Dear Dr. Nasca and ACGME,

AAEM’s mission statement includes the following:

The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine, and to ensure a high quality of care for the patient.

AAEM also believes every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine, which is defined as someone who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).

Recognizing that residency training is an essential step to become board certified and involves multiple parties - residents, fellows and attendings, in providing excellent patient care; AAEM surveyed its membership in order to gather information for your request for formal recommendations on accreditation requirements for residency duty hours.

The survey was sent to all AAEM members, and over a five day period in mid-January 2016 there was a 14.7% response rate, which was impressive. Also, 34% of respondents sent in additional written comments. The learning and working environment for graduate medical education are of tremendous interest to our members.

As we reviewed the survey results, we note that the changes in rules have coincided with remarkable changes in the way health care is delivered in the US. Our members’ comments reflect this sentiment.

In review of the survey results and comments, the overwhelming themes seem to be:

- Professionalism is suffering i.e. lack of responsibility felt for patients.
- Current specific time restrictions are too restrictive.
- Concern about the lack of patient encounters leading to ill-prepared attendings in knowledge and possibly skill.
- Ill-prepared attendings for the "real world" of true work hours.
- Patient needs and the ability to handle them.
- Interns should be treated like residents in hours to avoid above problems.
Other concerns such as increasing for-profit pressures, educational debt and administrative burdens on this next generation of physicians were frequently cited in the survey responses.

One theme that we heard again and again from our attendings and from some fellows is the sense that medical training “feels like it is shifting.” Our senior members think that there is something about the “residing” or “living around the clock in the hospital with the patients and their families” during residency that engenders a sense of shared experience and empathy toward the patient and their family. They seem to feel that this establishes a sense of seriousness toward the MD role and a level of responsibility toward patient care that they are concerned is being lost with today’s trainees.

The results of our survey are attached. The first section lays out a summary of the membership’s responses. The second lays out these responses sorted by academic tenure with the comments submitted by our members, which were sorted by tenure and then within that group, by general opinion.

We have tried to present these results in the clearest possible fashion and hope you will read our members’ comments. They are heartfelt, and represent our membership’s desire to help you strike the right balance in this difficult task. Because residents in our specialty rotate through a broad variety of medical specialties, we believe that the EM perspective is particularly valuable.

Please let us know if we can be of further assistance.

Sincerely,

Mark Reiter, MD MBA FAAEM
President, AAEM
AAEM Survey Results Regarding ACGME Resident Duty Hours Requirements
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Attendings with Leadership Responsibilities Survey Results and Comments ........ 55
Q1 Are you a:

Answered: 953  Skipped: 0

<table>
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<tr>
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Q2 Do you believe that the current residency work rule restrictions of up to 60 hours (ED rotations) / 80 hours (off service rotations) per week result in residents working:

Answered: 947  Skipped: 6

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Total 947
Q3 Do you believe that the off-service restrictions on consecutive duty hours (of 16 hours for PG-1 and 24 hours for PG-2 and above) result in residents working:

Answered: 952  Skipped: 1

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Total 952
Q4 Do you believe that the required 8-10 hour rest period after off-service clinical shifts for residents is:

Answered: 949  Skipped: 4

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<td><strong>Total</strong></td>
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Q5 In an effort to represent your views, we will share any comments you make about the current residency work rules with the ACGME. Unless you choose to add your name in the comment section below, your response will be anonymous. We believe that your perspective on how the work hours impact patient safety (especially transitions of care), resident wellness, the quality of physician education, professional development, and the changing culture of medicine would all be particularly valuable for us to send on to the ACGME.

Answered: 328    Skipped: 625
**Q1 Are you a:**

Answered: 289  Skipped: 0

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Answered: 288  Skipped: 1

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Answered: 288  Skipped: 1

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<td>51.39%</td>
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Answered: 289  Skipped: 0

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<td>No opinion</td>
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<td><strong>Total</strong></td>
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Answered: 83 Skipped: 206

COMMENTS FROM RESIDENTS

25% of Residents who responded to this survey also submitted written comments for ACGME review

13 (18%) of these respondents felt the rules were too restrictive
10 (13%) expressed mixed sentiments
12 (16%) thought the rules were OK
30 (41%) felt residents should work even less
9 (12%) had other comments about the regulations

Participants who feel the rules are too restrictive:

I have not been a resident without duty hour restrictions, but I do not believe the restriction on how much we can work results in safer conditions for residents or patients. In fact working less hours may make us poorer physicians and definitely have less patient care time.

I strongly believe that moonlighting hours should not count toward ACGME work hours.

I think the work hour restrictions have a solid intended goal, but I am concerned that they are not successful in achieving that goal. Too many hours is indeed not good for residents, but the myriad restrictions do not necessarily result in a particularly agreeable schedule and it is unclear whether they have resulted in safer conditions for patients or for the residents who work them.

Implementing strict work hours without addressing massive work/patient overload and overworked entire hospital staff does nothing. The only thing that strict work hours cause are longer and more inefficient sign-outs due to more residents being involved in an individual’s care.

More transitions of care, people end up staying the same amount of time to finish their work.
The required time off in between shifts and the requirement regarding consecutive days, hurts residents more than it helps. It interferes with residents’ ability to stack shifts or help others. Some residents prefer to work long stretches of consecutive shifts with the opportunity for a chunk of days off as a result. I do not think working stretches like this interferes with patient care, and it does increase resident wellness.

The duty hour rules have been the WORST thing to happen to graduate medical education in the past 15 years. While the spirit was to make sure residents weren’t overworked or too tired from long shifts, the result has been a total mess. If I want to work a little longer one day to get out early the next day, I can’t. If I want to bunch all my days off so that I can travel out of town for an extended weekend, I can’t. If I want to swap shifts with another resident so that one of us can go to a wedding, we can’t. Working longer, extra shifts, or bunching days off is a HUGE priority for residents who want to use their time off to do whatever they want, and not being able to do this has been a resident wellness disaster. I strongly encourage the revision of these rules across the board as it has negative impacted residents, and has caused more transitions of care (aka more high risk sign outs that could lead to patient safety issues), a decreased quality of physician education as I am often not able to attend didactics because of duty hour violations, and a terrible shift in the culture of medical education.

I believe that transitions of care and resident wellness is actually worse since the implementation of the new work hour restrictions regarding 16 consecutive hours. Often times this meant that I was working 16hr days 6 days a week. There is no time for relaxation and little time for sleep when you are home for maybe 7 hours before going back to work. My quality of life was terrible during this time. I would have been much happier working 30hrs then having a longer period of time off to sleep, read, grocery shop, or do any recreational activities. ACGME should abolish the extremely restrictive 16 hour work rules and go back to the old system. Having worked 30hr shifts in my upper years, it has been much better and while tiring, I was far less tired overall than during intern year.

I think PGY-1 should do 24hrs as well.

I feel that the current restrictions attempt to balance resident fatigue with fewer transitions are an overall good approach. Unfortunately the duty hour restrictions also add an extra layer of difficulty to resident scheduling. The number of duty hours, shift lengths, turnarounds, and required days off makes scheduling difficult, and shift switches nearly impossible at times.

I think the hours rules should be an average. Some days there might be a rare case that is worth the violation.

Currently, the restrictions do nothing but force residents to complete the same amount of work in a limited or even shorter period of time causing more stress and poorer quality of work.

For emergency medicine it works great, I did see other surgical specialties feel there was not enough time.

**Participants who had both good and bad things to say about the rules (Mixed comments):**

There are pros and cons to the restrictions. It is good from a personal well-being standpoint but I do not know if training suffers as a result. I do not know which system is better.
Ultimately, the problem with duty hours is not that residents are working too many hours but that the free
hours are not structured correctly. Having only 8 hours off between shifts is inadequate for healthy
lifestyle. And ideally the schedule would minimize day/night transitions by grouping shifts or intelligent
rotation of shifts from day to evening to night.

The rule restrictions are appropriate as they stand. The restrictions on interns I feel could be extended as I
feel this would allow them to have additional educational experiences they might not be able to
otherwise. A particular restriction of interns not being able to take overnight call does limit their
experience, particularly in the ICU or other settings. Of course interns would have to be supervised by a
more senior resident, but nevertheless would have more learning opportunities.

Be careful to not make these rules too restrictive. Stringent guidelines, like the ten hour rule, can often
place undue stress on residents that would have otherwise had a more manageable schedule without its
hindrance. Hours rules should be continually evaluated to identify those rules that actually improve
resident wellness and safety.

Limiting the number of hours we can work consecutively just means we are going to be working more
days instead of longer shift which means less days off total. And just because you have a consecutive 24
hours off doesn’t mean that you actually had a day off.

While designed with safety and wellness in mind, the restrictions created more harm than good in my
opinion. As we were not allowed to have more than 16 continuous hours at work at a time, our internal
medicine rotation resulted in us being at work every single calendar during that block, which is frankly
demoralizing. Had we been allowed to do 24 hours shifts, we would have actual days off, not the required
“day off” starting at noon on one day and ending at six in the evening on the subsequent day. It was
awful.

Work hour restrictions for ED rotations at 60 hours per week plus conference time seems to be about
right but off service rotations having 80 hours per week with one day off in seven days averaged over the
length of the rotation usually means that off service rotations who have less invested in our education as
EM residents take advantage of this and schedule us for the max every week leaving us with little time to
do reading for our education or preparation for our annual in service exam or weekly conferences. Since
the day off per week is averaged it often means working 2-3 weeks straight without a day off and having
days off grouped together which means that 80 hour work weeks for 2-3 weeks without any time off is
exhausting. When we are on call as a senior for 24 hours straight plus 6 hour sign out the shifts are
scheduled for a full 30 hours every time as they are again always maxed out/taken advantage of by those
services getting free work out of off service residents. Most importantly being up for 30 hours straight
taking care of critically ill ICU patients is not safe; by this point in residency I have become pretty efficient
at various procedures including central lines, intubation, etc. but me doing this 2 hours into my shift
compared to 29 hours in is just asking for mistakes to be made and that doesn’t even take into account
my decision making as a whole. And when we are kept more than 30 hours our program is flagged for the
work hours violation not the attending or service who knew about the violation and told us we had to stay
anyway. Overall I think the work hours are a step in the right direction and have improved resident life in
some ways however research is clear that the human brain functions at the level of an intoxicated person
after a certain amount of sleep deprivation and yet this level of sleep deprivation is allowed while a drunk
doctor taking care of your family member clearly wouldn’t be. This suggests to me that there are still
many areas that could be improved upon especially for a profession that touts being evidence based.
Work hour restrictions I think are particularly important in the intern year and less so as training continues. Work hour restrictions must be balanced with trainees being able to learn and follow a patient’s course of their hospitalization. This is probably more important for surgical services, internal medicine and critical care trainees than it is for emergency medicine residents. EM residents and attendings must constantly function in a world of high turnover with signouts and I don’t think that work hour restrictions impact patient safety negatively in that regard. However, I can see work hour restrictions adversely affecting patient care on the floors and surgical services because of increased resident turnover and signouts. However, this should be mitigated by continuity of senior residents and fellows on the service. Finally, work hour restrictions can impact the quality of a resident’s training if they do not see enough patients or volume because of the restrictions. It’s a delicate balance that I think is currently satisfactory for emergency medicine, but I am skeptical of it’s balance for trainees in other specialties.

Current duty hour rules are well-intentioned, but inadequately understood and inconsistently implemented. Further study should be done (e.g. iCOMPARE) to assess patient- and trainee-oriented outcomes from these rules, as well as better understanding and implementing best practices for hand-offs, etc.

I’ve finished over 3.5 years of residency. ED shifts should not be limited to 60 hours a week, I believe my personal training with frequent shifts made me the physician that I am. But I believe 80 hrs a week off service is a good limit. 24 hour off service shifts can be too taxing (usually on ICU) as after rounding you will have spent a few extra hours.

**Participants who felt the rules are fine as is:**

I think that it is unlikely, based on available data, that work-hours restrictions have meaningfully impacted patient outcomes. The increased number of handoffs undercuts the gains made by a happier and (perhaps) more well-rested workforce. However, I do believe that making the residency work environment more humane to its members is a goal worth attaining for itself. Resident wellness has greatly improved, based on anecdotal discussions I have had with attendings and other residents, and I would like to see more studies investigating this.

The 16-hr consecutive work hour restriction results in less days off and ultimately is more exhausting than 24hr shifts. 2. Work hour restrictions are meaningless. Exhaustion is rampant in residency based on the culture of the rotation. Yes sleep matters, but having time off doesn’t mean residents are sleeping. More days off and a good ED environment is more important than hours worked. 3. As long as the culture of medicine is to be perfect, make the patient happy, and document everything or it didn’t happen, there will always be mistakes and exhaustion. However from a regulations standpoint, the hour restrictions are perfect except for restricting the number of consecutive shifts and the number of hours between shifts because it prevents vacations and makes switching much more difficult.

The hour restrictions are well intentioned. The problem is that most residency institutions are ill equipped to enforce them in most departments (EM is the exception). I highly doubt there is a neurosurgery resident in the country who abides by these hour restrictions. It may look like it on paper, but its because they are not being honest in their duty hours logs. For me as an EM resident, I think the hour restrictions are important, especially the 8 hours off between shifts. Having done several off service ICU rotations (where the hours are longer), I know what its like to only sleep 4 hours a night for several rough days while in the MICU. The thing is I can still go in and do my job the next day without
endangering patient safety. It may not be sustainable long term, and certainly worsens job satisfaction and increases rates of depression, but it is not an acute danger to patients for me to operate temporarily on less sleep. That’s because the job of a MICU resident requires less focus and stamina than a typical ED shift. In the MICU, I can basically sleep walk through rounds, slowly sipping on coffee, intermittently giving a brief presentation while staring at my notes, and then jot down the plan after discussing with the fellow and attending. This process literally lasts 4-5 hours. Then I get a lunch break and spend most of the rest of my day writing pointless progress notes in the team room. Yes I do make important decisions, but I do so while sitting in a room full of other residents. Yes there are often medical emergencies, but not all day, and again I’m surrounded by other residents. My point in all this is saying that operating on a little less sleep in the MICU isn’t fun and it probably isn’t a good model going forward, but I don’t feel like im endangering patients. If I was consistently (like on a weekly basis) going into ED shifts on 4 hours of sleep because of a late shift the night before, that would be a totally different story. ED shifts fly by at warp speed comparatively. I often don’t have time to eat as I bounce from room to room. I do simple procedures and see a variety of complaints, all without spending much time at all sitting down, except to blaze through notes as fast as humanly possible so that I don’t fall too far behind. Maybe I am biased, but this requires a great deal more focus and mental energy than a day in the MICU as an intern. Which is why I’m very grateful, that at least in my program, ED work hours are taken very seriously. I have yet to see a violation appear on my schedule (while in the ED) and I’m thankful for that because the job would be a lot more difficult and could be dangerous to patients if I was forced to violate these restrictions.

Seeing as I’m an EM resident, I think our hours are great. Sure we go to off-service rotations (e.g. PICU, NICU, MICU, trauma) and suffer with 30-hour calls, but overall our lives are great. I wouldn’t want to work less than I currently do 55-65 hours on service and I’m ok with dealing with an occasional rough off-service block. As I’m currently working Q3-4 30s on an off-service rotation, I can say I definitely am not learning more based on the rough schedule. I think I work and learn much better in short shifts, even if I had to work more nights and weekends. Beyond 12 hours I am mostly going through the movements and counting down until my time off. I think more programs should look at the ED model of shift work because I don’t think it makes us worse doctors and because it allows us some time to sleep and breathe and learn. But these are just the humble, but happy thoughts of an EM trainee.

I think there is a push against work hour restrictions from administrators and certain specialties, and the excuse is always “transition of care”. But if time is protected to ensure that handovers are done in a safe manner - along with appropriate time to document plans in the patient’s chart, this can be abated. We have a hard time quantifying the benefits of work hour restrictions to physician wellness, but I think the benefit cannot be understated. A tired physician is a dangerous one.

The 60 hour work week found in the ED is an appropriate work week. Not only are you able to learn during shifts, but you can also study on your own time and attend to your personal health. I find that when I am on off-service rotations and work 80 hours or have 24-30h shifts every 3rd/4th night, I no longer have time to study and be involved in other resident activities. Furthermore, your personal life takes a great sacrifice. I often see it in my self and fellow residents that eating habits worsen, physical activity greatly decreases, family life feels the impact, and overall wellbeing decreasing. In EM we are fortunate that not all of our rotations require such stamina and sacrifice; however, residents often feel the consequences of long work hours when they occur over sequential rotations.

Burnout is at an all time high across medicine. I think this is in part because we operate at full capacity all the time. In the past, our seniors did work longer hours than those currently allowed. However in those days, the patient populations were different. Patients were not rushed in and out of the hospitals like they
Currently are. They were not as acutely ill because we didn't have all of the life support we currently do. We also documented more for ourselves not for billing/legal purposes as we do now. Times have changed in medicine over the years. Residents now are constantly running at capacity for their entire shift. There is no down time to eat or some days even use the restroom. I think the duty hours in place are a great idea to address the above stated changes in medicine. I think it is a good thing to continually review the hours as medicine continues to evolve because further adjustments will likely be necessary as medicine continues to change.

I believe the work duty restrictions are appropriate. More hours would cut into necessary sleep and studying time. Less hours would result in inadequate clinical experience.

Sign outs naturally introduce mistakes. As an intern, I prefer the policy to not pick up new patients about 20 minutes before the end of a shift.

Nice to have some rules that put weight on the importance of both mental and physical fatigue in practicing medicine.

The current system allows for wellness and flexibility. I think it works well.

**Participants who felt the rules still do not protect residents enough:**

The requirements are fine but it is a well known unwritten rule in every program that you do not report duty hour violations. If you want an accurate reporting of actual duty hours there needs to be a centralized anonymous reporting structure with a time lag between reporting duty hours and when programs get the results and the appropriate disciplinary action.

The only thing the rule really changed was that interns can’t do 24 hr calls on paper the whole “6 hr post call transition time” is totally abused - no one pays attention to that, no one actually obeys time rules - your paper schedule may say you work a 24 hour call but you actually work 36/40 hrs - but as long as your paper schedule says 12 hours (intern) or 16hr (pgy2+) then "it’s okay" so I don’t really think it matters what the ACGME really says because the work is still there and residents will still be working more than the rules say.

There is a difficult balance between gaining the necessary exposure to become a good doctor and burnout from too much work. Extended consecutive duty hours are extremely valuable for resident education and for limiting potential safety issues related to transitions of care. These shifts would be more palatable if separated by a longer rest break (i.e., 12 hours).

There is strong evidence that learner well being, health, "well restedness", are critical factors in acquisition, application, and retention of knowledge. It is also clear that there is no substitute for experience and that total patient hours/encounters are also critical for learning. In this way a balance must be struck between accumulating patient experience and providing time for rest, reading, and non-clinical work/learning. I feel strongly that resident work hours should be limited to no more than 50 hours/week while in the ED, with a goal to be between 40-45. In addition all efforts should be made to increase routine. Certainly hours in Emergency Medicine are variable. But, it must be recognized that there is a significant learning curve expected during residency and all efforts should be made to reduce stress and barriers to learning. If a typical community EM attending is scheduled between 30-40 hours clinically each week it is striking
that residents would be scheduled for significantly more, and then be expected also to take one
significant reading, conference attendance, research, and other academic responsibilities without
sacrificing quality of life. Residency may be difficulty, but it does not need to be dehumanizing. Ultimately,
this is a patient safety issue as much as reducing handoffs or continuity of care.

There is a difference between quality and quantity. Good working environment including passionate
faculty, reasonable expectations, supportive nursing and tech staff, available resources for patients, helpful
consults and other service residents/attendings, etc. make long hours much easier. I don’t really care
about how many hours I work as long as I am treated with respect, consideration, enthusiasm, equality,
kindness, etc. ED rotations are fine- we work a good amount but it is balanced with appropriate time off.
I don't much care for the off-service rotations in inpatient medicine service like ICU or trauma surgery.

These rules must reflect the possibility that a resident may sleep 8 hours a night, like we supposedly
recommend to all our patients. A 24h shift or an 8 hour transition does not allow for this. If you cannot
sleep eight hours a night, this does not represent wellness of the resident.

The nature of 24 hour shifts, 60-80 hour weeks, and too little time between shifts conspire for a work and
practice climate that is hazardous to both personal and patient safety. Particularly for the 24+ hour calls,
their deleterious and dangerous nature have been widely published on. Further, their contributions to
young physician burnout, depression, job dissatisfaction are immense, and poised to intensify. Expression
of burnout and mental health deterioration are becoming, if anything, more common among residents as
a population. Although net hours in the hospital may be fewer than before duty hour changes, programs
have mitigated this by simply adding more shifts (i.e. fewer total hours, but more total days spent over
any given interval in the hospital) and shifting more of the administrative and academic activities (required
or otherwise enforced) onto the resident’s own time that often does not get logged or accounted for as
subtracting from their personal time and well being. I believe deterioration of resident wellness in light of
overwork, underappreciation, and dearth of wellness support options threaten to change the culture of
medicine for the worse. In general, burnout and depression across specialties are at an all time high. One
has to wonder, why is that? Thank you for undertaking this important survey and work.

The work duty hours restriction are helpful and also misleading. I don’t know what it was like prior to the
implementation, but I believe the restrictions are there to prevent abuse of residents. The bad part is that
they also lead people to believe that they’re going to “have a life,” leading to disappointment. The work
duty hours, in general, are fine, but the quality of clinical experience during those hours is crucial. A bad
shift or bad week in the ED, MICU, PICU, on Trauma, etc., can make any number of hours feel like torture.
Bad clinical experiences can cause any schedule to feel unfair whether it is or is not. I want more clinical
experiences and would work more hours in certain rotations because of the quality of teaching. As a
combined resident, I work a lot of different schedules, and my primary complaint about my schedule is
working 80hrs in a bad rotation (bad environment, scut work, little to no clinical or procedural education)
or working 7 days in a row with a lot extra-clinical requirements.

We are the only first world country that has such heavy work hours for residents. The hours we work crush
curiosity and compassion. We should move towards a system more like the EU where resident work hours
are humane and foster learning.

We have recently begun to participate in off-service trials of increased work hours as a PGY1, where
PGY1’s work 24 hours of patient care, plus additional admin time. This often ends up with 32-36
consecutive hours, with only the last few dedicated to administrative time. This is unsafe! Further,
Saturday call where a resident works M-F up to 12-14 hours a day, then comes in Saturday morning, works 30+ hours, then returns to work a normal M-F is also unsafe. This is not only unsafe for patients but is unsafe and unhealthy for residents.

Eighty hour intern work restrictions are good. I'm currently on a service taking part in a study and I therefore have no work hour restrictions. I worked 107 hours this week and by the time I went home I didn't feel like I should be taking care of patients or driving.

As a resident enrolled in the current study analyzing duty hours and patient outcomes, there have been multiple weeks of being over the 80 hours and it is unsafe practice. 24-30 hour call results in inappropriate care and decision making, especially at the tail end of a shift. Working upwards of 80 hours per week does not breed a environment of reading outside of work, as there is no outside of working. We thus become products of our hospital system and not necessarily developing medical decision making based upon fact or reading, but clinical experience from physicians we hope follow clinical guidelines. I do not know the solution to this problem, however extending residency to allow for the same amount of clinical experiences before becoming an attending may help alleviate the situation.

After working multiple 80 hour weeks or at the end of a 24+4hr shift, residents are no longer providing the same quality of care to patients. Also, the number of handoffs may have been shown to correlate to mistakes made, but the quality of handoff from an overworked, exhausted resident can be terrible.

FAA regulators are subject to work hour rules for good reason - managing the inbound and outbound air traffic is a very strenuous and concentration intense job. Likewise, physician training is grueling and requires much attention to detail in order to provide patients with appropriate care, in addition to providing a proper learning experience for residents. When work hours are extended and physicians are subject to decreased amounts of rest and nutrition, human behaviors change and attitudes may become careless in both learning and care, evolving into a "just keep going until I get out of here" mentality. I have seen this on a few lightly staffed rotations including trauma surgery, and cardiac ICUs that take MICU overflow without proper ICU attending oversight. It is understandable the argument that work hour restrictions decrease the amount of patients residents need to see in order to gain the experience to be an attending physician. Also is understandable that a consistent caregiver for patients avoids patient handoff mistakes. However, I believe these are separate issues to consider in light of resident fatigue and well being. How much can be learned on the 16th hour of a shift where no food or drink has been consumed? How patient will that resident be towards his patients, and will this affect the patient's review score towards the hospital's care? With the changing culture of medicine and patient satisfaction at the forefront, care must be taken to remove as many factors impacting quality care and learning for our future physicians.

I believe after 16-18 hours your brain starts to shut down and your patients are at risk. Shifts like 24 hour call which at my institution turn into 28 hours straight not only is hard on your body, they are hard on your personal lives and place your patients at risk. No resident, staff or fellow should work a full 24 hours because it is not compatible with life.

I have definitely noticed an increase in apathy, a lack of motivation and overall decreased wellness during weeks where I approach and/or exceed the work hour limit. My patient care is absolutely affected. I strongly encourage decreasing the work hour limits. I'm involved in the Harvard resident sleep hour study currently and by noting my hours each month along with aspects like caffeine use, patient care mistakes,
falling asleep while driving... I can definitely see a negative effect of long working hours of my health and those around me.

I know that for me, personally, adequate rest and sleep comprise an enormous part of my overall wellbeing and ability to perform well on the job. I have noticed repeatedly that my performance decreases significantly when I am lacking sleep, and this absolutely affects patient care. I think a greater emphasis must be placed on helping residents lead balanced lives, with enough time for sleep, exercise, relationships/social life, healthy diet, and hobbies.

I think it is absurd and unhealthy to have residents work 24 (really 28-32, come on) continuous hour shifts. It is not like we ever are really "on-call" where you can grab sleep. You work your butt off for that whole time. I feel horrible after these long shifts and accumulate an unhealthy amount of sleep debt. I don’t know why medicine doesn’t follow the nursing shift style with 12 on, 12 off and appropriate, timed hand-offs. Perhaps research is not backing this up, but it is totally unhealthy and awful and leads to problems for residents and lower quality of care. I am firmly against it.

I think medicine would be well-advised as a discipline to take the lessons of the aviation industry regarding sleep deprivation and bad outcomes. No other industry thinks that working 16-24 hours in a row is a good idea and most of the evidence regarding sleep hygiene and how we learn suggests that sleep deprivation is not in concert with the role of learning. It is time for medicine to wake up and re-visit what is best practice for education.

I still think 24 hour calls are really the way of the past and more of an effort should be made to implement a shift system.

I think the real benefit in terms of learning on off-service, particularly Critical Care comes with circumstances of less oversight, more autonomy, and learning to be confident with your decisions. That being said, I am not sure of the added benefit of making these decisions under the duress of sleep deprivation on 24hr shifts.

Often, these rules are actually ignored by attendings or they act like you are weak or don’t care about your patients if you invoke them. Also 8 hours off between shifts is nicer than no rule, it is still not much. By the time you drive home, shower, eat a meal, drive back to work, it is functionally 6 or less, which is less than what adults are recommended to sleep - and that is if you don’t spend any time with your family or any down time.

Research has shown that working more than ~18 is the equivalent of being intoxicated. Pilots and truck drivers aren't allowed to work that long...why does the medical field think that it is better suited to perform and make decisions working longer periods of time? Would you want your loved one being cared for by someone who is exhausted (or the equivalent of being intoxicated) or by someone who is well rested and in a good state of mind?

The consecutive duty hours for PGY-2 and above is still excessive. I have routinely done 30+ hours.

The mandatory off time is too short largely because it doesn’t take into account signout/handoff periods as well as these often occur around rush hour so getting home is often time consuming vastly shortening the off time period.
To date, required residency activities (ie, didactics) are not factored into ACGME regulations. There have been many times where I have had less than 6 hours off between a shift and conference and would have to work again later that day. I have felt the most fatigued during these days and, at times, feel as though my clinical judgement is subpar because of this. I feel strongly that didactic sessions and other required residency functions should count towards duty hours and have the same regulations governing them.

Sixty hour limit in the ED is appropriate, but 80 hour work weeks on off-service rotations is too much. 60 hour limit for all rotations would result in well rested, happy residents who are better able to care for patients.

I believe that the limit for continuous hours spent at work on the job should be hard limited to 24 hours and not any longer. 28 hour shifts are too long.

Sixty hours/week in ED is fine as it is shift work and rarely exceeds the 60hrs one is scheduled for. Off service, however, the lack of ‘shift work’ mentality means a scheduled week of 70-80 hours can often turn into well over 90 hours.

The 8-10 hour rest period is usually an 8 hour rest period. The 8 hours are not enough time to rest sufficiently after a shift, especially if you commute to work.

The off service 80 hour limit I believe is too much especially for services that do not offer much further education to our own specialty.

Participants with “other” comments about the rules:

Figure out what is best for patient care (i.e. Outcomes such as mortality, medical mistakes) and do that. How we feel subjectively is not really important. Patient care is all that matters. The new system does not decrease amount of mistakes made... Just decreases continuity of care.

For EM residencies having 8 hour duty between shift restrictions as well as conference attendance requirements poses conflicts with no impact on patient care. May wish to have 8 hour rule only for clinical duties.

I believe that the work hour restrictions have been good for residents. No one is at their best after being awake for 30 hours. However, despite knowing that implementation of these rules would obviously result in increased patient hand offs, the ACGME did not require any improved or additional resident education regarding safe transitions of care. Most residents are not taught how to sign out patients or transition care. As this is standard in EM, I feel like we were better prepared to deal with sign out, but many other specialties had never had to sign out patients with a lot of work still in progress before. The work hours restrictions are important for maintaining resident wellness, but need to be accompanied by both improved training in safe transitions and making sure residents are allocated sufficient time to actually transition care properly.

Questions about whether or not any specific hour restrictions are just right/too much/too little are completely irrelevant because reported duty hours have no correlation with hours actually worked at this time.
Rules are great. However there are a multitude of violations particularly when residents go off service at our institution.

I feel like duty hours have become an obnoxious portion of residency that a majority of residents are not truly honest in reporting. I know for a fact there is significant under reporting of duty hour violations and there is a culture of intolerance for duty hour violations. If we’re not going to collect data on how often duty hour violations truly occur then why are we wasting our time putting in monthly reports. Either residents need to be honest in reporting or just get rid of the whole duty hour stuff all together.

The ACGME should be clearer on how to factor in “non-clinical” duties to duty hour restrictions. There are many conferences, lectures, etc. that residents are required to attend and even sometimes to present at - some occur post shifts in the morning, and the guidelines are vague as to how these should be factored into duty hours.

The problem is that we still don’t know how to sign out well. Shorter shifts are okay as long as communication is clear.

The sign out culture pervasive in our specialty is hazardous to patients and our education. Though necessary in the ICU, it should be avoided in the ED.
Q1 Are you a:
Answered: 18  Skipped: 0

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Q2 Do you believe that the current residency work rule restrictions of up to 60 hours (ED rotations) / 80 hours (off service rotations) per week result in residents working:

Answered: 18  Skipped: 0

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Q3 Do you believe that the off-service restrictions on consecutive duty hours (of 16 hours for PG-1 and 24 hours for PG-2 and above) result in residents working:

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Total: 18

Answered: 18  Skipped: 0
Q4 Do you believe that the required 8-10 hour rest period after off-service clinical shifts for residents is:

Answered: 18  Skipped: 0

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Total 18
Q5 In an effort to represent your views, we will share any comments you make about the current residency work rules with the ACGME. Unless you choose to add your name in the comment section below, your response will be anonymous. We believe that your perspective on how the work hours impact patient safety (especially transitions of care), resident wellness, the quality of physician education, professional development, and the changing culture of medicine would all be particularly valuable for us to send on to the ACGME.

45% of Fellows responding to this survey submitted written comments for ACGME review

4 of these respondents felt the rules were too restrictive
2 thought the rules were OK
3 felt residents should work even less
1 had other comments about the regulations

Participants who feel the rules are too restrictive:

I am concerned about the work ethic that the new ACGME rules foster. There is a lack of ownership for patients and given the number of handoffs per day that occur in inpatient settings, no one has any idea what is going on with the patients.

Residents have become weaker and weaker under the duty hours. It has now become about watching the clock until "the end of your shift" and "they have to leave on time" and not about patient care. Some programs have even instituted "caps" on the patients they see. While this may offer the illusion of safety it is unrealistic as to the requirements of the job. While no one wishes a return to the old days of residency hours, more common sense initiatives would have been better.

The restrictions for scheduling - taking into account conference time, mandatory 1:1 hours off post shift - are way too restrictive. Sometimes you work from 10 - 10, and you cannot return for a 7am shift because you didn’t meet the required # of hours off. I think it should be reduced to 8 hours off between shifts - no 10 hour requirement.

I think the 80 hr average work week is easily managed by residents and fellows. It protects those that are at high risk. I DO NOT think the 16 hr work restriction is beneficial for the following reasons - It increases patient transfer of care between providers - it reduces continuity of care (limits ability to see
disease progression) - it decreases resident exposure to patient volume - variety and pathology
Overall, I have seen the absence of 30 hr call lead to weaker interns. Their training is limited by hours and
there is a lack of ownership that also can develop when people know they are going to "sign out in an hr
or two"

Participants who felt the rules are fine as is:

60 hours on ED months is a touch too restrictive, but not much. Honestly, the work hours rules being
hard and fast as they are winds up creating problems in and of itself, but there clearly is not a good way
around it. To set up “80 hours a week +/- 10%” would effectively be an 88 hour work week, for example.
Honestly, through med school, residency, and fellowship, I only overshot (or really even came close) to
work hours in my 3rd year of med school doing peds and surgery rotations. I never even really thought
about them in residency. We were scheduled for 9’s, so assuming you got at least one day a week off,
everything worked out fine.

I think the duty hour changes are very reasonable and necessary for emergency medicine residents. I think
they only really impact transitions of care during off-service rotations, such as ICU wards. This is best
addressed through thoughtful scheduling and adequate training in appropriate transitions/handoffs. I can
see how this would be a bigger issue for other specialties such as surgery, however, I think the duty hours
changes are overall good progress. The duty hours changes work well for emergency medicine residents,
so if other specialties need changes to their training environments, we should build off the current
regulations/add nuance for different specialty needs, rather than starting over.

Participants who felt the rules still do not protect residents enough:

I have gone through an intern year in Saudi Arabia prior to my PGY-1 year in the US. In Saudi we did full
calls (i.e 24-30 hours), and during my intern year we had the 16-hour rule. I felt I had much more rest
during my intern year in Saudi (24-hour calls) because I had the chance to rest after the full call as well as
having 4 days off per rotation (month). Working 24 days out of the rotation was exhausting, especially
when we had two rotations in like this back to back. I recall a particularly difficult time when I had to work
17 days in a row. Thank you for the survey!

The rules aren’t actually followed. No one wants to be called into the PD’s office to explain why they went
over hours; it makes you look bad for not finishing your work on time, so people clock out and chart at
home. I was routinely working 14 hr shifts and well over 60 hrs/week in the ED and over 80 hours on off
service rotations. Only if the hours are anonymous will people MAYBE be willing to honestly report them.

The rule of counting average duty hours over 4 weeks is ridiculous. 12 days on duty non-stop - if anyone
thinks it’s a good idea, then they clearly don’t care about resident’s well-being.

Participants with “other” comments about the rules:

Junior doctors now fall within the working time regulations in the UK and the rest of the Europe. These
limit average hours to 48 hours over a reference period of 26 weeks, with a minimum rest period of 11
hours between 2 shifts. Working time directive (WTD) allows opt out of the 48hour week only if agreed
by the employee - but it requires compliance with rest breaks at all times. WTD ensures doctors should work no more than an average of 48 hours unless both they, and their employer, agree that they should - a sensible ‘safety check’ on their hours. There were multiple instances where because of the long hours doctors made mistakes and caused patient safety issues. For example, a doctor administered a fatal 100mg rather than 10mg dose of Morphine. Dr. Sri Banala, MD.
Q1 Are you a:

Answered: 466    Skipped: 0

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Q2 Do you believe that the current residency work rule restrictions of up to 60 hours (ED rotations) / 80 hours (off service rotations) per week result in residents working:

Answered: 461  Skipped: 5

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Q3 Do you believe that the off-service restrictions on consecutive duty hours (of 16 hours for PG-1 and 24 hours for PG-2 and above) result in residents working:

Answered: 466 Skipped: 0

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Total: 466
Q4 Do you believe that the required 8-10 hour rest period after off-service clinical shifts for residents is:

Answered: 463  Skipped: 3

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Total 463
Q5 In an effort to represent your views, we will share any comments you make about the current residency work rules with the ACGME. Unless you choose to add your name in the comment section below, your response will be anonymous. We believe that your perspective on how the work hours impact patient safety (especially transitions of care), resident wellness, the quality of physician education, professional development, and the changing culture of medicine would all be particularly valuable for us to send on to the ACGME.

Answered: 163 Skipped: 303

COMMENTS FROM ATTENDINGS NOT INVOLVED WITH RESIDENCY ADMINISTRATION

31% of Attendings not involved in residency administration who responded to this survey also submitted written comments for ACGME review

94 (59%) of these respondents felt the rules were too restrictive
22 (14%) expressed mixed sentiments
3 (2%) thought the rules were OK
21 (13%) felt residents should work even less
19 (12%) had other comments about the regulations

Participants who feel the rules are too restrictive:

We are rapidly destroying our medical education system with a myriad of regulations. While I believe in treating residents humanely, I believe that the focus of residency training should be on learning to do what’s best for patients. Sometimes this means working longer than one might like or going without sleep. Teaching residents the shift-work mentality, or that their work hours or their sleep must be rigidly regulated, will not serve them well when they enter the real world after residency.

The mainstay of Residency Training includes two key components relevant to the time standard.
-- Residency is about having an increasing degree of responsibility, and ultimately, near total independent responsibility for the patient. With frequent patient handoffs required by shift length requirements, the responsibility for the patient gets transferred to the next shift. Physicians become shift workers, with no one learning that they have responsibility for the patient. --Residency is about seeing the natural course of illness and interventions over time. One needs to see cause and effect to learn. This isn't afforded by short shifts, where the outcomes of the interventions aren't seen by the provider who directed the initiation of the intervention. --With varied experience and knowledge, frequent shift changes mean either frequent changes in the direction/approaches to managing a patient, or merely following protocols and guidelines. Frequent changes in direction of care exposes patients to a lack of continuity. Too great a
reliance on protocols has the risk of discouraging the independent development of critical thought processes. --Performing a safe exchange of patient care responsibility takes time, and the more changes that occur, the more time is spent performing these exchanges, with less time spent caring for patient. --None of these standards discuss what would be described in military environments as "off duty employment." In spite of residencies' intent to train physicians to be BCEM providers, we still have Residency Directors who either turn a blind eye to, or profit from physicians practicing Emergency Medicine by moonlighting in small EDs. These are the very EDs where a BCEM provider is most critical d/t the lack of other specialists.

Unfortunately I have noticed a decrease in the quality, knowledge and skill base of new residency grads and current residents over the past several years as the work restrictions have come into play. I have also noticed a decreased work ethic in both. I think that while the longer hours were very challenging physically and mentally they instilled a different attitude and work ethic as well as increased knowledge and skill base. On the other hand it was all consuming, especially intern hours but I look back on that year and my residency training as the most challenging years of my life but also some of the best. I would suggest somewhat of a compromise, that is some hour restrictions but along with that increasing the training times, perhaps adding another year.

Residents have been taught to have a mediocre work-ethic. They have been shown they are not required to work hard, put in late hours, nor learn to be efficient. Most residents currently have no idea what it is like to spend the night in a hospital. The residents here leave by 9pm and perish the thought if they are here at 9:01pm as the program they reside would be upset and if the residents were pulled out, the attendings would have to see patients at night. There is a piece of medical training that has been lost and it is the piece of seeing a sick patient or trying to solve the mystery of their deterioration at 2am. Yes, there is some sleep deprivation involved but this is the medical field and there is never a time when you aren't at least a little tired because of it. The big concern is are these residents learning and the big question is if they are not, who is going to care for the rest of us as when we need it?

With the reduced number of hours and shifts that residents put in for work/learning, they now need to add a year of residency to have the same number of patient encounters that occurred prior to the change made in work rules. Residents who are coming out of residency now are far weaker in knowledge and skills than those who came out prior to the residency work rules were put in place. This holds true for all specialties. I have watched the changes for over 30 years and am concerned for what lies ahead, who will be well enough trained to take care of my generation when we retire?

Transition of care is dangerous for patients. Short work hours increase the number of care transitions. Therefore short work hours are dangerous for the patients.

Work hour restrictions result in residents graduating who are unable to handle the work requirements of an actual job in private practice. It also results in numerous unnecessary patient handoffs and a marked increase in errors as noted in our resident treated patients. Furthermore, I have noticed, that it does not appear to engender an ownership of the patient in today's residents as was taught in the days before work hour restrictions became mandatory.

I believe the ED work hour restrictions (60 hours per week) is reasonable and does not negatively impact an ER resident's education. However, the off service restrictions may have a greater impact on resident education. Many of the off-service rotations are in the ICU and the greatest amount of learning occurs during a 24-30 hour call. By not being able to stay for longer periods of time (including first year resident restrictions), residents are potentially missing out on seeing critically ill patients progress or decline
clinically and do not learn how to properly resuscitate and treat such patients. Also, there are more transitions of care (sign outs) under the current work hour restrictions, which can negatively impact patient care and outcomes. The work rules are starting to create a culture of not having any ownership of patients and create a mentality of punch-in, punch-out medicine which is not how medicine has been nor should be practiced.

I believe that residents are not developing a work ethic. They prioritize sleep and lectures over patient care. This has led to a new generation of physicians who do not have any allegiance to their patients - they send them to the ER when they are sick. They refuse to see people who show up to the office 15 minutes late. What happened to Libby Bell was very sad, but it was not because residents worked too hard. It was because they did not have adequate supervision. With all the work hour rules, we have not fixed the fundamental problem - we are pretending to teach residents when there is no faculty presence for many of their work hours. Reducing work hours is not the answer. Improving supervision and bedside education and role modeling behavior is the answer.

I trained just before the 16-hour restrictions were implemented for PG-1s, so can speak to the experience of 30-hour days vs. 24-hour days, and the number of handoffs involved with the change to the 16-hour shifts. Taking call and admitting patients for 24 hours (e.g., 7a-7a) carries the right balance of education and continuity (admitting, taking care of patients as they present, performing diagnostic studies, and initiating therapies) and attention to issues of work/life balance, patient safety, circadian rhythm. The 16-hour day often requires an odd start time (4p or 5p--doesn’t allow for pre-sleep) or end-time (3a or 4a--essentially a night shift), an additional handoff (patient safety issue), and is often not going to be long enough to fully participate in the critical first hours of a patient’s diagnosis and care. Second, it requires the senior resident--who is supposed to be building on clinical competency and medical decision-making--to do a number of lower level intern tasks (and anecdotally stay later than they’re supposed to. While 30-hour days are certainly too much (I’ve fallen or nearly fallen asleep driving home after Burn/Surgery/Medical ICU rotations at 1p), a 24 hour shift would maximize benefits and minimize the unavoidable downsides (e.g., longer/odd hours) that are a required part of medical training and a realistic part of life as a community physician. The best rotations I had were those -- including SICU -- where the attending made it a priority to round in the morning early with the previous nights’ admitting team and get us home at 24-26 hours: I had extensive experience and learned many lessons from caring for these patients, but had no more than the usual number of handoffs to the oncoming day or call team. Finally, some consideration should be made to mirroring resident hours to those of real-world community and academic physicians. I am an emergency physician with administrative responsibilities as the medical director of my department, so my schedule isn’t typical. I currently work 50-55 hours per week, and when I was solely clinical I worked 45 hours per week. However, my surgeon colleagues work easily 70 hours per week and take overnight call prior to full clinic days (not ideal, but they don’t have a solution for it).

Thank you for investigating this very important topic!

I have noticed an erosion in the quality of resident training since the requirements have taken effect.

I have spent the last 12 of my 20 years in EM active in GME. I have served as an ombudsman, APD, PD, on clinical competency committees and helped with milestone development. I believe that the intent to protect our patients and trainees with the duty hour restrictions has gone overboard. For an individual to become a master of any craft / profession takes thousands upon thousands of hours and patient encounters. The very limited hours both within the department and on off-service rotations significantly slows development as a physician/clinician. The lack of seeing a patient’s condition improve or deteriorate over 36 continuous hours of care (supervised by attending’s) is crucial to a physician’s
development of problem solving and critical decision making skills. Young physicians need to see the tipping point in a patient's care and even though they might not recognize it, their supervisor can teach them in the moment. We are turning out a new generation of physician who can score better than ever on a test, but lack clinical acumen and interpersonal skills that are developed over thousands of hours of patient interaction. With the current duty hour limitations I believe we should extend EM residencies to 48 months. I trained where 23 (12hour) shifts a month was the standard, as seniors we were down to 20 or 21 shifts a month. 36 hours on or longer and 12 hours off for months at a time were what surgical and all icu rotations demanded. The real protection for our patients is truly dependent on attending physicians and senior residents doing their job appropriately supervising young residents. Currently I am the chair of a level 1 trauma center with > 80,000 visits a year with a EM residency (48 residents), EMS/Disaster medicine fellowship, US fellowship and multiple peds/tox/us/ems/cc trained staff. EM is the future of care delivery in the US, we need to prepare our residents better by more patient encounters and that requires time. Cheers, Mike Hilliard

I personally feel the information lost during handoffs is far greater than the mistakes made as a result of sleep deprivation. I do no feel this applies to the Emergency Dept, rather inpatient settings, particularly medicine rotations. I feel the residents do not learn enough during their PGY 1 and this knowledge deficit transfers up through the remainder of their residency.

Residents are graduating unprepared due to lack of sufficient exposure to illnesses and or proceures.

I believe the 2003 ACGME rules are better than the 2011 rules. My full thoughts can be found here: http://www.policyprescriptions.org/sleep-over-safety/  Feel free to cite me by name. PASTED BELOW: Dr. Atul Grover, the Chief Public Policy Officer of the AAMC, alerted me to the fact that Public Citizen and the American Medical Student Association were up in arms over the current study deliberating between the 2003 and 2011 ACGME duty hour rules. While I am no expert in the subject, as a product of the 80-hour workweek (I trained between 2006 and 2010) my firm belief is that the 2011 duty hour restrictions go too far. And while I hated being on call for 30-hours, driving home “sleep-drunk”, catching a few zzz’s on my post-call day, and then returning right back to work the next, I do believe I knew my patients better when I met them in the emergency department and carried them through their entire admission. Something about picking a patient up the next day from the night float team just didn’t provide the same amount of continuity and investment that today’s physicians need to learn during their formative years. So reading the objections, I went to find what the evidence would say about the subject. Recalling a study in JAMA Internal Medicine from 2013, it’s clear that the 2011 duty hours restrictions (which essentially eliminated overnight call for interns) lead to decreased work hours, without any significant change in sleeping habits or well-being for residents. All of this occurred while leading trainees to dramatically feel that patient errors were more commonplace (by over 15%). We all know it is much easier to adjust internal medicine schedules to accommodate the 2011 ACGME duty hours, however the surgical experience has been much more difficult. I found a systematic review from the Annals of Surgery that indicated that most studies addressing this issue show that patient safety and resident education suffered as a result of the 2011 duty hours, while the 2003 duty hours were safer for patients and residents. “There was no overall improvement in patient outcomes as a result of RDH; however, some studies suggest increased complication rates in high-acuity patients. There was no improvement in education related to RDH restrictions, and performance on certification examinations has declined in some specialties. Survey studies revealed a perception of worsened education and patient safety. There were improvements in resident wellness after the 80-hour workweek, but there was little improvement or negative effects on wellness after 16-hour duty maximums were implemented.” Again, I am no expert at this particular issue, but from what I do know – and from the available evidence – it seems to me that we ought to at least study the issue if not go back to the 2003 regulations that limit duty hours to 80-hours per week and 30-
hour overnight call. Otherwise, you can have a well-rested resident caring for you now at a teaching hospital, but a poorly trained community hospital attending with a shoddy work ethic in 10 to 20 years.

I have found the experience and number of cases seen with the resident hour restrictions has negatively impacted the skills and knowledge base of physicians coming out of training.

I don’t feel residents should work excessive hours excessively, but with all the limitations currently, they graduate having worked much fewer hours than residents 10-15 years ago. Currently there is so much more information to know, there is no way for them to master more information and skills with significantly less clinical time. I feel resident will be underrepresented when they graduate, without the breadth of experience they used to get in the past. Additionally, the amount of hours and consecutive hours do not adequately reflect the work loads and amount of hours that practicing physicians currently maintain. So when residents graduate, they will not be prepared for the increased workload and number of hours they will need to work. They also will not have the appropriate level of time management skills nor the ability to adequately multi-task will be required to maintain their professional lifestyle, and have a balance with their personal lives. I see this as a struggle for many young physicians.

As safety and quality becomes more and more our focus in training, as opposed to labor needs and "maximum exposure" we must train up a new physician whose reflexes are honed to recognize and react to issues that threaten the integrity of care delivery. We should reject the "treat ‘em and street ‘em" mandate.

Less hours worked has resulted in more hand offs which has resulted in more errors because of miscommunication and less familiarity and knowledge of patients.

I work in a Hospital with 3 DO residency programs. I think they are over supervised and the pace they will have to work when they get out will not work for them when they get out. I am worried that we are creating a generation of docs who may have book knowledge but freeze when volume and acuity and making clinical judgments alone comes to hand. I was a pioneer in getting rid of the 36 hour shifts we had to do in residency as but I think things have gone way too far the other way. Thanks for asking my opinion. ER doc who also did IM Res and Cardiology fellowship.

I believe that the unfortunate biproduct of limiting resident work hours is a generation of physicians whose focus is on their well being and not that of their patients. The pendulum clearly can swing too far in either direction and the art is in getting the balance of maximal learning, dedication to the patient, and resident/ physician wellness just right.

Although useful for resident wellness, I feel that there is a negative impact on patient care & safety. The increased handoffs result in more potential areas of misinformation. In addition, residents lose the continuity of caring for a patient through an acute event. The culture of medicine becomes a ‘shift worker’ mentality with a goal of handing off care at the end of ones shift sometimes regardless of the acuity of the patients illness...

Constant changing patients between different doctors to accommodate resident life style is impacting patient care. In the ER, the hand offs are the most dangerous, and this applies to interns/residents. Also, I do not trust surgeons trained after 2004 because of the lack of experience.
With these changes, I have found that residents will often leave the ER for a "lunch break" at their own discretion, some times up to an hour, no matter how bad or critical conditions are in the ER, leaving us "real docs" to keep things under control (they like to emmulate the nurses break schedule). I am dumb-founded by the lack of concern or connectedness that is essential for a successful and safe ER environment. Maybe, getting (the proverbial) tar beaten out of us, gave us a better sense of our "skin in the game". The new limitations seem to give the new recruits a sense that this is just another "punch clock" environment. Maybe I'm just sick of cleaning up their mess after midnight (when they are legislated to go home, although no such work hour restrictions exist for those of us truely holding down the fort). Post-residency life must be a brutal awakening.

Signed - The Southern Crumudeon.

While working less hours in a row is nice for residents it reduces continuity of care and decreases the opportunities for teaching and learning. If you want less hours worked in a row you need to increase the number of years for the residency. Residents are coming out with less knowledge and experience. They also have less commitment to the hospitals and patients. It is more about me and less about the care now than before.

Residents are being poorly prepared for real life as an attending physician by artificially limiting hours to such low levels. Allowing residents to "cap" their service will do them no good when they are attendings and the ACGME is not there to coddle them. Life as a physician is, at times, very challenging, time consuming and exhausting. If residents are not challenged to perform in a supervised setting while tired, what is going to happen when they have to perform unsupervised and without the safety net of a cap as an attending physician when their patients need them?

I have seen a difference with the quality of residents since the rules have been implemented. I feel that they do not have as much clinical experience as previous residents did. This is ultimately not a benefit for the physician or patient. Unfortunately, if the rules stay the same actual years of training need to be increased.

The current model of hours restriction has resulted in very poorly trained resident. There is no continuity of care for patients. Resident A admits the patient. Resident B rounds on patient Day #2. Resident C rounds on patient Day #3......

Since the residency work hours restrictions took effect, I have found the residents less knowledgeable and less prepared to perform in the ED and in off service rotations. The work restrictions allow the residents more time for reading; however, it seems that the residents aren’t using the additional time away from work to read or otherwise learn about their chosen field.

For question 2, I think the hours would be just right if the duration of their program were extended. To limit their hours and not extend the length of their program means they get less experience, exposure to medicine and patient interaction. They are leaving residency now without the same clinical acumen as previous graduates because they simply did not have a same exposure to medicine as their predecessors. My biggest concern is that there are no restrictions on work hours once the residents graduate and begin working in the real world. Residents have the very real possibility of graduating and then working more hours than they did in residency. It seems like it would better for physicians to worker longer hours in
training, when they are supervised so that they can learn their limits. I also don't understand the argument that the work hours are dangerous for residents, yet the long work hours are not considered dangerous for attending physicians.

Longer work hours are needed, especially to allow residents to see natural progression of disease. However there should be rules requiring at least 36 hours off at least twice a week to allow for sleep recovery and real time off when rotating night to day or vice versa.

Residents graduating after the work-hour restrictions went into effect, though proficient with technical skills like ultrasound, do not have the breadth and depth of knowledge needed for independent work. Much greater need for calling consultant - both specialist as well as their own partners. Indeed, at times I've wondered if the new crowd was trained in or even allowed to make their own decisions. Significantly less stamina for a long shift and significantly less willingness (or ability?) to stay after 8 hours if the place is in need.

One of the unintended consequences of the restricted work hours and I suppose there are other factors that play into this is the lack of respect most residents show to attendings on other services and sometimes even their own services. I was doing a rescue on our campus with the Chief of Staff of the hospital who is also the Chief of Medicine. A patient had collapsed in the parking lot and the COS just happened to be walking by. He called me and I came out with our ambulance and a Code Blue was called. The patient was very orthostatic with a major lower GI bleed and when the Code Team arrived the COS said start writing orders to put the patient in the ICU, the medicine residents were arguing with him saying we could just give him some fluids and put him on the floor. When I was a resident I would not have argued with the Chief of Staff about how to manage a patient. Work avoidance has risen to an art form and resident skins have become very thin. I think that is partially because they don't know what they don't know and partially because everyone gets a trophy.

There is a finite amount of time to gain enough clinical experience to become a solo practitioner. With the continued decrease in amount of time a resident is allowed to stay in the hospital, he or she loses a significant amount of time to gain this valuable experience. A young physician must learn to practice when he/she is tired and sleep deprived because this is how he/she might have to practice when out of residency due to circumstances out of his control. Residency is a once in a lifetime experience. Use this experience to the maximum benefit possible. I believe the pendulum has swung too far in an effort to help patient safety. This does cause more transitions of care which may adversely affect patient care. It certainly limits physician education and experience. It has forever changed the culture of medicine.

Being an attending physician is a 24 hour a day, 7 day a week job for most specialties. Emergency Medicine is perhaps unique in its' shift work structure which allows for extended periods off, but this is predicated on the short case, episodic nature of our cases. By the very nature of the cases dealt with in Surgery or Internal Medicine for example, there will need to be 24 hour continuity of care and one physician primarily in charge of each case. One will simply not be able to say, "Well, I was off duty...". In order to prepare our young physicians for the realities of practice, we should instill a sense of ownership in them for the cases they work on, not just 9 to 5.

As best I can tell, the only impact of duty hours is that residents spend less time in the hospital, study less, and graduate with far less knowledge and experience. They do seem to socialize more outside of the hospital, but I have seen no discernible decrease in fatigue.
I graduated from residency in 2014, and in my opinion the limitations on PGY-1 robs them of the vitality for their education regarding patients’ continuity of duty, shifting responsibility to the senior residents.

Reduced work hours has not led to better care. It seems the millenial generation does not want to work as hard as they should and I see this reflected in residents’ attitudes with work hours.

Resident work hour restrictions do not allow residents to obtain adequate patient care experience.

It does not really make sense to arbitrarily change the hours after the first year of residency. Does one acquire the ability to safely work 24h instead of 16 after a year? Bottom line is that since residents work less they see less and this has to be supplemented somehow. It is safer for patients to have the restrictions in place but the resident experience will suffer somewhat.

Residents have dramatically fewer hours of training when they graduate than ever before. New Grads that we have hired lack the breadth of experience necessary to function as independent attendings. If the weekly hour limits are kept where they are now, residencies need to be extended to 4 or more years to make up for this lack of experience.

I have to say that those long call days (the 80h standard of 2005-2008) were the times that truly taught me medicine. Learning just how far I could push myself and having the safety net of a senior resident "just in case" was key in my post-residency career. Yes, it was brutal. Q3 call is brutal. Heck, q4 call is brutal, especially if you really didn’t get much downtime. (Ahem, trauma and ICU months.) But residency is short and better to cram in as much experience as humanly possible. I'm glad I had that time.

For any 3 year residency, the hour restrictions on interns and residents does not allow for enough time to see patients and gain good clinical judgement. If current three year residencies, such as some EM programs, peds, FP, and IM were increased to four years, then such restrictions would be acceptable, as the addition of the 4th year would allow for enough time to gain adequate clinical experience. Additionally, as an attending physician, there are times when I have to work weird or long hours, and when I have to work when I’m tired. Presenting the illusion to residents that they have "protected time" as a doctor results in unprepared residents for real practice. While there is a need to protect patients from excessively tired inexperienced doctors, perhaps in the PGY-3 and beyond years, hour restrictions could be decreased to more adequately reflect actual practice.

The time liberated for Residents by hour limitations is, in general, neither used for academic pursuits nor sleep. This is why efficiency is not improved and mistakes are not reduced. It also provides NO preparation for the reality of Attending, where there are no workhour limitations, and no experience with self-checking techniques used to increase accuracy and safety when fatigued. Lastly, there is no experience with the long hours that may be encountered during a crisis of any kind.

The reduction in resident hours was not offset by a proportional increase in residency length. Therefore residents are completing their training with fewer clinical hours. This may have a negative impact on their ability to function as attending physicians.

I agree with the residency work week time restrictions on the principle that tired docs make mistakes and they need to be able to function without being constantly deprived of sleep/rest. However, I think the overall volume of info that must be learned in order to practice well is increasing. If they must shorten the hours per week, then residents need to be working more weeks (i.e. - residencies should be 4 or 5 years). Of course, the general push from Obamacare is for more of our work to be done by NP’s and PA’s who
don’t get ANY residency training, so it may not matter in the end (sorry, long shift today, hard to suppress my thoughts on where the real problems in healthcare lie).

>more errors are caused with transitions of care than caused by sleep-deprived residents. >learning from time spent at bedside, following the clinical changes of a patient, cannot be exchanged for hearing what those changes were during the next shift.

The real world of clinical practice doesn’t have these sorts of hour restrictions much less the rest interval. Although what has been proposed is ideal it is not reality nor does it adequately prepare the resident for what is expected in the real world.

An unfortunate consequence of the shortened on duty hours is a reduction in the number of clinical cases they encounter or manage. In my opinion, today’s residents graduate with less of a foundation of knowledge and clinical acumen compared to when I was an emergency medicine resident.

Yes there is a balance. However when residents finish, there are times you will work much harder than in residence with greater obligations that you need to be prepared to handle. I see our new grads having difficulty stepping up to the plate.

These restrictions are compromising our ability to train physicians. Continuity is being lost and we are losing our ability to train the next generation of physicians. This is a patient care issue, a quality issue, a safety issue for our patients. The road to hell is paved with good intentions. This policy needs to be revisited and modified.

The consecutive work hour restriction leads to less time off, more handoffs, and negatively impacts resident social life.

There are times as a practicing physician when I have to work and attend meetings the same day, or have meetings the day following a late shift. It seems silly the residents can’t sit through conference after working a late shift. I think having common sense recommendations without rigid rules makes more sense.

After many years teaching at resident, med student and at medical schools, I think the young doctors are not really resting, but not studying. Our system of training needs more clinical skill and certainly more study time to better learn the broad practice knowledge base to be competent Emergency Physicians. You have to spend time in the ED to get to do the core procedures more than once which is a basic necessity to be competent. Moonlighting is the guilty party for residents to utilize time off to make money unsupervised which I understand, but don’t condone. Just like smoking. Hard habit to get rid of but necessary for good health.

Resident work hours/24h or /wk fail to account for the “easy” rotations where they might only be working an 8h clinic or ultrasound shift and truly leaving at the end of that time. They may be getting multiple days off/wk or taking vacation weeks during rotations, thus cutting down on their effective learning time. I have no opposition to residents working these kinds of hours but the overall length of the residency then needs to be increased. The nearly 1/4/-1/3 few patient contact hours they have now “than when I was a resident”, significantly negatively impacts their preparedness at graduation. Critically important time on internal medicine wards (to not only learn internal medicine, adjusting patient regimens for discharge, AND being exposed to subspecialty medicine consult services as well as other consultants) has been eliminated entirely. The cutbacks in experienced EM faculty in favor of cheaper Fellow labor has also
negatively impacted the education on shift for the Residents. Other services pulling their Residents out of the ED for various GME reasons has meant our EM Residents are being used as "slave labor" with far less time (or inclination) to be actually LEARNING EM rather than just cranking through patients (and not realizing what they have missed or done wrong because their "Attendings", who are green Fellows themselves, are also not prepared to be working in that role). These duty hours have also led to a mentality that "when my shift is over, I'm supposed to go home." So the shorter (8 hour) shift, now becomes 6 or 7 hours since they are to be slowing down, protecting the end of their shift to write charts, and not seeing patients that come in the last hour. The "work til the work is done" and "stay to help your colleague who is slammed", is getting to be a rarely found ethic.

The residents are working too few hours and therefore learning less. The residencies need to be longer or lessen the restricted hours. Residents work fewer hours than attendings so they won't be prepared for private practice.

It's not that I think the residents should work more absolute hours, or even have fewer hours between duty shifts necessarily. But the way the rules are written and enforced severely limits the ability of residencies to configure their resident schedules that balance the clinical, teaching and service missions. For example, overnight call with sign out the next day should be allowed. Consecutive 12 hours shifts with a sign out period should be allowed, such that a resident works 13 hours, has 11 off and then comes back. ED shifts that end at 12 midnight should not preclude a resident from being required to come to conference at 7:30 am, as long as they aren't required to come back for clinical work at 7pm the next evening. These hard and fast work hours restrictions create a need for more frequent patient handoffs, which I believe are more risky for patients than a resident working fatigued. There needs to be reasonable flexibility in interpretation of these requirements rather than every incident of "non compliance" be viewed as a "violation." At least in EM, I believe residents and their program directors can work together to provide reasonable accommodations that preserve wellness and patient care. Senior faculty and former residency director (10 years) and former department chair (11 years).

Managing the wellness by hours worked impacts resident learning experience. Mostly good but sometimes bad. The entire consideration of work hours puts medicine into a category of just another job ....and that is clearly reflected in effort by learners in many programs as well as new attending hires. An alternative system of wellness should be considered and available to learners who's experience and learning opportunities are adversely affected. Additionally wellness measures and outcomes should be considered for those interested and available to extend learning hours.

I believe that a 3 year program is too short for residents to learn and become competent with new duty hours requirements.

Consecutive duty hours > 16 hours as an intern helps build mettle and current restrictions do that forming doctor a disservice. My rotations off service of 30-36 hours were not pleasant but made me who I am today.

Too much to learn if they're sitting at home not seeing patients. More clinical time.

Residency length may be extended with work hour restrictions to accommodate less time spent with patients.

I am an attending, but only graduated in 2014, so I had experience under both rule sets. The current off-service PGY-1 hours are ridiculous. I pulled 24-30 hour call as an M3 and then was subject to the new
hours. I got LESS rest, was MORE tired under the new hours and was happy to go back to long call as a PGY -2 off service. There is nothing inherent in human physiology that magically changes from 1st to 2nd year to better tolerate 30 hours of no sleep...if anything, one is a year older and LESS able to tolerate. As to in-service...the current rules really hamper seniors who are in a program that still demands a large number of shifts and want to trade shifts, but can't because of hour and turn-around time restrictions.

The only way to learn clinical medicine is to see patients. The limitation on patient contact has adversely affected skills and decision making capabilities.

I am currently an attending physician in the U.S. Navy's emergency medicine training program in San Diego. I also work in an emergency room in rural Wisconsin. As such, I have the opportunity to be a part of training our new physicians and also I have had the opportunity to work with young physicians as a graduate and move into private practice. I believe that the current residency work rules are detrimental to the development of solid clinicians. I do not believe that the curb on hours allows our young staff the opportunity to fully develop their clinical acumen. Also these hours restrictions failed to prepare new grads for the realities of civilian healthcare. There are no hours restrictions in the real world to protect physicians when they are tired. The reality of medicine is that there are not enough physicians, particularly in rural America, to meet the needs of these communities. I have seen many a young physician flee rural healthcare because they felt that the hours were too long and they were unable to adapt to this reality. Mind you at the same time the season physicians in these rural communities continue to persevere and deliver high quality care, albeit without hours caps. I think that you should train the way you fight. Having served as a physician in the military for over 21 years, I have seen time and time again that there is no substitute for experience. So if you are out of the hospital half of the hours of the day you were missing half of the good cases. Restricting our residents ability to remain in the clinical arena has been an enormous detriment. I believe that if the hours caps are to be maintained, we must lengthen our residencies commensurately to ensure that residents participate in sufficient patient care and procedural evolutions. Without a sufficient quantity of those critical experiences, they cannot develop solid competent clinical physicians. Also, without training under stress while supervised they cannot develop the skill sets required to function when they are sleep deprived. I believe that the current ACGME hours restrictions do not help prepare our current trainees well for the realities of medicine. I have seen far too many young physicians who successfully graduate from residency flounder when they are cast adrift into the real world of healthcare. They simply have not seen enough cases, done enough procedures, or developed the stamina and fortitude to function when their patients need them. I appreciate the opportunity to share my thoughts and I hope that the august body of clinicians who are assembled in the ACGME will consider the second order effects and ramifications which stem from what seemed at the time to be a prudent decision, i.e. curbing hours. I hope that you all will look at how we can better optimize the current training precepts and guidance to prepare our residents to meet the needs of their patients and succeed in after they graduate.

We used to work 24-26 shifts a month in the ER and 120 hours a week (off service). The current residents do not spend enough time seeing patients. Now the EM residency has been cut down to 3 years, instead of the 4 years I completed. I believe the clinical exposure is not enough.

As a general rule people learn most from doing. We need to be very careful not to undermine the touches they get that leads to mastery.

I think that duty hour restrictions across residency programs has led to less patient ownership, too many handovers, and leaves residents less prepared for the real world practice of medicine. Particularly for EM, duty hour restrictions plus the continuing issue of boarding leads to less learning opportunities.
I completed a four-year em residency finishing in the early 90s. All those that didactics are now greatly improved Current residents doing a three-year em program end up seeing approximately half the patients and doing half the procedures I did during my training. And it shows.

Length of residency programs should be expanded by at least 1 year to make up for fewer patient contacts under work hour restrictions.

Ultimately, regardless of what one believes regarding the current work hours, one thing is certain; it results in residents not getting enough expose or experience with patients or disease processes. Being well trained is about the experience and teaching gained during residency. With limited work hours comes reduced experience and teaching thus residencies need to be lengthened accordingly.

The restrictions are appropriate. However, the length of a residency probably needs to be longer to make up for the lost experience.

For those of us who worked 116-120 hours/week, this schedule is a vacation! While sleep is important for healthfulness, if fewer hours are worked per week, then residencies need to extend their length in years because the residents will not be having enough exposure to a variety of illnesses. I already wonder why this has not been done...

Obviously there needs to be a balance between hours worked and patient safety. The historical work hours of residents, specifically surgical residents, working 120 hours a week was excess. However restricting work hours to the current extreme is also excessive. The restrictions regarding call are ridiculous. There is benefit in learning to function under sleep deprivation at the end of a 30 hour call shift in a controlled, supervised setting. The real world of practicing medicine will create situations such as this, so it is important to be prepared. However, unlike residency, you are on your own with no one to be looking over your shoulder. Likewise, it is ludicrous to make a surgical resident leave a large complex surgical case (eg Wipple) because they have reached their maximum allowable duty hours. This may be the one and only opportunity to witness and assist with such a case during their surgical residency. They now will be underprepared for the real world. If ACGME continues to enforce such restrictive hours, I believe many residencies, especially surgical residencies, will have to expand the length of the training program in order for graduates to have adequate experience to care for patients in the community setting.

I believe that the work hours were intended to ensure quality and safety of the care delivered by residents. I am not sure if this has been shown in data, however, I do sense a lack of readiness for attendings who come directly out of residency to work full time. There is a lack of understanding of the real life workload and pressures that face physicians daily. I think there needs to be a better balance of working efficiently but not unsafely.

For rotations that are mostly call with less than 4 hrs of clinical duty per day, there should be no restrictions.

I understand the desire to limit work hours in the name of better patient safety. However, I believe the current 16 hr and 24 hr maximums increase the number of patient turnovers, one of the most dangerous times in patient safety. These maximums also limit a resident's ability to work on-call and get a
meaningful experience. I worked with the 30hr maximum and 80 hr work weeks. This seemed alright. I was surprised it was shortened further.

ED time is fine as-is. Interns off service should not be limited to 16 hours. They should have same rules as all residents: 24 hour call +4 hours as needed.

Graduated residents are not familiar with or used to the sometimes longer hours required in a non residency work environment and are not prepared to function at that higher level.

I trained before the work hour restrictions. I feel that the time on call for off-service rotations (ICU, trauma, etc) was an invaluable learning experience. Sure, we were tired at times. But the real world of medicine once out of residency does not accommodate work hour restrictions, limits on number of patients, etc. I feel that restricting these things during training does not prepare physicians well for their future practice of medicine. Perhaps for true primary care specialties and office based specialities with 9-5 hours, but for EM, critical care, surgery, etc., I feel that the restrictions impair learning.

Most of the hours presented above get in the way of logistics for coverage of patients in the hospital.

You can't see enough pts to learn medicine with the restrictions on resident hours like we have now.

ACGME rules for shorter rotations and longer time off, while in good faith of patient safety, are not conducive for tough learning. While not suggesting the antiquated surgery schedules of the 70's (so I have heard), loosening of the current restrictions would benefit the learner. We as attending must take more time and attention to resident decisions and be aware and take responsibility for all patients' safety instead.

Too little hours worked lead to less patients seen and less education. Now they leave to the real world unprepared for the real world stress and work load. The real world used to be easy compared to residency.

We are no longer teaching residents to manage time and be efficient. We do not educate on thinking when fatigued or getting something down so it can be recalled without really thinking about it. Life after residency doesn't guarantee time off or limited numbers of patients or limited shifts in a row.

The rules can get in the way of learning. They also can restrict maybe better ways to schedule hours that would normally violate the rules but would lead to better learning and time off. Residents are adults and should be treated that way and not required to follow rigid rules. Most lie on their hours anyway. I know I did because they are extremely inconvenient to document and I didn't allow them to prevent me from learning.

Disease processes evolve w time in acutely ill and injured pts. When residents come and go too much they miss the learning process of seeing symptom/sign evolution I'm pts. I.e. Admit pt w abd pain ......go home and come back and they are post op day one. Also in private practice you are it, there is no one to call sometimes and understanding you can work w fatigue is important.

I believe there should be careful oversight of resident work hours for safety reasons. However, the new arbitrary limits can result in degradation of education as residents may miss out on following a particular case to completion/logical hand-off point. I'm not sure what the solution is, perhaps allowing a certain number of exceptions in a given month. Another possibility is making a simple cap on work hours in any
given month to allow residents to follow a given situation all the way through for maximum education, but prevent this from being a continually repeating pattern.

I believe that current and recommended work hour restrictions have not shown any decrease in medical errors or improvement in resident morale. Due to increased hand-offs which stem from resident hour reductions there is a greater risk of medical errors. Moreover, from a patient and family satisfaction perspective, due to so many handoffs because residents go home earlier, patients and families have less of an opportunity to speak to the primary team and cross-covering teams may not provide adequate explanations due to less familiarity with patient cases.

I think it’s important to have some work hour rules in place. I know studies have not shown better patient outcomes and some of that may be due to the shift work that has resulted from the work hour changes in 2011. I think the one thing that could change in the 16 hr consecutive rule for interns. This does result in more shift work, negates continuity of care, and takes away from critical care experiences that are generally key in the intern year.

I believe the 16 hour limitation for PGY1s is too much of a limitation, however I do agree with the 24 hour call restrictions for PGY2+ trainees.

With only a 3 year residency, you need to work more...the more hours you work, the more patients you see, the more you learn. Going to be a difficult sell with this current generation, though....they want to make $500K a year w no responsibilities and no meetings outside of work.

If you are not exposed to this and that in person, learning is restricted...it requires one's presence in ED as much as possible - watching videos, etc cannot replace hands on, eyes on experience.

**Participants who had both good and bad things to say about the rules (Mixed comments):**

Although during my training we worked whatever hours suited the rotation or service and sometimes a 36 hour stint in the hospital with some "nap time" only was the deal and surviving it made us feel indestructible - it was not probably the best balance! I have noted that even though I am well into my career (25 years +)I have no aversion to working unlike many of the younger docs who seem unwilling to handle more than 2 shifts in a row and ask how few shifts they need to work in order to be hired. My age group typically asked how many shifts we could work a month! My how times have changed - the pendulum does swing with the generations. It’s nice to talk about how work hours affect all of the things mentioned in the question above, but the ultimate discriminator I believe is the individual person’s character and motivation for being a doctor in the first place - if it is your passion and it helps define who you are - then you will be attentive to detail, compassionate, caring and untiring. In all fairness, I believe that one of the things that has kept me in the game, was learning how to diversify my professional activities across several related EM related fields of interest.

I am faculty at a residency program, but not leadership. The hours rules within EM are just about right, and far more humane than what I endured as a resident. Everybody deserves a day off occasionally. The 16-hour rule for PG-1 on other services creates bizarre discontinuities in care, handoffs at bad times, and frequent confusion for the nurses in trying to determine who is responsible for a given patient. To me, that is the biggest mistake made by the current regime.

My opinion is this since I don’t know the optimal amount of time a resident should or shouldn’t work. No one knows. No study will ever answer this question. It’s a relative issue. However the obsession about the
hours is an impediment to learning and patient care. We worry more about signing out and leaving the hospital than the patients. And the studies show that to be the case. We are producing softer, less resilient physicians, emblematic of our society as a whole. Stop the coddling, roll up the sleeves and lets get back to training physicians.

The restrictions on resident work hours are a necessary positive development as programs could not resist the temptation to abuse residents in the past. My only comment would be that perhaps there is a little over-protection of PGY-1’s. I would make the work hour guidelines the same across the spectrum of PGY training. Overall, as an EM educator, I strongly support the work hour limitations described above.

The excessive hours I worked "off service" in my ER residency (1989-1992) provided me with tons of time to gain experience in procedures and being independent but quite honestly the hours required were just ridiculous and at some point the fatigue affected everyone and mistakes get made. The need for experience needs to be balanced with reasonable rest, and proper oversight and training by the residents above you. I did it, I survived, and my training was exceptional. But ER shift work always allowed for ample down time. The off service 36 hour plus days, multiple times per week, was not needed. After working all night, it’s time to round, eat breakfast, and wrap up loose ends, and call it a day at noon. This seems like a very reasonable plan. This will provide plenty of hard work and experience, but without danger to patients.

I agree with all except the PGY 1 limited to 16 hours during an off service rotation - obviously the surgical specialties - PGY1s, need to be able to work similar hours as the rest of the residents on the team.

If ACGME sees fit to limit clinical hours in an effort to improve patient safety, the total number of clinical training hours should remain the same as before the revolution. It would seem difficult to learn/simulate how to function while mentally and physically fatigued during the course of a structured work day after a solid night of sleep. Admittedly, it would be better for a well trained resident well into the third year of training to "practice" under duress. This would obviously need appropriate safeguards and oversight to ensure parent safety. Furthermore, perhaps adding an additional clinical year to every current training program in order to "make up for lost time" with regard to the limitation of clinical hours seen in the past several years.

I trained 35 years ago. Being on call for 24-30 hours at a time, several times per week was standard. My weekend was Sat morning to Mon at 5. My ICU rotation was 28 hours on 20 hours off for a month. This overall pattern did not occur on elective months. I really appreciate the goals of education and the specific opportunities this long exposure had for training me to be committed to the patient not the clock and to learn first hand the remarkable disease processes right in front of your eyes. I found some rotations and shifts thoroughly exhausting. I don’t think this is completely necessary anymore. I did sleep on lounge couches and on call beds when I could but I was still tired and I don’t think I performed at my best. Today’s patients are much more intense. I think our current system is a very good modern healthful approach to training which also includes actual Attending supervision.

I would rather see residency increase in duration by a year than see residents work as many consecutive hours as I did when I was a resident. I feel that I lost the opportunity to learn many things that I could have learned if I had not been so exhausted all the time during off-service rotations.

When off service the Emergency Residents should act as a full member of the team and work as many hours as the others. This is often their only complete exposure to other specialties and they need to maximize their experience and responsibilities. Rest hours after continuous duty on call should allow for
regeneration. The body and mind needs more than the time/sleep lost to get back to baseline. Plus longevity and effective care depends on a good family life and time to study. PGY1 residents should be allowed to do 24 hour call for reasons above, so they learn the subtleties surrounding continuity of care.

I am a recent training graduate -- EM residency followed by Critical Care fellowship. My intern year was the last year of the 30+ hour calls, with subsequent training done under the new work hour restrictions, so I have a unique perspective on the work hour regulations. It’s much easier to do a 16 or 24 hour shift than 30+ hours, but I really don’t believe that it’s made a huge impact on things likely patient safety, transitions of care and education. If anything it may have harmed patient safety because of an increase in transfers of care.

Work hour restrictions definitely increase transitions of care for patients. I don’t believe things should return to the pre-80 hour work week but there is not good evidence that the current reductions (or any reductions) have improved quality of care for patients. That said, I accept that residents need to have some down time. I just wonder if it is at the expense of learning experiences.

I think that training under stress is an important aspect of residency training and these work hours allow that balance of working under pressure but with appropriate time off. I also think that if there are less hours then residency would have to be extended and that sounds terrible.

I agree with limiting the work week to 80 hours. However I believe that limiting the length of shift hours has resulting in more transitions of care and has had a negative impact on training and patient safety.

I believe our residents are coming out of residency less prepared than they were previously. It is difficulty to discern whether this is due to work hour restrictions or more related to generational and work ethic differences.

I believe these questions are very poorly written and are too simplified to take into account medical education and the realities of medical practice. For example, it isn’t that 80 hours is too much or too little. It depends on the rotation, what learning occurs, what else is expected. Much of a surgical rotation may be non-educational as a first assist it may be spend holding retractors. Thus, the learning value may be lower than say an ICU rotation. The surgical rotation may need to incorporate more hours to transfer reasonable knowledge content. This is just one simple example. 80 hours does not necessarily need to be hard. It incorporates meals, rest, leisure, socializing...

I applaud the duty hours requirements, but the second iteration with restrictions on consecutive overnight call for interns seem onerous without direct benefit. Additionally, it’s important to track outcomes such as handoff related errors and reduction in total patient care hours.

I felt like I spent a disproportionate amount of time getting to- and from-the hospital between shifts. Fewer, but longer, shifts wound decrease this travel-in-out time, as well as making for fewer sign-outs.

The duty hours restrictions has mostly impacted handoffs on non EM work areas. This has caused a safety and quality issue in patient care. Trying to ensure that residents get rest is a good thing, but taking away their autonomy as to when maybe an appropriate time to leave to work space is dangerous.

The work hour restrictions are generally ok in the ED setting, but are complicated by didactic learning responsibilities. Work hour restrictions should apply only to clinical hours. In the inpatient setting work hour restrictions can be problematic from both educational and patient care perspectives. They often
result in an increase in the number of hand-overs, and an increase in the patient load carried by each resident on each work day. From an educational perspective, residents learn by taking care of patients. Fewer work hours are fewer educational hours. Increased hand-over frequency and patient loads are less educational than caring for fewer patients over more of their hospital course. From a patient care standpoint, it is unclear whether hand-over frequency or fatigued residents are more common sources of errors, but there is currently no evidence that restricting work hours has been anything more than even trade-off. I support the ongoing study investigating this is a controlled experimental manner. The best argument for work hour restrictions is to enforce fair labor practices. Residents should not be exploited merely as a cheap source of labor. However, reducing this complex issue to one of fair labor practices adversely affects our profession's perception of ourselves (and our culture of professionalism) as distinct from nonprofessional employees.

I believe in humane hours for mental well being, preventing burn out, and patient safety. However, I also believe exposure to many cases and experience help form a well rounded physician - one who can flourish once out.

I think that there does need to be a balance between work hours, the inherent danger of over tired/overworked residents without appropriate supervision, and have sufficient clinical time to learn clinical medicine. I do not think the hours should be significantly extended, but certainly not shortened. Call shifts 24 hours + transition are important learning off service, and the volume of patients seen during the duration of the residency is important as well. Significantly reducing resident hours I think would be a detriment, and would necessitate further months of clinical rotations to make up for that loss. Thank you.

**Participants who felt the rules are fine as is:**

The rules seem fair and safe.

While I do believe that long hours likely increases the rate of medical mistakes, the increased risk associated with more sign outs probably results in even more mistakes. As a result, the current set of rules may actually be associated with more medical harm. This particularly relates to the 16 consecutive hours portion of the work hour restriction. From my observations and discussions with residents, this seems the most problematic portion of current requirements. Either elimination of this requirement or the development of safer means of signing out to minimize the risk associated with this process I believe is highly necessary in the name of patient safety. The 80 work week seems reasonable, and I believe it should stay in place. Further reductions would detract from medical learning, and without additional ACGME funds to increase the length of residencies, training will suffer.

The residents need time after a shift to get adequate rest and 10 hours is about the limit.

**Participants who felt the rules still do not protect residents enough:**

As medicine becomes increasingly shift-work oriented, there’s no justification for excessive, abusive hours during training. The old rationale which was to gain experience as quickly and as broad an exposure as possible during the training years is not defensible. After working too many hours, residents aren’t learning or retaining anything and are much more likely to make serious mistakes during the hours when direct supervision is least available. The rite-of-passage mentality (I did it, you have to, too) needs to be put to rest.
What other employment sector allows anything remotely like this? Are they students or employees? If students, then if not there would not need PA/NP to fill their shoes for hospitals to function. So I would argue they are employees upon which hospitals need them to function. Normal work requirements that apply to other professionals should apply to residents. Normal work week, overtime, shift differentials, sick leave, etc.

Either medical care requires a well rested, non-burned out physician or it doesn’t. There are examples to be drawn from other industries including airline pilots and truck drivers where working and rest hours are mandated and for good reason. Residency is already a difficult proposition for many people and to either increase shift work hours and/or shifts will result in a decrease in physician education during weekly conference hours (working overnight and not being awake enough to understand the material or leaving conference to go home and sleep), decrease in residents’ mental and physical wellness (decreased exercise, eating fast food on the go). It takes a certain kind of hubris to think that physicians are more special and more capable to deal with working longer hours, taking on more work than capable, or otherwise to think that we are “superhuman” than others. We have families, children and parents that we are responsible for too. Increased work hours dehumanizes us to the point that we are medical automatons with little outside social interaction.

The "we walked uphill both ways" (despite the journey having been roundtrip) is no defense to the more rigorous and apparently more abusive forms of medical education that older physicians had been subjected to during training, especially in the very regimented, and overly hierarchical east coast “ivory towers” of learning... But the new physician now finds himself in a very different environ than the earlier doc, who was assured a successful fruitful life and enjoyed unquestioning cooperation from patients, limited regulation, limited professional documentation necessary, limited interference in work scheduling, “just do the right thing” was all the job description we needed to help the patient.. Insurance and 3rd party payor were partners in trying to help the doctors do their job better i.e. help the patient/insurance company client achieve optimal health. Now the bottom line is keeping the shareholders happy, better to disregard the goodwill or respect of physicians. Often the CEO's pay has been tied to the increase in company value or stock or "non-profit” company valuation and fundraising or cash flows. The CEO of UnitedHealth Plan made over $66 million recently with his stock options, while his doctors and health care providers are increasingly restricted and frustrated by corporate predatory business practices. These lucrative corporate “tricks” have become Standard Operating Procedure [S.O.P.], now, such as: pre-authorizations so burdensome that you can modify the physician’s behavior by having them think twice about being on hold a long time, answering questions which are being asked by a minimum wage employee and the filling out of a form, completing it and then to keep following up on the status by multiple calls and hopefully recruiting the patient to make inquiries to perhaps speed approval of this procedure or drug that the health plan doesn't think is worth it. (i.e. Administrative decisions, made for financial reasons, restricting the way the physician practices medicine) This is actually illegal in California where I have practiced 35+ years, because it is essentially the corporate practice of medicine. The writers of this California law banning the corporate practice of medicine showed great forethought as corporations are beholden to their shareholders and the officers have a fiduciary to increase this value, (usually by decreasing expenses and increasing revenues, such as premiums or recovering deep pocketed claims) which means finding ways to pay doctors less, and to find ways to increase premium income, increase # of people paying premiums, increase the premiums and manage risks, such as finding ways to eliminate the highest utilizers, such as the “worried well”, very sick and those with much increased genetic risk (Dad died prematurely with multiple medical problems). These physicians are often Hundred of Thousands of Dollars in debt compared to the often incomparable tuition of the early 70s(My state
medical school tuition was ~$1100 and I bought a used 1965 Dodge Dart with a "slant 6" with $200 that I was able to scrimp together working odd jobs. The new docs are subject to stressors that often older doctors cannot relate to because the environment has changed and will continue to change during our lifetime. The increasing clout of corporations does not bode well for either physicians or the patients, but the approval of Part D, Medicare in this country where the government is restricted (unlike Canada) from using its clout to negotiate lower drug prices, will ensure a nice revenue stream and sustained financial health for those corporations benefiting as well as those lawmakers who can now receive unlimited money, ...er I mean unrestricted “free speech” from these corporations due to the recent Supreme Court Decision and the resulting Federal Election Law changes. The new physicians should not go through trial by fire. The House of Medicine that we are leaving them is over mortgaged and underwater. They have more scientific and procedural demands on them then anytime in history with the explosion in computing and information management, yet we are restricting their freedom and choice of available armamentariums to help their patients. No more admitting for r/o mi, new onset CHF, or new onset afib. "Treat and street". We are D/C’ing them from the hospital "sicker and quicker". The job IS harder being a doctor today then 30 years ago. Patient “face” time is decreasing, yet medical problems more complex. Also, it appears the insurance companies and 3rd party payors have the upper hand and the doctors don’t need to feel happy or even well, as long as they see the allotted four patients per hour or more (but pre-authorizations are time consuming and likely better done on your "off" time as another phone call or inattention could jeopardize the connection and you will likely need to restart). What happened to the autonomy and independence of the physician? We are being increasingly groomed for a life of involuntary servitude to a corporation which cares more about the bottom line than optimal patient care and community wellness. My suggestion to ACGME is to help the poor physicians in training in any way they can, as it seems their future may be disturbing. In place of the shrinking allegiance we will have for the patients, our financial health will be tied to the corporation’s bottom line. The young physicians in training whose educational experience your organization hopes to standardize and improve, are like soldiers being sent out to be slaughtered. Does the ACGME have any influence on the increasing exploitation of physicians and patients by the growing current corporate climate? ("Medicine is now an art, a science and a business. Two out of three don’t cut it"). PEACE. Thanks for your work on behalf of physicians in training, they deserve the best.

The culture of the profession of medication needs to further adapt to better address both resident and working physician’s wellness. This is quickly becoming a "job" and not a profession. It is embarrassing that it took legislation to limit work hours to 80 hours per week. This is not sustainable and physicians that claim they did it are naive about the current stress that exists with this profession. We need more quality physicians that work reasonable and sustainable hours in these times and practice environment. ER Physicians have a 60% burn out rate currently and other specialties are at 40% overall. If our profession doesn’t tackle the problem of burn out, by better managing education time, among other things, then the federal government will continue to do it for us.

In terms of quality of life, with the amount of electronic documentation that is currently required, there is minimal learning that is done anymore during residency. More time is spent in front of a computer than a patient. The extra work hours are monotonous times that do not benefit the patient or the resident, only the billing and finance departments. It is a sad state of affairs. I feel that the amount of time spent at the hospital by residents is not productive, and this time could be better spent reading, since seeing more patients is not part of the issue.

I trained at a time when there was no limit on hour. It was slave labor with no real learning on the job. It was dangerous for the patient and me--and I am sure that there were patients that were harmed as well as several vehicle that I drove.  Roy Graves MD  FAAEM
Tired doctors make stupid decisions that hurt patients.

I believe off-duty time should be a minimum of 10 hours. Eight hours between shifts results in approximately 6 hours of usable sleep time (subtracting for time to travel to and from the rotation, shower and eat a meal). This is too little sleep. Additionally, I do not believe that anyone is functioning at their best at the tail end of a 24h shift. 12h max shifts with an additional 4 hours if needed for continuity of care is reasonable and safer for patients.

A 3 day weekend off monthly would be good.

Many of these hours are scut-work, basically slave labor for the large institutions. Make it a 40-50hr max/wk and make sure doctors are doing doctor-work.

Doctors do not make smart decisions when mentally fatigued. Doctors don’t walk the talk... we preach about wellness (physically and mentally), but we don’t practice what we preach. That is one reason there is so much burn out in modern medicine.

There isn’t a residency director in the country who would fly to a conference on a plane flown by a pilot who had been on duty for 24 hours. So why do they advocate risking the lives of patients by rules that guarantee residents get inadequate rest? Becoming a PGY2 does not make you any less susceptible to the effects of sleep deprivation.

Many attendings a shift workloads on to the residents so they can pursue “research”, administrative responsibilities or from simple fatigue on their part. I do not believe a resident can either learn effectively nor does the hospital live up to its patient care responsibilities when the clinical practice burden on the residents is excessive. I’ve often heard residents complain that they are too fatigued to effectively study the material which they are expected to master.

Intern work hours are too restrictive and hamper continuity. More focus should be given to a true day off per week (not just a 24hr period which may fall post-call) and at least one 2-day off period per month. These periods to rest and get things accomplished are more key than the periods off between shifts.

What I see too many times is that these rules are ignored. Sometimes it is due to not having enough residents to cover the shifts they usually do. Community Hospitals are particularly vulnerable to this.

ED schedules typically appropriate. Off-service rotations typically way over-hours with unreasonable call schedules, despite new restrictions.

I believe they should work a minimum of 40 hrs/wk with a max of 60 hrs in order to see as many cases as possible.

12 hours off between shifts is better than 8-10.

Sleep hygiene and rest are the bedrock of selfcare; I do not suggest increase hours on em service 14 hour shift offservice rotations is maximum I would like to see.

The ED 60 hour limit per week is appropriate and perhaps be even less. For the inpatient services, depending on the pace of that service, 80 hours a week may be too little.

**Participants with “other” comments about the rules:**
Distinction should be made of different "work hours." The emergency medicine environment is decision rich, cognitively fatiguing. Other rotation might have significant down time while being on call....

We are in a serious physician shortage. Although decreasing resident work hours makes residents happier, it does not prepare them for the real world. We are in dire need of more physicians. Yet we are producing fewer FTE’s after graduation (mostly due to women who are working part-time), preparing residents who do not expect to work as hard as their predecessors, while having an aging populace and ever increasing consumer health care needs. This quadruple threat is creating a public health crisis that cannot be fixed unless we: INCREASE the number of GME positions, EXPECT residencies to be difficult and PREPARE future doctors to work hard for the entirety of their career. "Lifestyle balance" is not a valid goal for physicians who are trying to keep America from drowning in the mire of our heath-care system. We must expand physician training now.

Resident physicians I work with are immature irresponsible and frankly scare me.

There needs to be an ability for residents to have charting hours after a 12 hour shift, when back to back shifts are scheduled. If they work less, with only 60 hours/week with EMR charting, then they don’t see enough patients and have had a significant decline in clinical competence upon graduation compared to years past prior to EMR implementation.

I would find it hard to believe that anyone can stay focused for more than 12 to 16 hours, without sleep. Getting enough clinical exposure is certainly another part of the equation. I have recently changed practice to a position with no night duty (after more than 30 years in Emergency Medicine). I am now more than a year out and my sleep patterns are still disturbed. I wonder if we can’t do something with all the “wellness” information we have about shift work to make a shift and training schedule with a bit more sanity? I don’t really know what to suggest in this regard but technology should be able to help us --- video the night cases for review, move to all night shifts for longer stretches, video taping lectures that can be watched when the person is less fatigued if coming off a night shift (he/she would be responsible to watch) are a few things that spring to mind. I think we should prioritize what we are trying to accomplish --- training residents to be good clinicians who can think on their feet, who have enough clinical exposure and patient interaction to feel comfortable with varied dynamics, and who appreciate the life-threats associated with various complaints --- then determine what is necessary to get that done for at least 80% of individuals. Determining the number of hours, etc., should follow pretty easily.

I just graduated residency 6 months ago, so I’m not far removed from residency. Nearly every program breaks hours, sometimes it’s actively encouraged. Thankfully, my program was run by decent people and they followed the rules. Saying “8-10 hours” of rest between shifts just means 8 hours. Don’t kid yourself, ACGME. Residents have absolutely nothing to gain by reporting work hour violations. At best, nothing is done. At worst, the resident is punished (I’ve seen it) or ostracized by the program who will later give them job recommendations. The only way to solve it is serious punishments for programs that don’t punish residents (if you put a program on probation or disband it, it only hurts the residents) or force residents to physically clock in and out. If a resident is clocked out, they can’t access the computers.

I hate the duty hours.....I hate them because we as leaders embarrass ourselves, our specialty and our profession by not practicing what we preach to our learners. I personally average 100 hours a week, an actual decrease from previous. When we pulled our academic group with one possible exception every attending was working more hours than the residents! I frequently finish a shift at 3 and need to be at meetings at 7. So my big issues with the duty hours are these. 1. We may need to extend the residencies with funding because it is clear to me that the residents (who are top tier) do not leave the residency with
the same fund of knowledge that residents in the past did; especially in areas like pediatrics and in important areas outside the 80% most common presentations. People get upset but facts are the standards are different. 2. With decreased hours you would think they would do more reading but in fact many do nearly no text reading because they have bought the non-sense that they will learn all they need to know from a blog, lecture, sim session, and a few Foam sites: this is not true. One reason they aren’t reading is we have supplanted reading time with 2-3 hours after every shift at a computer doing documentation. This is criminal that we have allowed this to infiltrate our specialty pulling us from our patients without demanding increased personnel to absorb the 15-25 % increased work burden away from the patient this has caused. For faculty we have tacitly accepted at decrease salary of 15-25% with greater risk of law suits and we accepted lowering the teaching of our residents during their, now limited shift time. This is central to the issue of how many hours they work. Since now they only spend <20 % of the time with patients that means they actually are spending only 12 hours a week max actually engaged at bedside with patients. Most of their time is as a computer entry clerk: something we used to pay 10 dollars an hour for. Before we extend residencies at 100s of thousands of dollars cost to our resident’s careers we should insist that computer order entry etc. be streamlined and if necessary given to surrogates like scribes to allow the doctor to see patients. We suddenly need massive increases in PA and NPs because we don’t insist on the management of our own time wisely: nothing intended against our AP providers whom I love and absolutely require. But know this, the gravy train of physician billing for these positions will stop: soon. Independent practice is only around the corner and where there is cost savings to government there will be rapid action. So where will that leave our residents..... 3. We as a specialty should take back our lives and insist that the same rules applied in residency apply to all EM physicians: private and academic unless they choose to negotiate for additional reasonable hours at elevated rates like double time. Many other countries do this now such as Argentina. It is a fallacy that the money is not there to support this. The reality is that the money to do this is currently being spent for the administrators instead of the doctors. In the past we had doctors stealing from the pockets of the doctors: that is better but now it just the huge numbers of unnecessary administrators who just have meetings 8 hours a day ..In some departments 15% of their professional positions or more are administrators (non-physicians: not seeing patients) and in many cases they make more than any of the physicians who generate the income. A serious issue that everyone says is progress. I think otherwise. We were far more effective with one administrator who worked for us than we are with 10. If we did this we would have time to teach our residents again and use this money to put more faculty on shifts which would allow us the time to actually provide meaningful oversight of our residents during basic procedures, death telling, social interactions, etc. etc. We need a reformation in education and that is we need the educators to have the time to educate and we need the learners to be pulled away from secretary duties and given opportunity for reading and one on one education with their faculty.

I learned the most, when I was by myself working late and tired. Unfortunately, mistakes are made and patients suffer for it. However, learning physicians either make mistakes early in their career or later, but they will make them. If you reduce work hours, you just push off into the future when mistakes (and learning) are made.

No opinion all the way; it is all we knew. Need studies. The big problem for residents is not hours but harassment by un-evolved attendings.

I don’t know too much about it but patient safety has to be job 1.

ED work hours consistently do not include hours spent charting after shift, which significantly increases the amount of time worked.
It's good as it is. We should be working to align their workloads with those of professional life. That means pretty busy for most of us, but not so busy that patient care and medical management decisions are impacted.

Well done.

It is better to have residents work at or above their comfort level WHILE THEY'RE SUPERVISED than to have them never having been uncomfortable and then go out into unsupervised practice. The KEY regardless of how many hours you ask a resident to work is that they do need supervision. I had precious little of that as a resident.

During the clinical hours it is a mistake to limit the amount of patients that a resident can see. There always needs to be oversight but that should be up to the attending supervising.

Residency training is a balance between working hrs and rest periods. I feel this balance needs to be individualized to fit the characteristics of the individual resident. There needs to be some flexibility in this scheduling. Guidelines should be just that.

At my training facility as a resident. Interns were not allowed to work more than 12 consecutive hours. That was too little and a waste of their time. There was no more call nights.

The ACGME spends too much time searching for "work duty hour violations". Data shows these strict "rules" do not improve patient care. The real work of being a physician does not require this skill of fanatically tracking work and off hours. While I support general guidelines that support resident health and wellness; the details of the rules often compromise resident educational opportunities and flexibility when it is required for their education and for patient care. Please advocate for relaxing the policing and fanatic adherence to rules that do not change patient care outcomes.

I think there needs to be "saturated" time for learning during residency.
**Q1 Are you a:**

Answered: 123  Skipped: 0

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<tr>
<td>Attending with a leadership position in a residency program</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Total 123
Q2 Do you believe that the current residency work rule restrictions of up to 60 hours (ED rotations) / 80 hours (off service rotations) per week result in residents working:

Answered: 123  Skipped: 0

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too little</td>
<td>30.08%</td>
</tr>
<tr>
<td>Too much</td>
<td>4.07%</td>
</tr>
<tr>
<td>Just right</td>
<td>60.98%</td>
</tr>
<tr>
<td>No opinion</td>
<td>4.88%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123</strong></td>
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</table>
Q3 Do you believe that the off-service restrictions on consecutive duty hours (of 16 hours for PG-1 and 24 hours for PG-2 and above) result in residents working:

Answered: 123  Skipped: 0

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
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<tbody>
<tr>
<td>Too few hours at a time</td>
<td>47.15%</td>
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<td>Too many hours at a time</td>
<td>6.50%</td>
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<tr>
<td>Just right</td>
<td>36.59%</td>
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<td>No opinion</td>
<td>9.76%</td>
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<td>Total</td>
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</table>
Q4 Do you believe that the required 8-10 hour rest period after off-service clinical shifts for residents is:

Answered: 122  Skipped: 1

**Answer Choices** | **Responses**
--- | ---
Too short | 13.11% 16
Too long | 18.03% 22
Just right | 61.48% 75
No opinion | 7.38% 9
Total | 122
Q5 In an effort to represent your views, we will share any comments you make about the current residency work rules with the ACGME. Unless you choose to add your name in the comment section below, your response will be anonymous. We believe that your perspective on how the work hours impact patient safety (especially transitions of care), resident wellness, the quality of physician education, professional development, and the changing culture of medicine would all be particularly valuable for us to send on to the ACGME.

Answered: 59 Skipped: 64

COMMENTS FROM ATTENDINGS WHO INDICATED THAT THEY HELD LEADERSHIP POSITIONS WITHIN RESIDENCIES

40% of the respondents to the survey in this category also submitted written comments for ACGME review

36 (65%) of these respondents felt the rules were too restrictive
- Decreased sense of responsibility among residents
- Residents don’t use their time off to read or rest
- More handoffs means residents make worse clinical decisions for patients they don’t know
- Decreased training time means residents today graduate less prepared
- Rigidity of rules makes time off awkward to use and shifts hard to swap which hurts wellness
- Attending work hours can be worse than residency hours and thus a shock
- Interns should not be in their own category

6 (11%) expressed mixed sentiments

2 (4%) felt residents should work even less
- Immediate patient safety is paramount and it’s wrong to let MD’s work while impaired
- Residents should “have a life”

11 (20%) had other comments about the regulations
- Violations are not reported
- A “night float” system is optimal
- The rules need more flexibility

Participants who feel the rules are too restrictive:
The duty hours do not do what was intended. Residents are not reading more or sleeping more. More free-time does not equal better doctor. More time for hiking, biking, etc, while enjoyable, should not be the goal. The current system protects residents from working long hours until their 1st day as an attending...where they work long hours. If residency is meant to prepare residents for the life of an attending, then the duty hours rules fail in this pursuit.

You learn to function against adversity by training under adverse conditions. Be it fatigue, stress, long hours, pressure, expectations....it does not matter. By babying residents you create doctors with no work ethic no ability to function under duress no ability to push themselves. I'm so glad I trained just before the joke residencies began. I'm so underwhelmed by what we now turn out. Less hours equals less cases equals less knowledge and skill.

I fear the pendulum has swung too far and that duty hours are directly eroding our professional standard and duty to our patients. We must always be attentive to patient safety but fear our effort to limit work hours has resulted in physicians who are not able or willing to stay longer or take ownership of a patient's care when necessary. Many faculty members must work longer and harder than our physicians in training and when they graduate they are not always prepared for the work load. But perhaps more important is their sense of duty and sacrifice which has afforded medicine a rather high professional standing is no longer so apparent and I fear this is eroding our patient's trust in us to do what is right and best for them in their time of need. Couple work hour restrictions with productivity based compensation models and I fear our professional standard will continue to be negatively impacted which will ultimately compromise patient care and safety.

Shift work is now the order of the day. Residents currently don't display ownership of their patients and appear more disengaged with the concept of professionalism. With more time off most residents appear to spend less time worrying about reading or studying medicine. They are balancing their lives with their personal pursuits and are "acting" as doctors with the aplomb of technicians.

Shorter shifts = increased turnovers = decreased patient safety and poorer training

Less hours better for wellness but deleterious to education and quality of residents at completion of residency

There have been negative impacts with respect to care transitions; internal medicine residents leave sharply at pre-designated times. Work hour restrictions mandate that these residents leave early prior to full signout. This is coupled with an overall reduction in the amount of time off-service residents spend in the ED- that negatively affects collaboration.

I believe the residents have a better work/life balance due to these rules but I don’t think we have improved patient safety. We have replaced fatigue and errors from that with increased transition of care errors. I feel that the residents leave residency less prepared because of fewer patient encounters as well being unprepared for the rigors of medicine as an attending with no hours restriction or rules. I feel there is likely a happy middle point which allows for more patient exposure and fewer hand off and the number of hours worked. I think the pendulum has swung too far in one direction.

Residents are not getting enough clinical experience due to work rules. Furthermore, the work rules result in excessive sign outs, handoffs, and other transitions of information that are high risk. Finally, an
extended call in the hospital may actually be less cognitive work for the residents because they do not constantly hand off cases.

I do not feel residents should have work hour restrictions in any way. The best way that I learned medicine and to be good at it was being required to perform all my tasks to completion -- regardless of the time it would take to do a thorough job. Additionally being on-call or working great than 24 hours played a huge role into being a leader and controlling patient management on whatever service I was on. I think the time limit rules are producing a poorer grade physician who is loosing the ability to use human ability to exam and plan to perform real medicine.

Too many handoffs due to lower hours; dangerous for patients. The focus on hours has negatively impacted the work ethic. The long hours used to be hard, but we felt duty bound to care for our patients, and this was the focus. There was pride in that. The focus now is on bean counting and not on patient care and learning. Entitlement amongst Housestaff has skyrocketed. Residents who want to stay for procedures or work ethic are penalized for violating hours. Madness. Number of supervised patient contacts have dropped. Preparation for clinical practice has suffered.

Too many transitions of care on off-service rotations; the ACGME has significantly "jobified" the profession of medicine and encouraged young physicians to abandon patient care in many circumstances and instead sign out patients to other residents who don’t know the patients well; decreasing work hours and making people more rested is sensible, but it compromises patient care by forcing a multitude a sign-outs; rather than trying to improve patient safety by improving resident rest, they should instead mandate better supervision of the residents on off-service residents; frankly, off-service supervision is atrocious at most academic institutions.

I am finding that residents (especially when on non EM rotations) are missing the key course of events in the acute care of patients. By limiting hours in the hospital, learning from patient cases has diminished significantly. I have encountered senior medicine residents who cannot manage acute copd or asthma exacerbation. When asked what they want to do, the response is consult pulmonology. This is just one example how the work rules have interrupted resident education by not allowing the resident to follow and manage the disease course. Of course I am not advocating 48 hour stretches as in the past, but we need to have a nice medium.

While I feel that the work hour regulations protect residents, I feel that it significantly limits (along with patient caps) the number of patient exposures that many residents experience during training. I also feel that as an attending physician (private practice or academic) - to have this protected time may set an unrealistic expectation. Because it does not exist the day that training is completed.

While a resounding victory for physician wellness/health, work hours restrictions have unintentionally generated an educational environment where young physicians are leaving residency training ill prepared to enter the work force. Funding of GME is guarded at best, so extension of training in years does not seem a viable solution to improving the educational experience of our trainees. Finding a 'happy medium' that respects provider wellness and provider preparedness should be our focus.

These rules are too stringent and in some ways DECREASE wellness. For example, the 1 day off every 7 is a major issue. It requires the residents to miss didactic conferences and valuable clinical experiences and doesn’t allow them to "stack" their shifts so that they can get a long weekend off. As for the 60/80 hours per week, many residents independently push (or exceed) these limits voluntarily by moonlighting. Their
clinical experience is more limited, and the transition of care increase has been bad for patient care, on the one hand; but it has also created a culture of "clocking out" and passing off your patients and never really taking ownership and full responsibility.

The current duty hours result in too many handoffs and missed opportunities for learning for the interns. It is actually harder now to be a resident as there is no downtime. You have to stay awake and get notes/orders done, and cannot work at your own pace as you are literally thrown out of the hospital. In the past, when there were no duty hours you could easily take a nap and then get up to do your notes. No they must be done by the time rounds are done so that you can leave the hospital so things are rushed and not done well. The current system is a failure and actually more stressful.

Work hour restrictions interfere with the necessary follow thru on patient care that serves an important educational function. I do not disagree that there should be guidelines, but hard rules force residents to leave mid-treatment when the potential for learning might outweigh the need for an extra hour off work. Resident wellness is important but work hour restrictions is a simplistic approach to an important topic

We need to eliminate several of the duty hours regulations but not all of them. We are giving up long term safety for the sake of perceived short-term safety.

As a residency program director, the hours per week are good and I see no negative impact on learning or patient care and this is good for residents' health. However, the limits on amount of time worked at once (16, 24 hour limits) are not ideal. Specifically, PGY-1 residents should not be limited to working 16 hours. Obviously they would not work this in an ED, but taking call is an important part of being a physician. Waiting until they are a PGY-2 resident and potentially the "upper level" on a service to take call is not ideal for patient care or learning. I strongly support allowing PGY-1 residents to work 24+ hours. Specifically, PGY-1 residents should be allowed to take overnight call when on off-service rotations.

I have yet to see any evidence that restricted work hours produces better Doctors or fewer medical errors.

Current rules makes interns/residents the most well rested physicians in some hospital systems and new/current fellows are now in charge of and supervising residents working longer hours and more sleep deprived than they ever were in training (picking up the slack). Dangerous. The constant hand offs and passing the buck leads to worse care (despite goal of improved sleep for trainees based on assumption that better rested equaled better care).

Having experienced night float in the MICU as an intern due to work hour restrictions, I felt that the hours restriction negatively impacted patient care due to the transition from the day team (that was on rounds with the attending throughout the day and heard the full plan, etc) to the night team (that only got brief sign out on each patient). The night team was basically just pinch hitting for the day team that had the full picture of the patient. After that experience, the rotation was changed to the senior resident doing 24 hour call, with the interns on night float (12 hour overnights), so that the transition was less dangerous and there was more continuity of care. The thing that bothers me most about the restrictions is that there are no such restrictions on attendings. There are no mandatory hours off between shifts or anything similar. We train residents under these new rules and then cut them loose into a world that has no rules. Now residents work less hours, which means they see fewer patients, but the length of residency has not changed. If we continue in this trend of less hours, same length of residency, eventually we are going to be graduating residents with subpar training due to lack of experience. This is something that I really feel
strongly about the ACGME investigating -- does the residency training length of time need to be increased?

I have found the residents now are giving up important clinical responsibilities on off-service rotations. They are having to hand off patient care issues that are important to continuity of care. They are also foregoing personal obligations to these same patients upon which they have built a relationship of trust in order to get out in an obligatory time period. I hope the pendulum hasn’t gone to far the other way.

I think the current work rules have created a residency teaching environment of entitlement among the residents. I am definitely not for working 110 hour work weeks on no sleep. However, I do think that there is some value in understanding what it is like to work when stressed or mildly to moderately sleep deprived while under supervision for a limited amount of time. After all, there are very few residents and fellows who graduate into jobs that observe the residency work rules so the training environment that the ACGME has created is one of false challenge and unrealistic work expectations. Again, to be clear, I am not suggesting over working residents or trying to push them until they cannot function but I am suggesting that the current rules and the unbending nature of them deny training environments that mimic real world medicine after residency. If the argument is that it is a patient safety issue, you will notice that I used the words “under supervision for a limited amount of time” in my description above. It seems to me that the reason that these work rules are in place is because often the residents are overworked and not supervised properly. Work rules should not be the fix for hospitals and programs that don’t have proper attending supervision.

I understand the motivation behind these rules which are well intentioned but I feel they interfere with resident education and can foster a culture of clock watching as opposed to what’s in the best interest of patients and medical education.

It is clear that the recent change in duty work hours has negatively impacted resident education and not helped pt care. They have also made it very cumbersome to schedule shifts, resulting in dangerous periods of no continuity, greater variability in physician coverage and increased work days per week, not less. It makes no sense to have R-1’s working less straight hours than R-2’s or above. What should be mandated is adequate supervision by upper year residents, fellows or attendings.

If Question #2 differentiated between PGY-1 and PGY-2 and above I would have answered it differently - I believe that there’s really no difference between levels when it comes to work hours so interns should be able to do the 24 hour consecutive work hour period just like upper level residents. That being said, work hour rules should be enforced and supported by faculty and residents must honestly report - I know this is not happening in other non-EM residencies at my own institution - that negates the intent of the system completely. I also understand that limitation of work hours has impacted patient contact hours/resident experience paradigm especially with regard to procedures in the operative specialties (I do not believe it has impacted EM). This in turn has dropped surgical specialty board pass rates; a real problem that could be answered by lengthening residency training time-but who would pay for that when the government is trying to cut back on GME funding. I only bring this up because it’s the same quandary that EM might face as the continual question of “should all EM programs be 4 years because of the expanded EM curriculum” is considered-same answer-who would pay for it?

Residents are no longer working enough hours to gain proficiency. Likely residency needs to be lengthened in order to maintain balance between reasons work hours and clinical proficiency in residency.
Restrictions on resident duty hours have been taken to the extreme. The best evidence of this is found on surgical rotations and in intensive care unit scenarios. Residents are unable to follow patients through the complete course from initial work up to definitive management and thus have lost the ability to recognize proper management courses. Fear of violating these artificial and mostly unfounded duty hour restrictions have lead to poor decision-making by leaders in the medical education field. Future physicians now experience their first clinical fatigue as attendings rather than during their residency. This leads to a lack of awareness of fatigue and it's detrimental effects on a physician's ability to care for patients in a safe and effective manner. Residents should be allowed to find their limitations while there is significant supervision thus allowing for self awareness and leading to the creation of a more professional and effective physician workforce. These strict limitations are more proof that good intentions and changes in educational theory do not always yield the proper result.

We should balance duty hours with the concern for adequate patient exposure.

The more handoffs the more mistakes. We can all tell stories of patient's being handed off "awaiting bed" that end up needing significant intervention and require extra detective work due to insufficient knowledge about the patient. Most recently we had a septic patient with a central line placed that persistently oozed due to supra therapeutic Inr. Probably would have advised the more senior resident to do the line instead of allowing the ms to attempt. Insufficient handoff without good follow up on labs were the cause.

A policy that stipulates a hard number of hours will lead to protests, hard feelings and eventually litigation. It will not be possible to limit hours and workload in post graduate practice. During residency there should always be an effort to get the post call people out of the hospital as quickly as possible unfortunately sick and injured people aren't always able to conform to our guidelines.

I think too few clinical hours dilutes the resident experience. This is where I felt I learned the most. Was hands on clinical work with supervision. ACGME can worry less about hours of working and more about the quality and quantity of supervision and teaching to improve resident education. Residents should experience a work environment similar to what they will practice upon completion of training. Programs should be able to determine work hours and schedules of residents.

The rigidity of the duty hours requirements can affect the ability to develop work schedules that are conducive to resident wellness, particularly in a 3-year training program.

Participants who had both good and bad things to say about the rules (Mixed comments):

Total number of hours feels about right. Restricting consecutive duty hours and having a long (8-10) hour required rest after clinical shifts is detrimental for 2 reasons. First, it's not realistic for the real world. Residents need to be prepared to do quick turn arounds and potentially to be awake for long periods of time (thinking of how the real world scheduling works, and the demands on time for working parents, etc). Residents learn by providing continuity of care to their patients which is lost with the current choppy shift work on inpatient services.

Someone should never work more than 24 hours. It is very peculiar that we would have two different requirements for PGY 1 and other residents. Either it is a good idea or it is not. With such a logically indefensible point in the rules, it causes derision that should not exist. Also, 8-10 hours is a good goal and should be our target. But to create a violation when there is a minimal deviation from this, on an
infrequent basis, is absurd. In keeping with my above theory, someone should never work exhausted. However, being "a little tired" from time to time is a way of life and is not dangerous. The ACGME has done a poor job of differentiating normal medical practice (and life) from something dangerous such as exhaustion. Exhaustion is inexcusable and was the intent of the rules. Unfortunately, they have also created a death penalty for a parking violation.

As in anything this is multifaceted. I think you need to take into consideration if it's day or night. Some just can't handle flipping shifts and this should be monitored by the PD.

I do not view the 80 hour limitation as an issue. Most would agree that working more than that leads to poor performance for residents, in particular during the early part of their training. That said, there are so many other restrictions that scheduling can become a nightmare.

I worked over a hundred hours a week in residency. Clinical hours is directly proportional to clinical experience. Working 12 hours a day 6 days a week is a reasonable amount to accrue ample clinical hours for learning during residency. Less than 60 hours of clinical experience per week would weaken clinical training and result in less experienced residency trained physicians.

Depends on the intensity of on call hours on off services - don't know how to measure.

**Participants who felt the rules still do not protect residents enough:**

Duty Hours are about patient safety. And that is determined not by how many hours residents work at a time. It's about how much rest they get. Debating the 16h vs 24h vs 30h is not helpful; it's like debating whether driving with 0.08 of EtOH is safe, or 0.10 is safe, or is it 3 drinks or 4 drinks. All duty periods are not alike and require different periods of physical or mental application. That's where the comparison to the airline industry breaks down. If we are serious about patient safety and lack of sleep impacting this, then we should absolutely state that residents will be sent home if they have less than 8 hours of sleep, and their training period will be prolonged (with appropriate funding provided for additional training). The perception is that duty hours are about resident wellness and the program's, not the residents' responsibility. Pilots must explicitly affirm fitness for duty at every period, otherwise they are not allowed to fly. Are we ready to do this for residents? The duty hours are currently an unfunded mandate. Properly addressing this problem involves creating redundant systems for resident coverage and a move away from fixed residency lengths. This will require significant system change and funding for additional providers to care for patients. If a pilot exceeds their work period, or has an insufficient break, the flight is cancelled and the passengers compensated. How will this happen in healthcare?

Overworking residents does not produce humane physicians. It is time for our residents to have a good balance of work, play, family or avocation.

**Participants with “other” comments about the rules:**

I still don't believe the hours are adhered to. I see residents intimidated to point out violations. I think also that a total number of hours is an inadequate measure. How those hours are used, whether days are advanced to nights appropriately, whether circadian rhythms are matched, etc., is a much more impactful goal.
I think a night float system -- perhaps a short 6-8 hr float -- with core sleep for the off service resident, and the night floater excused from daytime activities is the most circadianly appropriate system. Insisting on attendance at contemporaneous lectures even when working nights does not optimize learning. Overall, the hours total are not that onerous, even though most countries have less hours. Transitions of care would best be with a day team and night team, which would be the same people each day and each night for the month, so that each knows the patient. Vicken Totten MD, MD, FACEP FAAEM, FAAFP Institutional Research Director Kaweah Delta, Visalia CA

I don't object to the duty hours, but I do object to the strict attitude. There are lots of times when either patient care or documentation make residents stay a little longer. Would like an easier way to let this happen.

The primary focus should be the aggregated work hours per month then flexibility should be given to the hospitals and specific services to determine the most effective, feasible, and satisfying way to staff. Artificial and rigorous rules can make it worse for resident lifestyle and education, not better. I would agree with a minimum of 24 hours off per week with an aggregate of X hours per month and per year. Then services can figure out how to make this work.

As program director, the work hours are not the problem. It is there simply not enough residents to fill the schedule making maternity, paternity, or sick leave a disaster.

I believe work hour rules for off service rotations should be a reflection of the specialty residency program for which the resident is operating off service and not on the primary emergency medicine program. I also believe that the number of hours is less important for a resident to work than the number of patient's seen and the number of days in with clinical shifts. Even with shorter shifts, the more often (higher number of days) a resident is in the department, the fewer opportunities a resident has to pursue academic goals.

It would be more productive for residents to have greater opportunity to moonlight to aid in professional Development.

More flexibility to allow residents and program directors to optimize each rotation.

Resident protected time for conference could be replaced by implementation of the asynchronous "flipped classroom" model for those scheduled to work during conference to avoid potentially dangerous disruptions of ED staffing adversely affecting patient safety.

The overall guidelines are fine but have become to prescriptive such as short break violations. Also there are several off service rotations with a lot of downtime but still must be counted as "duty hours".

There is a need for a taskforce to study evidence-based about shift work with short, medium and long term outcomes.