



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

August 3, 2010

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

Dear Dr. ~~Nasca~~: *TOM*

On behalf of the American Medical Association (AMA), which represents more than 220,000 physicians, including resident/fellow physicians and medical students, we appreciate the opportunity to respond to the proposed duty hours standards of the Accreditation Council for Graduate Medical Education (ACGME).

Overall, the AMA is encouraged by the ACGME's proposed standards, which strike a balance among the many differing opinions on duty hour restrictions. The AMA also appreciates the ACGME's efforts to ensure that graduate medical education (GME) not only effectively trains resident physicians but also strives to improve patient safety. We commend the ACGME for recognizing that it is not only the hours that resident physicians are on duty, but also their overall experience and level of training that play roles in physician performance. In addition, we commend the ACGME for not accepting verbatim the duty hours recommendations of the Institute of Medicine (IOM) but rather basing any changes on the best scientific evidence available, with a primary focus on the education of physicians in training. We especially applaud the ACGME for not recommending implementation of mandatory "napping" during an overnight shift and allowing for flexibility in terms of work hours to care for sick or unstable patients.

Furthermore, we think the ACGME has done an excellent job of outlining the key components that are necessary for resident physicians to acquire the proper "skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency." In addition, we continue to support self-regulation of graduate medical education and resident/fellow duty hours by the profession of medicine, and believe that the ACGME is the organization that should monitor and regulate these requirements on behalf of both the profession and the public.

Although, in general, the AMA supports the ACGME in their attempt to update the duty hours standards, we have several specific comments and concerns about the proposed changes, which reflect input from the AMA Resident and Fellow Section (AMA-RFS), Young Physicians Section (AMA-YPS), and Council on Medical Education:

VI.A. Professionalism, Personal Responsibility, and Patient Safety The AMA wholeheartedly supports these requirements.

VI.B. Transitions of Care The AMA has some major concerns as to how these requirements can be met. Programs will find it difficult to “minimize the number of transitions” while the number of hours worked is shortened. Requiring programs to “monitor” handoffs will create new burdens and may be unrealistic. Finally, ensuring “that residents are competent in communication with team members in the handover process” is ambiguous and will require clarification specialty by specialty.

VI.C. Alertness Management We commend these recommendations. While the fatigue mitigation process and creation of a backup process might be disruptive, it is the right thing to do. The AMA also believes that safe transport home and sleeping areas for post-call are significant improvements that should be supported. Finally, programs should ensure that residents receive sufficient education in recognizing the signs of fatigue.

VI.D. Supervision of Residents The AMA supports the concept of supervision by upper-level residents, which is an integral part of training for residents and greatly enhances their own confidence and clinical skill. We have major concerns, however, about the need for an attending physician to be in-house at all times to supervise first-year residents. This will be very difficult and costly for programs to implement. We believe that a senior resident/fellow should be able to safely and adequately supervise a first-year resident, with an attending available for direct consultation via phone.

Additionally, mandating that a PGY1 resident must be supervised by an attending physician would make it impossible for interns to work with and observe senior residents as part of a “buddy call” system in which the PGY1 works directly with a senior resident overnight and learns how to care for extremely sick patients in the operating room or the intensive care unit in a controlled supervised environment. “Buddy call” is essential to ensure that when PGY1 residents complete their year that they will have observed the care of critically-ill patients and be able to care for such patients on their own once they become junior residents. Without “buddy call” small residency programs will be unable to ensure that sick patients are being cared for by adequately trained junior residents.

Also, we urge more clarification about the different levels of supervision. For example, can the supervising physician be a cross-cover (i.e., a different service’s senior resident who is on premises as the on-site backup while keeping the usual physician in charge of the patient available but not on site)?

Due to academic staffing shortages, some programs have resorted to the use of locum tenens coverage overnight and the use of non-faculty staff to provide required backup for residents. This usage will only increase if in-house supervision is required. Furthermore, it will increase the number of handoffs at the attending level and senior resident level, thus increasing the chance for discontinuity in care and errors via information loss.

VI.E. Clinical Responsibilities The AMA commends the ACGME for acknowledging that graduated responsibility is a cornerstone of physician training. Implementation of graduated responsibility in residency programs also could defuse an argument used to support moonlighting—as a way to transition to more independent practice in one’s training. Graduated responsibilities also will help trainees develop their skills and gain confidence in a carefully monitored environment with graded, increasing responsibility.

VI.F. Teamwork We agree with all of the recommendations in this area, but believe that teamwork may be undermined if interns are separated from the rest of the house staff. In small programs, the acculturation of interns into the total workflow of the service is essential. As an example, if interns can no longer stay the night like other residents, this may create resentment and negatively impact the camaraderie of the house staff.

VI.G.1. Maximum Hours of Work per Week Agree

VI.G.1.a. Duty Hour Exceptions Agree

VI.G.2 Moonlighting Although some young physicians recently completing their residency training objected to closer monitoring of moonlighting by program directors, both the AMA-RFS and the Council on Medical Education support these requirements.

VI.G.3 Mandatory Time Free of Duty Agree

VI.G.4 Maximum Duty Period Length We have serious concerns about the impact of the 16-hour duty period limit for PGY1 residents:

- 1) Exposure to cases and learning experiences will be limited.
- 2) More handoffs will be required, putting patients at a higher risk of adverse events, and the number of patients covered by those on the night shift will increase. As a result, programs will burden those suffering from the worst circadian rhythm disruption with a higher number of handoffs, without being able to rely on the consistency of the continuity of care from the daytime into the night.
- 3) Interns will not be able to take full “buddy call” with senior residents, reducing their educational opportunities.
- 4) A night float scenario is encouraged under 16-hour shifts, severely restricting learning opportunities for residents, which occur mostly during the daytime hours, and decreasing the number of operations that surgical residents participate in for those not covering trauma or emergency surgery call.
- 5) Programs will be required to have senior residents take more frequent overnight calls and/or require hospitals to hire additional hospitalist physicians or physician extenders.
- 6) Smaller programs may have to shut down, in light of the increased burden to cover patients and provide supervision in a program with only two or three senior residents. This is a particular problem in procedurally-oriented specialties. The limits would require more senior-level residents to stay in-house. This shift limitation would prevent some residents from participating in the non-emergent day time operative procedures and would effectively make it impossible to train surgeons in the time frame we now have. Even for non-procedure-based specialties, much of the didactic training is done during the daytime and would be lost to the residents who will soon be on their own.
- 7) Services often schedule teaching rounds to occur at a set time during the day. These requirements could negatively impact learning opportunities for residents if they have to come in late and miss teaching rounds or didactic conferences.

- 8) PGY1s will lack the opportunity to directly observe PGY2s in a supervisory role during the night but will then be expected to assume such a role in their next year of training.
- 9) Individual physicians need to learn their own personal limits. PGY1s should be the most supervised and observed trainees, as this may be the best time for a physician to learn his or her physical requirements for sleep and rest. If not early in residency training, under direct supervision, then when and where?

Additional questions on these requirements:

- 1) Do “unusual circumstances” (line 885) apply only after the four-hour window (line 880) or do these include the four-hour window?
- 2) Why “care to a single patient” (line 887)? What if a resident is managing two traumas simultaneously or tracking two patients of extraordinary education value, but not participating in their care?
- 3) Can residents exceed the 24-hour continuous in-house duty requirement to attend educational conferences? The current wording appears to include only patient care.

We would suggest allowing first-year residents to remain on-site, observing patient care only, for an additional eight hours after their 16-hour shift ends.

VI.G.5. Minimum Time Off between Scheduled Duty Periods We support the ACGME’s graduated approach to time off between shifts, but we believe that the eight-hour time-off requirement may be difficult since it might not leave enough time for proper handoffs for those working 16 hour shifts.

VI.G.6. Maximum Frequency of In-House Night Float This requirement may have the unintended negative consequence of dictating what programs moving to night float will do. Instead of setting an upper limit, six nights might become the rule for programs because the ACGME allows for it. In addition, this requirement could force the night float residents to never have a full weekend off.

VI.G.7. Maximum In-House On-Call Frequency We have major concerns about no longer being able to average call frequency over the course of a month. The “with no averaging” change means Q2 can never happen. This would eliminate residents’ flexibility/ability to change their own schedules to accommodate a need/desire to be off on a certain day if on a Q3 month.

Further, the proposed standards offer no explanation of PGY1 requirements. Are interns simply not allowed to take Q3 call at all? Many programs would currently be in violation of this requirement, and most programs and residents would likely feel it doesn’t help them in any way and restricts their flexibility. In particular, many small programs (with two-to-three residents per year) need to average call frequency to no more than every three nights over a four-week period to allow residents to schedule vacation, outpatient clinical time, or research elective periods. A small program will now be required to have residents always involved in the call cycle, whereas averaging would allow for certain periods where call was more frequent than every three days in order to allow for flexibility in the resident’s schedule.

Overall, we believe that averaging is needed for flexibility for programs and residents.

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VI.G.8. At-Home Call The AMA believes that the ACGME provides a good clarification related to at-home call. We agree that return to work does not reset the off-duty period.

We would also add that AMA policy (D-310.961) encourages the ACGME to collect data on at-home call by specialty from both program directors and from residents and fellows and to release these aggregate data annually. In addition, the AMA encourages the ACGME and the GME community to examine the effects of the increased use of at-home on call resident education and supervision and develop appropriate standards to ensure that appropriate education and supervision is maintained, regardless of the setting.

In summary, we note that the proposed standards create a series of unfunded mandates that must be addressed. For example, if annual institutional visits become required, this would be both onerous and expensive for the institutions as well as the ACGME. Further, as residents work fewer hours and become a less vital part of the patient's care, the current faculty can only take up so much of the slack. Ultimately, this will increase the cost of training, as more faculty will need to be hired to fulfill the workload, which will increase the need for more funding for physicians in academic settings. Lastly, the AMA is concerned that we may be creating a system in which physicians cannot meet their workload, opening the door for care to be provided by lesser trained, non-physician providers and leading to diminished quality of patient care.

Again, thank you for the opportunity to provide our feedback on this important topic, which is critical to the education and professionalism of our future physician workforce and the continued safety of our patients.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Maves". The signature is written in a cursive, flowing style.

Michael D. Maves, MD, MBA