

ACGME AND JCAHO

What is JCAHO?

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit organization. Established in 1951, JCAHO is the nation's predominant standard-setting body in health care. The 28-member Board of Commissioners that governs JCAHO brings together people with experience in health care, business, and public policy. The corporate members of JCAHO are the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), the American College of Surgeons (ACS), the American Dental Association (ADA), the American Hospital Association (AHA), and the American Medical Association (AMA).

JCAHO evaluates and accredits approximately 18,000 health care organizations and programs in the U.S. including, hospitals, HMOs, PPOs, integrated delivery networks, home care organizations, nursing homes, assisted living facilities, behavioral health care organizations, ambulatory care providers, and clinical laboratories. To obtain and maintain accreditation, an on-site survey by a JCAHO team must be conducted at least every three years. An organization's performance level is measured in key functional areas that affect the safety and quality of patient care, focusing not on what the organization can do, but what it does.

The JCAHO accreditation process seeks to support and enhance safety and quality improvement efforts that lead to improved patient care. By successfully undergoing an accreditation survey, an organization demonstrates its commitment to these areas. Furthermore, JCAHO accreditation may substitute for federal certification survey for Medicare and Medicaid and fulfill licensure requirements in many states.

What is the ACGME?

The Accreditation Council for Graduate Medical Education (ACGME) is a private association formed by five member organizations with four representatives each: the American Board of Medical Specialties (ABMS), the American Hospital Association (AHA), the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), and the Council of Medical Specialty Societies (CMSS). Each member organization also selects two public members. The Resident Physician Section of the AMA selects a resident representative and the Secretary of the U.S. Department of Health and Human Services selects a federal government representative. The Chair of the Residency Review Committee Council, an advisory body of the ACGME, serves as its representative.

The ACGME is responsible for establishing national standards for graduate medical education by approving and continually assessing educational programs for physicians in training. Residency Review Committees (RRC) under its authority make determinations regarding whether graduate medical educational (GME) programs are in compliance with these standards. The ACGME accredits nearly 7800 residency programs in 110 specialty and subspecialty areas of medicine.

For residency programs, ACGME accreditation is a voluntary process. Participating programs undergo regular review and show substantial compliance with the *Program Requirements* developed by the ACGME review committee for programs in its specialty. These standards address the essential educational content, instructional activities, responsibilities for patient care and supervision, and the necessary facilities of accredited programs in a particular specialty. The ACGME has final authority for approving all *Program Requirements*. Furthermore, the sponsoring institution must demonstrate a commitment to GME (1) by being in substantial compliance with the *Institutional Requirements* set forth by the ACGME and (2) by assuming responsibility for the educational quality of the sponsored program(s). Site visits are conducted every one to five years, with a longer period indicating that the ACGME and RRCs are more confident about a program's or institution's ability to provide quality education.

With regards to resident work hours, the ACGME states that it "is continuing its ongoing effort to refine its standards for resident duty hours, and to clarify the role of these standards in contributing to educational quality and patient and resident safety." Currently, the *Institutional Requirements* state, "the sponsoring institution must ensure that each residency program establishes formal policies governing resident duty hours that foster resident education and facilitate the care of patients...The educational goals of the program must not be compromised by excessive reliance on residents to fulfill institutional service obligations." The requirements for duty hours of each ACGME-accredited specialty can be found at <ftp://www.acgme.org/new/dutyrequirem.pdf>. The ACGME has also appointed a work group to review and refine the Council's accreditation, education, and related activities related to the issue of resident duty hours with a final report to be disseminated in March 2002.

AMA POLICY ON RESIDENT WORK CONDITIONS

AMA RESOLUTION 310 (I-01) (Adopted as Amended) – RESIDENT/FELLOW WORK AND LEARNING ENVIRONMENT

That the AMA may draft original, modify existing, or oppose legislation and pursue regulatory or administrative strategies when dealing with resident work hours and conditions.

That the AMA work with organizations such as the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and other appropriate organizations, toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms.

That the AMA encourage the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patients safety and to explore possible solutions to the problem of work hours and conditions.

H-310.979 RESIDENT PHYSICIAN WORKING HOURS AND SUPERVISION

(1) The AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education... Graduate medical education must never compromise the quality of patient care... (c) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents... (g) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the applicable General and Special Requirements of the Accreditation Council for Graduate Medical Education (ACGME). (h) *The program director, with institutional support, must assure for each resident effective counseling as stated in Section 5.1.4. of the General Requirements: "Counseling: Graduate medical education places increasing responsibility on residents and requires sustained intellectual and physical effort. For some, these demands will, at times, cause physical or emotional stress. Institutional awareness, empathy, and responsiveness towards these problems are vital to the educational process. Program directors and teaching staff should be sensitive to the need for the timely provision of counseling and psychological support services to residents."* (i) The program director, with institutional support, must provide effective support systems; residents should not be required to provide patient care services that can be provided by ancillary personnel. Thus, the educational mission must not be compromised by a routine reliance on resident physicians to fulfill institutional service obligations, such as but not limited to IV services, phlebotomy services and messenger transport services, which can and should be provided by ancillary staff to meet reasonable and expected demands. (j) Is neither feasible nor desirable to develop universally applicable and precise requirements for either the supervision of residents or the maximum time that they are assigned to direct patient care. Because the number of patients, the intensity of illness, and the hospital support services vary among medical specialties, the RRC for each medical specialty must define these requirements for residents in the graduate medical education programs which they accredit... (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government. (CME Rep. C, I-87; Modified: Sunset Report, I-97)

MSS LATE RESOLUTION 2 (A-01) (Adopted as Amended)

That the AMA-MSS will work with the AMA-RFS to make the improvement of hospital working conditions, including resident/fellow work hours, a top priority for the AMA, and supports the concept of pursuing avenues in addition to working with the ACGME to alleviate resident work hours concerns.

REFERENCES AND MORE INFORMATION:

www.ama-assn.org www.amamedstudent.org
www.acgme.org www.amsa.org
www.jcaho.org thomas.loc.gov
www.aamc.org/advocacy/corres/ed/conyers.htm

American Medical Association
Medical Student Section

RESIDENT WORK CONDITIONS

An Informational Guide



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Historical Background

The issue of excessive resident/fellow work hours is not new. It is well known that for decades physicians in training typically have been expected to work 60-130 hours each week in order to fulfill the clinical and educational requirements of their training program. Several factors contribute to the problem of excessive resident work hours, including:

- Inadequate financial resources and severe nursing and ancillary staff shortages at hospitals often mean that residents have to perform numerous hours of tasks that neither advance their education nor require a physician.
- Increases in the amount of required paperwork has dramatically increased the time spent by residents carrying out clerical and administrative duties.
- Out-dated beliefs that countless hours spent in the hospital are necessary to adequately train physicians and "toughen up" young doctors persist despite efforts to change these beliefs.

These factors have created an environment that makes excessive work hours a symptom rather than the ultimate cause of the need to improve resident working conditions and optimize patient care.

Resident work hours received public attention as a result of the Libby Zion case in New York in 1984. Libby Zion, an 18-year-old woman admitted to Cornell Medical Center, died allegedly due to negligence by overworked and fatigued residents. Though a grand jury later found the hospital and physicians devoid of guilt, there were concerns expressed about the potential risks to patient safety of a system that has physicians in training working excessive hours with little direct supervision. In response, New York State formed the Bell Commission to establish work hour regulations for medical training programs. In 1987, New York became the only state with regulations mandating work hour limits on residents. However, more than 10 years after these regulations, an unannounced investigation conducted by the state's Department of Public Health revealed that more than 37% of residents were required to work more hours than allowed by the regulations, and all programs reviewed were in some state of violation.

Beyond state regulations, the principal mode of regulation and enforcement of resident/fellow work hours has been through the Accreditation Council on Graduate Medical Education (ACGME). The accreditation of general specialty and subspecialty graduate medical education programs is accomplished through 27 Residency Review Committees (RRCs) that function within the ACGME. Each specialty has a set of program standards that are developed by the applicable RRC. Although all specialties have different standards, some common standards have been adopted by almost all of the 27 RRCs. The standards require that residency programs not require residents to be on call more than every third night and give residents one day in seven off from clinical duties. These common standards are a direct result of extensive lobbying by the RFS of the AMA and the

WHAT ARE RESIDENT WORK CONDITIONS?

Finding the perfect balance between providing adequate training of resident housestaff while maintaining both resident and patient safety is the impetus in developing a clear and enforceable set of attainable conditions. In current plans to address the issue, "Resident Work Conditions" includes each of the following:

- "Duty Hours"- The total number of hours spent providing patient care per week. Current proposals advocate for an 80-hour work week. The time spent within "duty hours" should be based on an "educational rationale and patient need."
- On-Call Scheduling – Current recommendations by the AAMC, ACGME, and the "Conyers Bill" state that on-call within the hospital should be no more than every third night.
- One day out of seven free of patient care responsibilities.
- Adequate formal and informal education. This includes conferences, attending rounds, and other directly supervised activities.
- Adequate supervision and advising from attending physicians.
- No change in resident's salary if such changes result in a reduced amount of "duty hours" or time spent on-call.
- Ancillary/Support Staff – An institution should provide adequate support services such that residents are not required to perform patient care services that can be performed by ancillary personnel.

Issues **NOT** considered in current "Resident Working Conditions" reform:

- Resident's Quarters
- Vacation/Sick Leave
- Facility Safety
- Health Insurance Benefits
- Child-care
- Weekend Responsibilities
- Moonlighting Restrictions

ORGANIZATIONS RESPOND

"Focusing on excessive duty hours is to focus on the symptoms, not the root cause of the problems affecting graduate medical education (GME). The central issue... is improving the quality of GME." — Jordan Cohen, M.D., AAMC

"Limiting required duty hours does not imply that residents must cease providing essential patient care services at arbitrary cut-off times. Priority must always be given to patient safety and well-being and to avoiding transferring patient care responsibilities to others at inappropriate times in the continuum of care (e.g. during an operative procedure, in the midst of a rapidly evolving clinical event)." — AAMC Policy Guidance on GME

"In [New York and European] experiences with regulatory efforts, to date there is indication that they have improved patient safety, but they may have negatively impacted education." — ACGME Executive Summary

"The most significant findings [in current research] relate to the impact of continuous duty periods exceeding 30 or 36 hours, with no studies to date having assessed the benefits of limiting weekly duty hours for residents." — ACGME Executive Summary

H.R. 3236 – THE PATIENT AND PHYSICIAN SAFETY AND PROTECTION ACT OF 2001 ("THE CONYERS BILL")

H.R. 3236, would amend the Social Security Act to reduce resident work hours:

- Maximum 80 hours per week and 24 hours per shift.
- Required one full day off per week and one full weekend off per month.
- On call no more than once every three nights (Q3).
- Annual anonymous surveys of residents to determine compliance with such requirements
- Whistleblower protections
- Violating hospitals subject to maximum \$100,000 penalty for each resident training program.
- Appropriations to hospitals for their additional costs incurred in order to comply with proposed requirements.

The bill states the following reasons for federal regulation:

- The government spends \$8 billion annually to train residents.
- The government has regulated work hours of other industries where the safety of employees and the public are at risk.

The Patient and Physician Safety and Protection Act of 2001 can be viewed in it's entirety at www.thomas.loc.gov by searching "H.R. 3236."

AMSA'S ACTIVITY

AMSA refers to themselves as the "national leaders in calling for federal legislation to limit resident work hours." They have led lobbying campaigns on Capitol Hill and letter writing campaigns in support of H.R. 3236. AMSA has supported other organizations that have supported federal regulation of residency work hours, including the Committee of Interns and Residents (CIR), Public Citizen, OSHA, and the American Medical Women's Association.

AMSA's diligent work and efforts to increase medical student political activity is commendable. They have forced the medical world and the public to confront this issue and determine an appropriate strategy to solve it. The AMA Resident and Fellow Section and Medical Student Section have been working closely with AMSA on this effort, and we look forward to continued efforts to find common ground so that we may reach a solution which is satisfactory for everyone. You can learn more about AMSA's work on this bill at <http://www.amsa.org/hp/reswork.cfm>.

OTHER IDEAS

One of the possibilities many groups have considered is providing another body the power to enforce work hour reform without relying on the Department of Health and Human Services or another government organization. Precedent already exists for this idea; indeed, the state of Illinois has legislatively mandated that resident physician duty hour requirements of the ACGME be followed under penalty of law. While the body to enforce such regulations is still a matter of debate, many proponents of this plan agree that the body should be within the house of medicine. Possibilities include the ACGME, JCAHO, or a new body with representatives from various medical organizations.

