



Michael D. Maves, MD, MBA, Executive Vice President, CEO

April 30, 2009

Thomas J. Nasca, MD, MACP
Chief Executive Officer
Accreditation Council for Graduate
Medical Education
515 N. State Street
Chicago, IL 60654

Dear Dr. Nasca:

I am writing in response to your February 12, 2009 request for a position paper on the recommendations in the recent Institute of Medicine report on resident/fellow duty hours.

Specifically, your communication requested the following information:

- *Your organization's formal position on the recommendations contained in the Institute of Medicine Report, including impact analysis, from your organization's perspective, on costs and impact of implementation;*
- *Your organization's formal position on the current ACGME Resident Duty Hours Standards including impact analysis, from your organization's perspective, on costs and impact of implementation;*
- *Your organization's formal recommendations regarding dimensions of Resident Duty Hours standards, and justification (wherever possible) for this position with evidence;*
- *Your organization's formal recommendations regarding standards governing key aspects of the Learning Environment, and justification (wherever possible) for this position with evidence; and*
- *Your organization's willingness to participate, if invited, in a Resident Duty Hours and the Learning Environment Congress, to be held in June 2009 in Chicago, Illinois. This Congress will be configured to provide the ACGME leadership with the breadth of perspectives of the medical community as they embark on review and revision of the Resident Duty Hours and Learning Environment Standards.*

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With input from various constituent groups of the American Medical Association (AMA), including the AMA Resident and Fellow Section, Council on Medical Education, and Section on Medical Schools, I am pleased to provide to you the information on the following pages. As you review this document, please keep in mind that:

1. This document provides a summary statement of *current* AMA policies.
2. The AMA is committed to be involved in the ACGME process of responding to the IOM report.
3. The AMA continues to monitor resident duty hours and plans another report to the AMA House of Delegates in November 2009 on this issue.

Introduction

In September 2007, the Institute of Medicine (IOM) appointed the Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety, at the request of Congress and the Agency for Healthcare Research and Quality. The Committee's two primary objectives were to:

- Synthesize current evidence on medical resident schedules and healthcare safety; and
- Develop strategies for implementing optimal work schedules to improve safety in health care.

The Committee held five meetings and two conference calls between December 2007 and August 2008, with presentations from invited experts and an opportunity for questions and comments from the public at three of the five meetings. The Committee heard from presenters representing the perspectives of the accreditation and certification community, organized medicine, medical students, residents, patient safety advocates, and researchers on sleep and patient outcomes, as well as program directors in primary and surgical specialties. Specific organizations included:

- Accreditation Council for Graduate Medical Education
- AMA Medical Student Section
- AMA Resident and Fellow Section
- American Board of Medical Specialties
- American Hospital Association
- American Medical Students Association
- Association of American Medical Colleges
- Centers for Medicare and Medicaid Services
- Committee of Interns and Residents
- The Joint Commission
- Public Citizen

The Committee's report (www.iom.edu/residenthours) was released on December 2, 2008. It does not recommend a further reduction of residents' work hours from the current 80-hour limit, but calls for:

- Reducing the maximum number of hours that residents can work without time for sleep to 16;
- Increasing the number of days residents must have off; and
- Restricting moonlighting during residents' off-hours.

The Committee's recommendations also call for greater supervision of residents, limits on patient caseloads based on residents' experience and specialty, increased interdisciplinary teamwork, and overlap in schedules during shift changes to reduce the chances for error during handoffs. In addition, the Committee calls for continued research and more data on duty hours and patient safety. The report notes that the biggest barriers to these changes are financial costs (an estimated \$1.7 billion per year) and an insufficient health care work force. Nonetheless, the report indicates that "action on all recommendations should be taken within 24 months," that is, by December 2010.

AMA Response to the IOM Report

The AMA's initial response to the IOM report congratulated the IOM on its support for the 80-hour weekly limit, which has been reflected in AMA policy since 2002. In addition, the AMA's monthly *GME e-Letter*, which goes to 13,000 residency/fellowship program directors, coordinators, and medical school/institutional officials noted that "the AMA applauds the IOM's proposal to spread the costs of implementing its proposal among all payers—which is consistent with AMA policy that all GME costs should be so shared." Early responses from some *e-Letter* readers, however, have been less supportive. One noted "problems with inpatient continuity and follow-up, growing resident knowledge-base deficits, declining sense of ownership of patient outcomes, and (anecdotally) an increase rather than decrease in medical errors."

The AMA House of Delegates (HOD) and its various student, resident, and academic physician component groups have not yet formulated a consensus response to the IOM report, so it is premature for the AMA to offer any detailed analysis as to potential costs and impact of implementation of the IOM's recommendations or to advise the ACGME's response to these recommendations.

AMA Reports/Policy on Duty Hours

As one of five member organizations of the ACGME, the AMA has been, and continues to be, heavily involved in issues surrounding the resident/fellow learning environment, including duty hours, sleep deprivation, burnout, handoffs, continuity of care, at-home call, medical errors and patient safety, enforcement of duty hours standards, reporting of violations, and protection for whistleblowers. The AMA is also concerned about the impact of resident duty-hour limits on attending physicians' schedules and medical professionalism/ethics, as well as on patient care.

Before and since the ACGME standards went into effect in July 2003, the AMA has developed policy and written several reports on the effects of duty hour limits, as well as related topics such as physician burnout and at-home call (for more information, refer to www.ama-assn.org/ama/pub/category/7094.html). These reports and their recommendations have been thoughtfully informed by the AMA's Council on Medical Education (CME), Section on Medical Schools, Medical Student Section, and Resident and Fellow Section; vetted through Reference Committee C; and approved by the HOD.

The last CME report on this topic (Enforcement of Duty Hours Standards and Improving Resident, Fellow And Patient Safety, Report 5-A-08) collated recent research on duty hour limits vis-à-vis patient safety, which have shown improvements or neutral effects on clinical outcomes. It also touched upon an overarching concern among educators and residents about the effect of duty hour limits on professionalism. Some argue that improved resident well-being inherently leads to better quality of care; others counter that the regulations translate into decreased continuity of care, the "shift-work mentality," less accountability toward colleagues and reduced teamwork, and reduced time for direct patient care. The report called for continued monitoring and enforcement of the standards, as well as flexibility and responsiveness to emerging research on their effects. In addition, it stated that medical organizations should work collaboratively to ensure that federal legislative action is not seen by policymakers and the public as the only effective solution. The report included ten recommendations, seven of which are particularly relevant to the ACGME:

- That our AMA reaffirm support of the current Accreditation Council for Graduate Medical Education duty hour standards;
- That our AMA continue to monitor the enforcement and impact of the ACGME duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back at the 2010 Annual Meeting of the AMA House of Delegates;
- That our AMA review, evaluate, and publicize the work of the ACGME Committee on Innovation, in particular its pilot projects related to duty hours, and encourage participation by ACGME Residency Review Committees and residency programs in these and other efforts towards innovation and improvement in graduate medical education and patient safety;
- That our AMA ask the ACGME to consider offering programs/institutions additional incentives, such as longer accreditation cycles or reduced accreditation fees, to ensure programmatic and institutional compliance with duty hour limits;
- That our AMA encourage publication of studies about the effects of duty hour standards, extended work shifts, hand offs and continuity of care procedures, and sleep deprivation and fatigue on patient safety, medical error, resident well-being, and resident learning outcomes, and disseminate study results to GME designated institutional officials (DIOs),

program directors, resident/fellow physicians, attending faculty, and others;

- That our AMA use the *GME e-Letter*, AMA Resident and Fellow Section publications, and other communications vehicles to raise awareness among residents (particularly first-year residents) of the ACGME and its role in monitoring and enforcing duty hours; and
- That our AMA urges the ACGME and AOA to decrease the barriers to reporting duty hour violations and resident intimidation.

Discussion

In discussions of duty hours and the resident/fellow learning environment, there are two primary values at stake—quality patient outcomes and quality educational outcomes. The effect of limits on resident duty hours on either of these values may not be straightforward, with consequences that can vary for different constituencies. As the key organization representing all physicians in the United States across all specialties/subspecialties, and the most well-known physician association among the public, the AMA is in a unique position to monitor the responses of various groups to issues related to duty hours, the resident/fellow learning environment, and patient quality. These include:

- Program directors, attending physicians, and trainees. Although most residents favor duty hour limits and many program directors decry the rigidity of their implementation, some trainees and many attending physicians, especially in surgical specialties, believe residents' education may be shortchanged by the 80-hour weekly limit. Although evidence is anecdotal, there appear to be a number of attending physicians and program directors who feel that the current generation of trainees is not as well prepared for the rigors of practice post-GME. Also, work not completed by residents/fellows during shifts often falls to the attending physicians.
- Surgical specialties versus other specialties. The RRCs for pediatrics, internal medicine, and family medicine had 80-hour duty hour limits in place years before July 2003. In contrast, leading organizations in neurological surgery, for example, "registered serious concerns" about the IOM recommendations and argue that continuity of care will suffer and increased handoffs will lead to increased errors. Questions have also been raised about the possibility of the need to increase the length of training in some disciplines.
- Patient advocates versus the GME community. Public advocates continue to compare residents' schedules to those of truck drivers and airline pilots, among others, and to call for reduced hours to increase patient safety and reduce medical errors. Some residency program directors, educators, and residents/fellows counter that handoffs may be more risky than long shifts and that educational goals, and service needs, are already being stressed under the current standards.

Summary

The AMA will continue to track this issue and the viewpoints of trainees and program directors, as well as coverage of the issue in the national media and relevant research in peer-reviewed

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journals. AMA Resident and Fellow Section (AMA-RFS) staff will also share insights garnered via postings by AMA-RFS members on its listserv. The annual meeting of the AMA HOD in June will provide additional opportunity to discuss the association's response to the IOM report and duty hours. For example, the Council on Medical Education and the Section on Medical Schools will hold a symposium on unintended consequences of duty-hour limits, for which ACGME participation would be welcome. Division staff attended the ACGME symposium on duty hours in March, and AMA staff are planning to collaborate with ACGME staff on a survey of residents/fellows, to follow-up on similar AMA surveys from 1989 and 1999. These and other data points will help inform a planned Interim 2009 follow-up report to the AMA HOD on duty hours, which was rescheduled by the Council on Medical Education from Annual 2010 to Interim 2009. That report will summarize new and emerging issues and data and may articulate additional AMA policies and actions that will aid the ACGME in its response to the IOM report's recommendations.

At its February 2009 meeting, the AMA Board of Trustees committed to the following three actions:

1. The American Medical Association will continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education (ACGME) duty-hour standards, as they relate to the larger issue of the optimal learning environment for residents, and monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back at the 2009 Interim Meeting of the AMA House of Delegates.
2. The AMA will continue to disseminate information about duty hours, through its monthly *GME e-Letter* and other communications vehicles.
3. The AMA continue to work closely with the ACGME (as one of the ACGME's member organizations) to help the ACGME respond to the recommendations of the Institute of Medicine's report.

In closing, the AMA is committed to continuing its close working relationship with the ACGME and to helping the ACGME respond to the IOM's recommendations. Accordingly, the AMA is willing to commit to full participation in the ACGME's planned congress in June.

Thank you for this opportunity, and please let me know if you have any questions or would like additional information.

Sincerely,



Michael D. Maves, MD, MBA

cc: AMA Council on Medical Education