associated with extended shifts. However, there are a few reasons why this awareness might not yet translate into **uniform policy changes** across the healthcare industry:

- **Resistance to Change**: Some **hospital systems**, especially those that are **overburdened** or face **staffing shortages**, might resist changing shift patterns due to concerns about **costs** and **operational efficiency**. Healthcare administrators may prioritize **continuity of care** (e.g., minimizing handoffs between staff) and **financial savings** over the well-documented risks of **fatigue**.
- **Varied Priorities**: While there is a growing body of evidence linking fatigue to poorer **patient outcomes**, hospital priorities can differ. In some hospitals, particularly in regions with limited healthcare resources, **staffing shortages** or a **lack of funding** may push administrators to

extend shifts or adopt practices that allow for fewer staff members to work longer hours. Additionally, healthcare workers may be inclined to accept long shifts as a way to balance work-life commitments or maximize income (especially for nurses).

- **Limited Enforcement of Evidence-Based Policy**: While studies and clinical research show that **fatigue impacts performance**, policies to restrict shift lengths or mandate more rest periods are often **voluntary guidelines** or **institution-specific decisions**. Some hospitals do not implement strict regulations or shift caps, leaving workers exposed to the potential risks of **long hours**.

So, while **evidence is widely available**, it has not necessarily reached a **unified consensus** on the issue at a policy level, nor has it led to universal changes in **practice** across all hospitals.

---

2. Is There Data Indicating that Financial, Staffing, and Convenience Concerns Trump Patient Safety?

There is **ample data** suggesting that financial considerations, staffing shortages, and operational convenience often **override patient safety concerns** in healthcare settings, particularly when it comes to shift schedules. Several factors explain why **12-hour shifts** continue to be a common practice, despite the evidence of their negative impact on **patient safety**:

Financial Considerations:

- **Cost Efficiency**: Hospitals, especially those operating with tight budgets, may prefer **12-hour shifts** because they reduce the number of **shift changes**, **staffing needs**, and overall administrative costs. With fewer shifts, hospitals can reduce the **number of staff** needed to provide coverage, thus **saving money** on labor costs. In many hospital settings, there is a **strong financial incentive** to minimize labor expenses, even if this comes at the expense of **patient outcomes**.

- **Financial Pressure on Healthcare Systems**: Many healthcare organizations face **financial strain**, particularly with rising healthcare costs and **limited funding**. As a result, hospitals often implement **cost-saving measures** like 12-hour shifts, even though these shifts may have a **negative impact** on staff performance and **patient safety**. According to a **2017 study** published in **Health Affairs**, hospitals face growing pressure to cut costs, and often **opt for convenience** (e.g., fewer staffing needs) instead of fully addressing concerns about **workplace safety** or **patient care**.

Staffing Shortages:

- **Chronic Staffing Shortages**: Healthcare organizations in many parts of the U.S. are plagued by **nursing shortages**, **physician shortages**, and other staffing gaps. In order to ensure **adequate coverage** for all shifts, many hospitals rely on **12-hour shifts** to avoid overburdening the available staff. With fewer employees, healthcare systems may be forced to extend work hours for those who are already stretched thin.

- **Shift Flexibility**: For some healthcare workers, **12-hour shifts** provide a **more flexible schedule**, allowing them to work fewer days a week. Although this can improve **work-life balance** for staff, it can also lead to **overworked employees** and potential **safety concerns**. For

example, some **nurses** and **physicians** may prefer the convenience of **fewer workdays** and larger shifts, but this does not necessarily align with best practices for **patient care**.

Convenience and Continuity of Care:

- **Fewer Hand-Offs**: One reason hospitals continue to employ **12-hour shifts** is the idea that having a staff member work a longer shift reduces the number of **shift changes** or **handoffs**, which are traditionally seen as **vulnerable moments** where errors or miscommunications can occur. This is particularly important in **ICU** and **surgical settings**, where continuity of care is emphasized.
- **Operational Ease**: The **simplification of scheduling** is another reason hospitals may choose 12-hour shifts. Staffing **12-hour shifts** for certain areas of care can make it easier to schedule, reducing administrative burden and ensuring that certain positions (e.g., **ICU nurses**) are always covered without requiring multiple overlapping shifts.

Evidence and Data:

- **A 2016 Study** published in **JAMA Surgery** found that **extended shifts** increased the likelihood of **errors**, but hospitals continued to favor longer shifts due to **cost considerations**. A **2015 report** from the **American Nurses Association (ANA)** highlighted that while **fatigue** among nurses led to more frequent errors and unsafe practices, some hospitals still relied on **12-hour shifts** due to the need to cover shifts while balancing a **limited budget** and **staffing gaps**.
- **Research on Financial Trade-Offs**: In a **2018 study** in the **Journal of Healthcare Management**, it was found that many hospitals did not alter their staffing practices despite evidence that extended shifts could harm patient care. **Cost savings** and **financial constraints** were cited as primary reasons why **12-hour shifts** continued to be standard practice. This aligns with findings from the **National Bureau of Economic Research (2017)**, which noted that financial incentives often led to the **prioritization of operational concerns over patient safety**.

Conclusion:

While there is significant evidence suggesting that **12-hour shifts negatively impact patient outcomes**, it is not yet universally accepted as **common knowledge** across the healthcare industry. Hospitals, particularly those facing **staffing shortages**, **financial constraints**, and a desire for **operational convenience**, may still prioritize **cost savings** and **staffing flexibility** over the well-documented risks associated with longer shifts. Despite this evidence, factors like **workplace convenience**, **financial pressure**, and **staffing needs** often **trump patient safety** in many healthcare settings, resulting in continued reliance on extended shifts.

In the face of these challenges, healthcare systems should focus on **balancing operational needs** with **patient safety** and adopt evidence-based policies that limit shift lengths, promote adequate rest periods, and prioritize the well-being of both healthcare workers and patients.

If you are a public representative or healthcare provider, please read the sample letter that makes my plea directly to you. I hope this sample letter will be accepted by the public and you inturn receive the public support and graditude for implementing this life saving plan.

Sample letter to your representatives and healthcare providers (suggest copy/paset from this document):

Dear [Lawmaker/Healthcare Leader],

We ask for your support in addressing a critical patient safety issue that contributes to over 250,000 preventable deaths annually in U.S. hospitals [Source: BMJ Medicine, 2024]. Our research demonstrates that implementing mandatory informed consent regarding extended healthcare shifts could immediately begin reducing these tragic losses.

Core Legal Theory - Failure to Warn and Willful Negligence

The research shows hospitals knowingly implement policies that increase risk of harm without warning patients:

Documented Risk Evidence

- *300% increase in medical errors after 12.5 hours [Source: Journal of Occupational Health, 2024]*
- *Patient mortality increases by 6% for every hour after 8-hour shifts [Source: JAMA Internal Medicine, 2024]*
- *Medication errors increase by 250% after 8 hours [Source: American Journal of Critical Care, 2024]*
- *Institutional Knowledge*
- *Joint Commission requires regular safety risk assessments*
- *Hospitals are aware of research showing increased risks*
- *Current practice violates informed consent principles*
- *Prioritizing profits over patient safety*
- *Legal Framework Similar to:*
- *Tobacco warning requirements (known risks require disclosure)*
- *Medical device warnings (informed consent standards)*
- *Surgical informed consent requirements (material risks must be disclosed)*
- *Patient Rights Violation*
- *Failure to disclose known risks*
- *Creating dangerous conditions for financial benefit*
- *Deliberate disregard for patient safety*
- *No meaningful mitigation efforts*

This approach focuses on hospitals' obligation to warn patients about documented risks, similar to how McDonald's must warn that coffee is hot. The evidence is compelling, the implementation is practical, and the opportunity to save lives begins now.

Would you join us in supporting this vital patient safety initiative?

[Your signature]
