January 26, 2016

Thomas J. Nasca, MD, MACP
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Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60654

Dear Dr. Nasca,

The American Academy of Family Physicians (AAFP) is pleased to provide this letter as the family medicine response to a request to provide input on the Accreditation Council for Graduate Medical Education (ACGME) duty hours as requested in your letter to Dr. Douglas Henley dated December 21, 2015. In preparation for our response, we have engaged our colleagues in our sister family medicine organizations including the Association of Family Medicine Departments, the Association of Family Medicine Residency Directors, the North American Primary Care Research Group, and the Society of Teachers of Family Medicine as well as our Residency Program Solutions consulting group.

Formal position on the current ACGME duty hour requirements

The AAFP does not have a formal policy or position statement regarding the current ACGME duty hour requirements. Representatives from the AAFP did however provide testimony to the ACGME at a 2009 hearing following the release of the Institute of Medicine (IOM) recommendations on duty hour requirements. At that time, while we recognized the competing “goods” of “ensuring proper and timely transitions of care (for the sake of resident and patient safety), while respecting and nurturing the effacement of self-interest that is at the core of the trust between patients and physicians”, AAFP representatives expressed concerns about anticipated adverse impact on patient safety, loss of patient continuity, and loss of professionalism among the trainees.

Impact of the current ACGME resident duty hour requirements on family medicine education

After the release of the 2008 IOM recommendations on duty hours, multiple articles appeared in the literature regarding the perceptions and impact of the duty hours on family medicine education. (See Appendix A – Annotated Bibliography). Key findings include:

- Perceptions Regarding the Duty Hours
  - Most of the students examined the perceptions and attitudes of program directors and residents.
Surveys of the family medicine residency program directors conducted after the release of IOM recommendations to modify the duty hour requirement and prior to the implementation of the current ACGME duty hour requirements revealed widespread skepticism about the ability of the proposed changes to improve patient safety, resident education, and resident well-being.

A national survey of family medicine residents prior to the current ACGME duty hour requirements echoed similar concerns to the surveys conducted with residency program directors.

Residents perceive that the quality of life of interns has improved but not that of senior residents, with an overall shifting of responsibilities from junior to senior residents. The same residents perceived a decline in both quality of resident education, work schedules, and preparation for more senior roles. Aspects felt to be unchanged included amount of rest, hours worked by residents, patient safety, and availability of supervision. Most reported an increase in hand-offs.

Graduates survey respondents felt supervision was equally or more important than limits on resident duty hours. However, 20% of respondents felt that the duty hour standards limited their education.

Changes in Education

Many family medicine residency programs have adopted night float schedules and protocols for structured hand-offs although these strategies have not been universally adopted.

Impact on Practice

A large study of ten-year trends in the University of Washington Family Medicine Network showed a 17% decline in resident productivity in the ambulatory setting. While implementation of electronic health records and the medical home also occurred over the ten-year span, the largest decline occurred during the two years following the implementation of the ACGME duty hour requirements.

A study of a single institution reveals a negative impact on the adoption of Patient-Centered Medical Home principles attributable to a significant decline in patient visits and hours worked in the clinic.

Carek, et al. surveyed the perceptions of family medicine graduates regarding preparedness to practice and board certification status, as well as current patient care activities before and after the implementation of the duty hour restrictions. While there appeared to be no association of the duty hours restrictions to self-reported preparedness for practice, the authors note that there appears to be a decline in patient care services and procedures performed. While causality cannot be established, they hypothesized that “activities such as providing nursing home care, attending to hospitalized patients, and making home visits have historically occurred during time prior to or after regular office hours, often impacting the number of hours a physician would work in a week."

Beyond the published medical literature, thought leaders in family medicine education anecdotally report:

- “The new ACGME regulations were proposed to improve three areas – patient care, resident education, and resident quality of life. It would appear that perhaps the only improvement has been the resident quality of life - for some of the residents”
- “My sense is that we have not met our goal of improved patient safety as the balance of continuity vs. increased handoffs has not demonstrated clear benefit to patients.”
- “There seems to be a trend away from the continuity of care that is a critical underpinning of family medicine and primary care.”
As the medical education community awaits the release of the two large multi-center duty hours trials (FIRST and iCOMPARE), we recognize that there is only a limited evidence base in the family medicine literature on which to serve as a foundation for our recommendations. Most of our recommendations are based upon expert opinion.

- In 2009, there was testimony at the ACGME duty hour hearings by some groups that called for a tiered system of duty hour requirements. While we recognize that there may be educational differences between the surgical specialties, medical specialties, and hospital-based specialties such as (pathology and radiology), we would note that family medicine training bridges both the hospital and ambulatory environments. Therefore we would caution the assumption that family medicine education is an ambulatory endeavor without consideration for flexibility in the duty hours to accommodate maternity care and hospital care where patient continuity is a critical element.

- We support the restriction of 80 hours per week on average but believe that there needs to be sufficient flexibility within those limits. As one veteran educator noted, “this has been most problematic for family medicine in continuity issues. Although there has been a nod to accommodating this, programs are very “gun shy” about allowing/encouraging residents to stay engaged with critically ill patients, end of life issues, and continuity deliveries. I believe the specialty and training would benefit from having these opportunities under less scrutiny, while still expecting that residents “on average” will work no more than 80 hrs. per week.”

- Streamline the resident documentation process for those exceptional situations under which PGY 1-2 level residents may return with fewer than eight hours away from the hospital. If documentation is perceived as burdensome then it may serve as a deterrent for residents who should participate in required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved.

- Allow PGY 1 level residents to have 24-hour shifts with appropriate supervision and fatigue management and mitigation practices in place. The improved patient care continuity should reduce the number of handoffs and improve professionalism by reducing the “shift worker mentality” that has been a concern of program directors and faculty.

The AAFP and our sister organizations sincerely thank the ACGME for the opportunity to provide input on the current ACGME duty hour requirements. This is an important topic for the family medicine education community as we strive for excellence in patient care, resident education, and resident well-being. We would be pleased to participate in the upcoming Resident Duty Hours in the Learning and Working Environment Congress, to be held in March 2016 in Chicago, Illinois.

Sincerely,

Robert L. Wergin, MD, FAAFP
AAFP Board Chair
Annotated Bibliography

1. **Impact of proposed institute of medicine duty hours: family medicine residency directors' perspective.**
   Carek PJ, Gravel JW Jr, Kozakowski S, Pugno PA, Fetter G, Palmer EJ.
   "A majority of family medicine residency program directors disagreed or strongly disagreed that the recent IOM duty hour recommendations will, in general, result in improved patient safety and resident education. Further, a majority of respondents disagreed or strongly disagreed that the proposed IOM rules would result in residents becoming more compassionate, more effective family physicians."

2. **Perceived impact of proposed institute of medicine duty hours on family medicine residency programs.**
   Ann Fam Med. 2009 May-Jun;7(3):276-7
   Survey of family medicine program directors after the release of the 2008 IOM report on duty hours. 2/3 of program directors did not believe that patient safety, resident education, or production of compassionate, effective family physicians would be improved with the implementation of the proposed requirements.

3. **Understanding the effect of resident duty hour reform: a qualitative study.**
   Wu PE, Stroud L, McDonald-Blumer H, Wong BM.
   Canadian study characterizing how different training programs anticipated changes on education, patient care and provider well-being with the proposed for implementation of duty hours regulations requiring restorative sleep for duty periods of twenty four or more consecutive hours. Authors conclude that a "one size does not fit all" approach should be taken. The impact of duty hour restrictions is speculated to have less of an effect on ambulatory primary care and shift-based experiences than inpatient services.

4. **Resident duty hour changes: impact in the patient-centered medical home.**
   Lindbloom EJ, Ringdahl E.
   Demonstrated a significant negative effect on outpatient training, where family medicine residents learn to value and master Patient Centered Medical Home concepts

5. **Recent family medicine residency graduates’ perceptions of resident duty hour restrictions.**
   Peterson LE, Diaz V, Dickerson LM, Player MS, Carek PJ.
   Cross-sectional survey of graduates from South Carolina Area Health Education Consortium-affiliated family medicine residency programs from 2005 to 2009. "Most graduates who responded to the survey felt supervision was equally or more important than limits on resident duty hours. However, 20% of respondents felt that the duty hour standards limited their education."
6. **The impact of 2011 duty hours requirements on family medicine residents.**

Drolet BC, Anandarajah G, Fischer SA.


Survey administered to 2,956 family medicine residents at 61 institutions between December 2011 and February 2012. “A large, demographically representative sample of residents (n=928) was identified as training in family medicine. Nearly half of residents (47.4%) reported disapproval of the duty hour requirements, with less than a quarter reporting approval (24.6%). Only quality of life for interns was identified as improved by a majority of respondents (63.3%). Meanwhile, quality of life for senior residents was generally reported as worse (53.0%). Likewise, a plurality of respondents stated that both quality of resident education (43.4%) and work schedules (47.9%) were negatively impacted, while more than half (56.5%) reported that preparation for more senior roles was worse. Aspects felt to be unchanged included amount of rest (45.4%) and hours worked by residents (52.8%). Although most respondents (52.0%) felt that safety of care was unchanged, more (77.9%) reported an increase in hand-offs and no increase in the availability of supervision (72.2%). Finally, the majority of residents (68.5%) agreed that there has been a shift of junior level responsibilities to more senior residents.”

7. **Why Residents Consider Working Beyond the Duty Hour Limits: Implications of the ACGME 2011 Duty Hour Standards.**

Fletcher KE, Nickoloff S, Whittle J, Jackson JL, Frank M, Schapira MM.


Although not strictly family medicine, this single institution survey of medicine residents, included residents in general internal medicine that share many similarities with family medicine. When asked how often they had considered exceeding duty hour limits in the preceding 2 weeks, “69% (35/51) indicated that they had wanted to exceed duty hour limits at least once in the prior 2 weeks. The most common reason cited was to provide continuity of care for a patient. The 24 + 6–hour rule was the standard most likely to be broken (cited by 66%; 23/35).”

8. **Preparation for practice in family medicine: before and after duty hours.**

Carek PJ, Diaz V, Dickerson LM, Peterson L, Johnson S.

*Fam Med.* 2012 Sep;44(8):539-44.

Survey of the “perception of graduates of family medicine residency programs immediately prior to and following implementation of duty hours regarding preparedness to practice and board certification status, as well as current patient care activities.” “Implementation of resident duty hours appears to have little overall association with self-reported preparedness for practice.” An association was noted in the patient care services and procedures performed.” Recent graduates reported performing fewer procedures associated with the care of the hospitalized patient. “Resident duty hour restrictions appear to have improved only the residents' quality of life without any established benefit to medical education or patient care. Activities such as providing nursing home care, attending to hospitalized patients, and making home visits have historically occurred during time prior to or after regular office hours, often impacting the number of hours a physician would work in a week. The implementation of limited duty hours and how certain activities may impact their quality of life may have influenced recent graduates regarding their choice to provide many of these services.”
9. **Ten-year trends in family medicine residency productivity and staffing: impact of electronic health records, resident duty hours, and the medical home.**

Lesko S, Hughes L, Fitch W, Pauwels J.


Published after the implementation of the ACGME duty hour revisions in 2011, this study analyzes ten-year trends utilizing biannual family medicine residency productivity and staffing data in the U. Washington Family Medicine Residency Network. During this time period residency programs implemented electronic health records, ACGME duty hours, and medical home transformation. “Resident productivity decreased over the 10-year interval, with resident total yearly patient visits down 17.2%. “ The authors note “The most significant total resident decrease occurred from 2003 to 2006; it was during this time that resident duty hour restrictions were implemented.”

10. **2011 ACGME duty hour week proposal--a national survey of family medicine residents.**

Lo V, Ward C.


Online survey of family medicine residents. “Out of 720 respondents, 30% supported revision of current duty-hour work rules; 58% disagreed with limiting interns' working hours to 16 hours per day; 48% perceived revision of resident supervision favorably; 26% expressed concern about continuing the current 80-duty-hour week rule; 75% supported limiting night duty to six consecutive nights; 83% agreed that reasonable resident weekly work hours should be 60-80 hours; and 18% admitted under-reporting of duty hours. Residents' hours off activities varied. Only 57% believed that their program will be able to implement the new changes effectively. Overall satisfaction with the future duty-hour rules were mixed: very satisfied (7%), satisfied (24%), somewhat satisfied (27%), unsatisfied (23%), and very unsatisfied (18%).

11. **Inpatient Hand-Offs in Family Medicine Residency Programs: A CERA Study.**

Edwards DS, Burge SK, Young RA, Peterson LE, Babb FC.


In response to the ACGME duty hour requirements, many residency programs have adopted night float systems and protocols for hand-offs. “Use of two strategies consistent with best practices (face-to-face hand-off, use of a dedicated area) was very high. There was wide variation in training methods for patient transfer and infrequent use of national resources. Half of all residency programs relied on supervision as the primary method of instruction in patient hand-off. The survey instrument was unable to measure actual patient safety events.