# Maximum Duty Period Length

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<thead>
<tr>
<th>PR Reference:</th>
<th>Program Requirement - Maximum Duty Period Length</th>
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<tr>
<td>VI.G.4.</td>
<td>Maximum Duty Period Length</td>
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<tr>
<td>VI.G.4.a)</td>
<td>Duty periods of PGY-1 residents must not exceed 16 hours in duration.</td>
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<tr>
<td>VI.G.4.b)</td>
<td>Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.</td>
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<td>VI.G.4.b).(1)</td>
<td>It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.</td>
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<tr>
<td>VI.G.4.b).(2)</td>
<td>Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.</td>
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<td>VI.G.4.b).(3)</td>
<td>In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.</td>
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<tr>
<td>VI.G.4.b).(3).(a)</td>
<td>Under those circumstances, the resident must:</td>
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<td>VI.G.4.b).(3).(a).(i)</td>
<td>appropriately hand over the care of all other patients to the team responsible for their continuing care; and,</td>
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<tr>
<td>VI.G.4.b).(3).(a).(ii)</td>
<td>document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.</td>
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<td>VI.G.4.b).(3).(b)</td>
<td>The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.</td>
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## Comments in Support

I would like to support this initiative and point out that in this day and age, to expect physicians in-training or otherwise to provide good, clear, accurate diagnosis and treatment in a state of exhaustion is just not necessary. I understand that physicians must be prepared for continuity of care, but physician resources are NOT what they were 100 years ago. I hope the next challenge the medical community embraces is that
### Maximum Duty Period Length

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<tr>
<th>Name: Lauren Coleman</th>
<th>Organization: community member and potential patient</th>
<th>Affiliation: individual</th>
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<td></td>
<td>This is a great improvement for interns. However, I feel that the compromise of patient care when physicians work extended hours exist not only as a resident but throughout all years including post-graduate training (i.e. Attendings, faculty, etc). I think the same 16-hour limit should be applied to all residents. As with all other professions including other medical professions we have a great responsibility to society to safely provide adequate care to our patients. Unfortunately, without setting a limit on the upper level residents the mere suggestion of strategic napping will not occur in a busy residency, program and therefore patient care remains compromised and we have done our patient no more good and if anything continued to do harm.</td>
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<tr>
<th>Name: Tangela Anderson Tull</th>
<th>Organization: UMMC resident</th>
<th>Affiliation: individual</th>
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<td>Thank you, ACGME, for proposing these important changes and acknowledging that physicians in training are not superhuman. Ask any patient whether they would feel safer knowing their resident will no longer be working for 24 hours straight and their answer will surely be in the affirmative. This decision by the ACGME sends the right message to patients and residents: the hospital will prioritize their safety over its exploitative appetite for cheap, captive trainee labor. To propose any less would surely undermine patient confidence in the medical system they trust with their very lives.</td>
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<th>Name: Adam</th>
<th>Organization: UCSF (Resident)</th>
<th>Affiliation: individual</th>
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<td>I will not allow <em>any</em> resident treat me if I know they may have been up for 24 hours in such a high stress place as a hospital. Of all the people in my life who I want to be well rested and on top of their game it is someone who is treating me in a hospital. And if I have no choice (because I am unconscious, for example) and find out I was treated by such a resident and if any mistakes are made I will sue the pants off the hospital, doctor, resident, or anybody I can. I have <em>always</em> thought this resident training system at the expense of patients was the most illogical thing I had ever heard of. When I was teaching (which is less stressful than practicing medicine in a hospital) at the end of an eight hour day I was exhausted. Eight hours is the maximum any medical resident should be allowed to practice. Period. End of story.</td>
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<tr>
<th>Name: Peter McGovern</th>
<th>Organization:</th>
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<td>This will greatly improve patient care. In the hospital I work at, an intern on call restarted a heparin drip on a post-surgical patient. This resulted in nearly fatal complications. Reductions in maximum duty length, maximum hours per week, and increased supervision are greatly needed.</td>
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<th>Name: Anon</th>
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<td>I think the proposed duty limits of 16 hours for interns is a spectacular idea. As a fourth year medical student who took q3-q4 call for three months, I found that only information I had utilized a great deal previously and knew very well remained available to me after sixteen hours. Otherwise, I started to forget important points of patient care and my ability to make quick decisions deteriorated. Additionally, I became physically ill from the schedule, which meant that the process of learning to be the dedicated knowledgeable physician I dream of being was placed second to my excessive fatigue and physical duress. Call is difficult for even senior residents, whose reaction times took a hit from the sleep deprivation - but it's even more dangerous for those of us just learning what to do. The 16-hour workday limit for interns is, I believe, in the best interest...</td>
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of the patients. New doctors get a chance to learn and develop their skills while remaining sharp and retaining what they learn, instead of stumbling bleary eyed through a lesson they will most likely forget in the morning. After being in a small car accident while driving home post call, I became even more afraid. I hadn't realized I was so impaired by fatigue. What if that had been a moment where I was required to make a critical decision for a patient on the limited experience I had as an intern. These new guidelines give me a newfound enthusiasm and hope for my intern year. I will be able to focus on learning, on being present and a good, attentive doctor for my patients, without the fearful anticipation of a fatigue-induced mistake that could have horrible consequences for their health and my confidence. Thank you so much for applying these changes.

Name: Catherine Bragg  
Organization: U of Arizona  
Affiliation: individual

I agree with this recommendation if it is expected, based on presently available data, to improve patient care and resident education. As a medical student it's difficult to imagine providing appropriate patient care and furthering my education after working longer than 16 hours without a rest period.

Name: Curt Nordgaard  
Organization: University of MN Medical School  
Affiliation: individual

This is a huge improvement relative to the current rigid requirements. Patient care and education have both been compromised by the 'shift work' mentality fostered by the current requirements. The new 'hand-off' period and the permission granted to residents to continue to care for their patients on the rare occasions when this goes beyond 'time' address the issue well.

In addition, the transition from PGY-1 (16-hour limit) to PGY-2 (24-hour limit) might be graded.

I would suggest that PGY-1's have limited exposure to 24-hour duty periods rather than none. I would choose rotations where the benefit of continuous care for education and patient safety outweighs the concern for fatigue. For internal medicine, that would be the intensive care unit and the cardiac care unit. Surgical specialties might include certain long operations in addition to intensive care units. The program requirement could limit PGY-1's to no more than 2 months of exposure to 24-hour duty periods (keeping all other rules).

Name: Joshua Safer  
Organization: Boston University Medical Center  
Affiliation: individual

I agree with the proposed maximum duty hours.

Name: Latisha Rowe  
Organization: BCM  
Affiliation: individual

Although the 16 hour maximum for PG1 will require some pain in adjusting, it seems like a good idea for safety and learning, at least in our surgery program. I am in favor of this.

Name: Tim Nelson  
Organization: University of New Mexico  
Affiliation: individual

I think that strategic napping is very important to the well being of on-call residents as well as for patient safety. Even four hours of a mandated break during a 24-30 hour shift would make a big difference. Many of the overnight calls are for minor matters that could be addressed before or after the break. It is this fragmenting of sleep time that creates problems with resident fatigue and health, thus impinging upon patient safety. I applaud the ACGME for this proposal and hope that it will be finalized in the interest of the well being of all stake-holders in this matter.
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<tr>
<th>Name: David Zalkin</th>
<th>Organization: Baylor College of Medicine</th>
<th>Affiliation: individual</th>
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<tr>
<td>I am a senior Physiology major at Southern Adventist University and am currently applying to medical school. I am in the top of my classes and have already been the lead author of a paper on sleep duration and incident type 2 diabetes (Annals of Epidemiology, May 2009). I am very committed to academic and clinical excellence. However, I am very concerned about the residency work hours and my future patients' safety.</td>
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<td>I believe the restriction on first year residents to 16 consecutive hours is excellent. This will reduce resident error and protect patients. In fact, this restriction to 16 hours really should be also applied to residents after their first year. Although second and third year residents may have more experience, they will still get fatigued and risk harming patients if they are worked beyond 16 hours. Residents would learn better and protect their patients if they worked fewer hours per day for a longer time (perhaps by extending residency for another year).</td>
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<tr>
<th>Name: Deborah Ann Beihl</th>
<th>Organization: Southern Adventist University</th>
<th>Affiliation: individual</th>
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<td>The 16 hour limit is humane to the resident and overall better for the patient</td>
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<th>Name: Audrey</th>
<th>Organization:</th>
<th>Affiliation: individual</th>
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<td>As a patient who has been cared for by medical residents, I appreciate the ACGME finally taking progressive steps to ensure that patient safety comes first. I appreciate the importance of training young doctors, but it is critical that we minimize the harm to patients during this learning process. Enabling resident physicians to have adequate breaks &amp; sleep during their training is a step in the right direction.</td>
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<th>Name: Jen</th>
<th>Organization: University of Texas</th>
<th>Affiliation: individual</th>
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<td>Speaking as an individual, very tentatively in favor of the change. 16 hours will limit exposure to the total number of patients. It'll be good for patient safety. Any decision to reduce educational exposure will need to be made in the context of addressing overall staffing needs in healthcare settings.</td>
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<td>I do NOT believe that limiting work hours will very significantly change the amount of time interns spend reading. Six 14 hour days is as, if not more, demanding than q3 overnights with q6 off.</td>
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<td>-- Andrew</td>
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<tr>
<th>Name: Andrew Fisher</th>
<th>Organization: UPMC-Main</th>
<th>Affiliation: individual</th>
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<td>On a factual level: Four years ago, as I'm sure you know, there was a study done that unsurprisingly revealed that residents are too tired for optimal patient safety. The study was released 4 years ago and I am horrified that it has taken this long to even come up with this proposal. We should care about improving patient safety and we should act on these findings expeditiously. We all know how it feels to be over tired, over worked, underpaid, and highly stressed. Common sense tells us that these are not optimal conditions for making decisions requiring attention to detail and critical thinking skills - particularly for those individuals working in health care. Please note, that even the &quot;generous&quot; 16 hour work shift is still DOUBLE what is required of a traditional &quot;9-5&quot; worker.</td>
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| On a personal level: My mother received treatments from an intern at a local hospital, and it was quite
evident that this intern (and many others) were overtired and at certain points during our stay, could barely make a complete sentence. I clearly remember when I asked if he was okay, he responded, "I'm so sorry m'am, I've been on duty 26 hours now." How do we expect these young professionals to function clearly under these conditions? It is completely shocking to me that it is legal to be expecting these doctors to make potentially life changing decisions after for 26 hours straight? The slightest oversight of a small detail can dramatically change someone's health care. Please think about this: Imagine one of your family members is in the hospital with a life threatening condition. Would you want an intern tending to your family member after 24 hours of being on duty - or 16? Personally, I would rather have the intern report to duty no more than 8 hours straight but the 16 hour proposal is a step in the right direction.

My mother has thankfully since been released from the hospital, but she still has a daily struggle to maintain her health. I am in constant worry that she may someday soon have to return to the hospital for more intensive care, and I cringe at her being there. I have lost countless hours of sleep just thinking about her health condition, and what makes me even more concerned, is that she will receive "care' from another intern who is delirious from lack of sleep. My mother means the world to me, and I would expect that if I entrust her health to a "professional" that he be at his very best. By following through on the 16 hour limit, we are moving in the right direction to ensure that interns can make quick, well informed decisions that will benefit countless families.

I have the utmost respect for the individuals who have chosen to pursue a medical career. They have invested so much of themselves and sacrificed so much of their personal lives for our benefit. I think the least we can do, is give them a more reasonable working day.

I sincerely thank you for reading my comments regarding this matter.
-Claire
Boston, MA

**Name:** Claire  
**Organization:** Doctors need sleep  
**Affiliation:** individual

I am please that residents may now be allowed, in unusual circumstances, to work beyond normal duty hours to care for an individual patient. Being present with/for patients who were critically ill with uncertain outcome, or actively dying, count among the most memorable and formative experiences of my training years.

**Name:** Soo Borson  
**Organization:** Uniververisty of Washington  
**Affiliation:** individual

I congratulate the Institute for looking out for interns. Some residency programs, however, have PGY-2 residents in an intern-type role. These residents need protection, as well. I hope ultimately the goal is for ALL residents not to work for 24 consecutive hours, though, because requiring anyone to do so is shameful.

**Name:** Jennifer Lyons  
**Organization:** Harvard Neurology Residency Program  
**Affiliation:** individual

The UW supports the unchanged ACGME requirement of a maximum of 80 hours of duty per week averaged over four weeks. Education and training in residency must include sufficient experience in the breadth and depth in the management of elective and emergency patients for residents to be appropriately trained to deliver safe, high quality care to patients in the future. The work hour requirements must take into consideration the special education and training needs of different specialties.

**University of Washington**

Specific items that we feel were particularly well handled, and for which we express our strong support: The specifics regarding the 16 hour limit on service by interns and the 24+4 hour limit on service by intermediate and senior residents. Flexibility for residents to stay beyond their scheduled hour limit to provide care for a
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<th>single patient when important for patient care, educational, or humanistic needs.</th>
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### American College of Physicians

The AHA supports extending the length of the maximum duty period to allow a resident four hours to transition the care of the patient over to another team member. Transitions in care are critically important to patient quality and safety. In addition, these "handoffs" provide significant educational opportunities - both in terms of teaching and learning - for the resident. Care coordination is an essential component of delivery system reform, and we applaud the ACGME for allowing residents the necessary time to perfect this skill.

### American Hospital Association

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<th>Comments not in Support</th>
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The ability for flexibility following a 24-hour period is key in fields that deal with patient emergencies such as trauma, neurosurgery, vascular surgery, etc... It is unnatural for a resident to pass off care for an unstable or seriously ill patient mid-care. It is also necessary for residents to learn to manage critically ill patients or perform emergency surgeries after a long shift. This will be a skill necessary when residents transition to post-residency practice.

The duty restrictions of 16 hours for PGY-1 residents will require a night-float system for our surgical specialties. This will end up in many "sign-offs" with daily potentials for medical errors from lack of information for the on-call individual. This can result in very serious patient care complications.

**Name:** Garni Barkhoudarian  
**Organization:** UCLA Neurosurgery  
**Affiliation:** individual

Don't agree with the 16h intern limit b/c will disrupt team-oriented teaching/learning. I have worked in a 16h shift setting and found it extremely disruptive. I feel that either a 16h or a 24h limit should apply to all residents uniformly so that a coherent team structure is maintained.

**Name:** Bennett  
**Organization:** UCSF  
**Affiliation:** individual

You can't be serious. Why are the PGY-1s being singled out in these new proposals? I assume it's because some report says that they aren't supervised as much as they should be, or that they cause more problems when unsupervised. The cause of the problem isn't the lack of supervision. The cause of the problem is the lack of willingness, comfort or general common sense to call a senior resident or attending about issues they have a question about. Some of my most educational moments were spent on call. They are lessons I will carry with me for the rest of my life. PGY1s should take call just like everyone else and should be subject to the same 24 hour (or 30 hour) work rule. Are PGY2s inherently more adept at staying focused through a 24 hour period? Why the distinction? An intern who knows to call someone else with any questions no matter how minor is a safe intern. Supervising them so rigidly (and the standards don't exactly say who the supervising physician is) is preparing them for failure. M.D. stands for "make decisions". They need to learn how to do it, right out of the gates. What will happen is one of two things:  
1. More nurse practitioners will be hired to cover call duty. In my experience they are less well trained than physicians at any level. Sure, a weathered NP is great, but I would rather have a weathered PGY2 (who did in house call as an intern) taking care of my patients any day.  
2. The PGY1 will enter the PGY2 year with less competency than the previous PGY2 years. They will then be expected to have responsibilities of call and other patient care activities that they didn't have to deal with before. The current PGY1s are taking burden off of the PGY2s so the PGY2s can focus more on being better physicians in certain areas (research, reading, covering certain clinics). With more call being pushed to the PGY2 level these things are compromised. Plain and simple. Responsibility is pushed further and further down the road to graduation where the physician leaving is less sure of them self and less competent.
In either of these scenarios you are violating the first objective that you sought to attain by these proposals - optimal patient care in our teaching institutions.

The PGY1 year should be no more distinct than any other in any way. It's a time to learn. They just need to learn to ask for help more if your main concern is patient safety related to their lack of supervision.

**Name: Andrew Tompkins**  
**Organization: OSU ENT**  
**Affiliation: individual**

I think the limitation of 16 hours for an intern is a mistake. Agree that 24 hours should be the max, and think that this should apply to everyone. There is too much discontinuity of care with less than 24 hours with too many sign-offs, and it endangers patient safety.

**Name: Melanie Green**  
**Organization: Childrens hospital, Peds resident Pl-2**  
**Affiliation: individual**

These new proposals will be detrimental to the learning of interns. You can't baby sit someone and expect them to learn. Future doctors will suffer from not having adequate training by the time they graduate and patients will suffer. The real reason mistakes are made while on call is not because of fatigue and being tired, it is because of lack of experience and inadequate learning on an individual basis. Blaming poor outcomes on fatigue and lack of sleep is a cop out for lack of knowledge.

**Name: Intern**  
**Organization: GHS**  
**Affiliation: individual**

I am the chairman of the Residency Training Committee at the Harvard/Brigham and Women's/Massachusetts General Neurology Program.

The new rule as stated will shorten the maximum work period from 24+6 to 24+4. I request that the committee strongly consider leaving the limit for the in-hospital time after call at 6 hours, because I think this small change in hours will have no significant effect on resident sleep deprivation and fatigue, and it will have a great detrimental effect on resident education. The reason is that our residents now terminate a 24hr call period at 7AM, and then they may stay, without further patient care duties, through the daily didactic conference at noon and depart at 1pm. These times represent natural hours for resident AM rounds and hand offs and for lunch, so I suspect that many programs encourage their residents to attend didactic noon conferences within a similar scheduling scheme. In summary, I think this change is a bad trade-off; the residents will gain very little rest, and they will lose a lot of educational opportunities. Thank you for considering this change.

**Name: Steven Feske**  
**Organization: Brigham and Women's Hospital Neurology Residency**  
**Affiliation: individual**

I don't understand why interns would have shorter periods of time in the hospital than more senior residents. If an R2 is capable of having a 24 hour duty period, then why don't the same rules apply to the interns? Physiologically, what is supposed to change upon the transition from the intern to the R2 year? The 16 hour duty period for interns will create havoc with the call schedule, likely resulting in more night-float. This is not without its own problems as frequent disruption of the normal circadian rhythm can cause just as many problems as long periods of wakefulness. Please reconsider this recommendation to make the inter requirements match those of the more senior residents.

**Name: Grant Hamilton**  
**Organization: University of Iowa Hospitals and Clinics**
In general I agree that patient safety is compromised if fatigued doctors are taking care of them. The limitation of duty hours for resident doctors has shifted the burden of excessively long duty periods to the attendings. For pilots and nurses, duty hour limits exist not just for trainees but for all practitioners. ACGME has pursued these duty hour limits for trainees only, without getting its own stakeholders (ABMS, licensing organizations, AMA), to simultaneously pursue similar limits for attending physicians. Patient safety doesn't seem to outweigh the enormous cost issue of attending duty hour restrictions for these organizations. When these duty hour-limited residents become attendings, they will be very poorly equipped to handle the long duty hours of attendings. Patient safety will then suffer, not get better. I am surprised that everyone is going into this with such a narrow focused vision.

Name: Vikas Dharnidharka
Organization: University of Florida
Affiliation: individual

I have difficulty understanding the rationale for a maximum of 16 hours PG 1 duty period. The impact statement notes that there is only 1 study of PG 1 residents in an icu and no other study evaluates meaningful clinical parameters related to maximum duty hour lengths. I am an editor-in-chief of an emergency medicine journal and if an article was submitted to my journal proposing such a significant clinical change in patient care based on one small study in a single institution ICU it would be rejected. The appropriate conclusion is that this is an issue that requires further study before making a change that has the potential for such impact on scheduling in residency programs.

Furthermore, in the impact statement rationale was provided based on the assumption that PG 1 residents are not ready for the rigors of a residency program and need to be "eased into it". I did not see any data provided, and I am not aware of any data to support this contention. Many PG 1 residents have come from medical schools where they regularly do "acting internships" and take overnight call along with residents. This could be increased at the medical school level instead of believing that it should be done at the PG 1 level with little supporting data. In my opinion the issue for PG 1 residents is not the length of shift, or that they need to be eased into their role, it is one of supervision. PG 1 residents need to be supervised better, have more availability of senior resident, and faculty input, and better back up -- not shorter working hours. I think it is arbitrary to make a distinction between PG 1 and PG 2 residents in terms of maximum duty hour length. Let the maximum shift length to 24 hours for all, encourage taking a rest overnight when it won't affect patient safety, create a policy at the institutional level for appropriate contact of residents during overnight hours to eliminate nuisance pages, and get residents out of the hospital as soon as possible the next day, even 2 hours of transition to care. This will work better than a maximum of 16 hours for only one group of residents.

Name: Stephen R. Hayden
Organization: UCSD Medical Center
Affiliation: individual

I think limiting it to 24 hours for everyone is adequate. 16 hours for the interns are going to create more problems and cause it to become shift work. Make it 24 hours consecutive for all. But there needs to be dedicated time for checkout/handoffs. I do agree that 30 is too long.

Name: Jarrod Dale
Organization: resident
Affiliation: individual

You and I both know that a "suggested napping" schedule isn't going to happen. "Allowing" an additional 4 hours for extra duties is a poor/PC way of saying "the real limit is 28 hours" Just set a firm limit. Any "allowable, extra time" will just get added into the scheduled shift length for the majority of programs. EX: At my school and my internship, we didn't schedule 24 hours periods, we scheduled 30 hour call shifts. I cannot stress the importance of establishing proper checkout/transfer/handoff rules.
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Comments not in Support

Name: Jarrod Dale  
Organization: resident  
Affiliation: individual

I am unaware of any evidence that the 80 hour limit has caused patient harm. I do not believe that a 16 hour workday is needed for PGY 1 residents if they are properly supervised. I believe that this limitation for PGY 1 residents will be the initial thrust to continue to shorten the work week for all residents. There is concern now that the shorter work week affects the training of residents. Will the ACGME plan to allow the extension of years of residency so that trainees get adequate training?

Name: A J HOTALING, M.D.  
Organization: Loyola Chicago  
Affiliation: individual

Enforcement of 4 hours for "continuity of care" is impossible.

Name: 
Organization:  
Affiliation: individual

As a recently graduated medical student who is about to begin her intern year as a Family Medicine resident in a few short days on July 1, 2010 I think this proposed duty hour change would be very detrimental to the education of interns and would negatively impact patient care. If I were to spend a year working in the hospital for a maximum of 16 hours and have no experience being on overnight call I would be completely unprepared to work 24 hours on my own as a PGY-2. At least as an intern taking call you have upper level residents as back-up to call with questions and help supervise you so you know what to do when on call when you're on your own. I think to suddenly throw me into this as a PGY-2 with no supervision and no experience would be detrimental to my education and patient care. Also, PGY-2 residents do not suddenly need less sleep, yes they have more experience and knowledge but they are subject to the same risks of making errors due to fatigue as any other resident regardless of PGY status. This system would also severely tax upper level residents as they would be responsible for all call, you would have your most senior residents very tired which would likely impact poorly on education of less experienced residents and impact the upper-level's ability to supervise these new physicians in their patient care. Also, I do not know much about the cost of running a residency program, but I have to imagine that implementing this would require hiring more residents and would cost more money on a healthcare system that is already financially out of control. This kind of duty hour system could possibly lead to shift work which would increase patient handoffs - a big problem in medical errors and reduced quality of patient care - and lead to overall lower continuity of care which is not beneficial for patients or physician education. I definitely agree with and appreciate the 80 hour work week rule and the 30 hour work rule, but if I were beginning my intern year with this regulation I would feel like my education was being inhibited and that my overall patient care abilities compromised.

Name: Elizabeth Yardley, MD  
Organization: none  
Affiliation: individual

This section basically appears to eliminate call for PGY-1 interns. I am currently a PGY-1 intern and while I have no special love for call, I worry that eliminating call entirely would diminish the PGY-1 experience in terms of the type, scope, and volume of problems a PGY-1 is called on to handle. I would see it as a negative thing if the PGY-2s and above simply started handling all the night work. An intern night float system would be one logical solution. These are my personal opinions.

Name: Atuhani Burnett  
Organization: Vanderbilt University Medical Center Dept of Surgery  
Affiliation: individual

Please reconsider these recommendations. We do not agree with your decision.
# Maximum Duty Period Length

## Comments not in Support

<table>
<thead>
<tr>
<th>Name: Jason Breed</th>
<th>Organization: Baptist Integris Family Medicine Residency Program</th>
<th>Affiliation: individual</th>
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</thead>
<tbody>
<tr>
<td>The proposals to further limit duty hours are absurd. The are tight enough already and further limitations will serve only to breed well-rested but clinically and professionally suspect physicians.</td>
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<td>- Handouts with lapses in care will increase.</td>
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<td>- The ability for housestaff to really become the &quot;doctor&quot; for their patient - by making evening rounds, visiting with family who come late in the day, etc. will continue to erode and fall to the attending as is already becoming the case. Please note I know how to do this and do it well; PGY1s do not....</td>
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<td>- The professional sense of patient ownership will continue to diminish.</td>
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| - The "out of the frying pan" trials by fire at night will be lost - How can an intern take night call with 16hr duty limits???
|
| My wife complains already that she feels like I am an intern again, and I can see why that's the case! This will only worsen in the future as I see things - housestaff will work less and attendings will work more to keep team ownership and limit the need to have handoffs in management. You see, we "old school" docs feel the professional obligation to care for our own patients and not pass off important aspects of care to others who do not have that doctor-patient connection that is so important to good care! The ACGME seems to have forgotten this.
| I jokingly sent an email back to our faculty when a note about reviewing these new rule proposals came out: "Why don't we just have our housestaff work 8hr days, 5days a week with all their weekends off? We'll be ahead of the curve when that becomes the norm in a few years!" Sadly, that seems to be what is coming, as things seem to be progressing.... |

<table>
<thead>
<tr>
<th>Name: Mark Schleupner, MD, FACP</th>
<th>Organization: VTC SOM - Carilion Clinic - Roanoke, VA</th>
<th>Affiliation: individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>I agree with resident duty-hour restrictions. As a physician who trained from 2001 -- 2004, I experienced both the bad old days and the new, improved ones. Tired residents are useless. However, these restrictions and the tremendous scheduling adjustments they require have made it such that we are raising physicians who have no idea what it is like to work without duty-hour restrictions. Even with home call in a non-surgical specialty, an attending may go without sleep all night and is expected to work the entire next day -- no leaving at 10 AM or noon; no refusing to see new patients. The new guidelines may be completely appropriate, but they do not carry over into the life of most attending physicians. These new duty-hour and supervision requirements may actually increase the workload of attendings. You are protecting the residents for 3 to 5 years. I agree they need to be protected. Who protects them when they are no longer residents? You have not prepared them to work when sleep-deprived, and you have created a system in which they will likely have to do more work and be more sleep deprived.</td>
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<tr>
<th>Name: Erin Palm</th>
<th>Organization: Stanford - Resident</th>
<th>Affiliation: individual</th>
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<tr>
<td>As a general surgery intern, I would like to give the feedback that this rule will make my schedule less humane. If my program were to comply with this rule without increasing the number of interns, it would effectively eliminate my ability to have 2 consecutive days off on a weekend. Currently, we have a night float system during the week, and we do 24-hour call on weekends. This allows the interns not on call to have full weekend days off. Without 24-hour call, we would have 12-hour weekend shifts, leading to multiple handoffs, less continuity, and less happy interns, and less happy families of interns.</td>
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<th>Name:</th>
<th>Organization:</th>
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### Maximum Duty Period Length

#### Comments not in Support

I am a rising PGY-3 for whom overnight call has been a crucial piece of my Internal Medicine education. Interns need the time overnight to develop the skill of formulating and revising plans as a clinical situation changes. Learning to admit patients and perform cross cover activities is also a crucial skill to have once we are in the workforce. Most importantly, being the single point of contact, information and support for a patient and their family during the very scary and confusing first 24 hours of an admission has brought me incredible satisfaction. I do not wish to see inpatient Internal Medicine turned into shift work. It does not seem appropriate that while we are given the responsibility to gauge our own limitations and exercise restraint as we see fit in most medical matters, we are not allowed to determine our fatigue level and set our own hour limits in the context of ongoing patient care. Patients already feel like they belong to somewhat of an "assembly line" when they are in the hospital, being wheeled from room to room, from doctor to doctor. Having a different doctor, every couple of meals is certainly no way to improve the patient-doctor therapeutic alliance. In my limited experience, the most important therapy I have been able to offer is establishment of trust. Performing this duty, however, takes 1) time and 2) me being with MY patient at their bedside for more than a few hours at a time.

**Name:** Karthik Suresh  
**Organization:** Johns Hopkins Hospital  
**Affiliation:** individual

It is irresponsible to give first year residents, who are just entering the true practice of medicine, the impression that medicine is a shift work specialty. By working only 16 hours max, they do not get the same level of ownership for their patients that you do when you spend a full 30 hours with them. They will be less invested in their patients and I worry that it will set a standard that will be hard to change in the future years when we are asking them to work longer. Intern year is when they have the most direct and detailed care of the patients and they should be taught to take ownership of the patients and a vested interest in what happens to them. Additionally, this is going to require at least a 50% increase in the number of interns and I don't think most programs have the money to do that right now. It is wrong to set guidelines that cannot be implemented due to financial circumstances.

**Name:** Alanna Rice  
**Organization:** individual

Limiting 1st year residents to 16 hr duty periods means they will have no exposure to being on call as an intern. As it stands now, this is a time where they have (at least in my program) direct supervision by the pgys 2 and gain a lot of hands on experience. With this experience, when they become PGY 2s and are taking primary call, they are not seeing things in the ED for the first time. I feel that taking away the ability to give pgy-1s some exposure to being on call it will render them much less prepared for the pgy-2 year.

**Name:** Karin Ijungquist  
**Organization:** OSU  
**Affiliation:** individual

Further restriction of resident duty hours will harm the professionalism that represents one of the core values of our practices. The arguments about "shift work" have been made - and I agree with them - but I do not need to restate them. I would like to make an argument, which I have not seen in print. We are teaching the residents a false reality. As a pediatrician who has been in private practice I can tell you that if you get one sick baby in the evening, just sick enough to need you at the bedside a lot but not sick enough to need transport to a tertiary facility, you're going to be up all night, and you're going to go to your office the next day and work all day long. You cannot call the families and tell them you've had a rough night and would they mind re-scheduling their children's appointments to another time. Such an action would frustrate your patients, potentially harming your patients since you delayed their access to care, and selfishly it would hurt your!  

Bottom line. Why have we set up a system that so poorly reflects what happens in the real world - at least the real world in towns large enough to support a pediatric practice but too small to support any subspecialists. This system was built by academic folks - I'm one now - who have little idea of what it is to practice in a town like I've described. At least I think that's true - otherwise, I don't see how they could be a
Maximum Duty Period Length

Comments not in Support

Name: Bryan L. Burke, Jr.
Organization: University of Arkansas for Medical Sciences
Affiliation: individual

The "strategic napping" is going to be very hard to implement without bringing in a second resident for an overnight shift on many services. This second person would likely be floating from somewhere else. This person would provide little in the way of continuity and would require sign/in and out at the end of their shifts (additional hand offs) and also communication between residents at the beginning and end of the napping period. This will increase the balance of day/night shifts in the residency. Finally for the "floating resident" assigned to cover the nap this will impact their next day activities (likely elective time) and will decrease their educational experience for that month.

Name:
Organization:
Affiliation: organization

The limitation of the allowed continuous duty hours for PGY-1 residents to 16 hours will effectively eliminate the internship as we know it. Although I understand that there is a cost to 24-hr on-call periods, there is also a great benefit in learning. I think this is a very unwise trade-off. The internship year provokes a metamorphosis in training physicians. This metamorphosis occurs, in large part because of the intensity of the experience and the engagement of the interns in it. This will be lost, nad nothing substantial gained by this new rule. People training for all sorts of jobs and professions accept risks and hardships because they feel that the training benefits are worth the costs. The dismantling of the internship is an ethical choice being made by the leaders of our profession...a very misguided choice based on an excessive desire to avoid risk.

Name: Steven Feske
Organization: Brigham and Women's Hospital
Affiliation:

It was only a matter of time before Dr. Czeisler managed to convince the ACGME of the fatigue factor. His work which has involved largely unsupervised medical interns in the ICU is not applicable to the surgical services in which there is not only senior resident backup, but attending back up. . I believe there is a vast difference between the medical ICU and the surgical service. Initially this involves the patient population and the need for continued familiarity with the patient and what happened at the operation and what team is concerned about as far as possible complications. Only the surgeon and at times other members of the team know that one of the sutures at the anastomosis was unsatisfactory but it was more dangerous to take the suture out and try and put another one in the than to leave it. So when the patient spikes to 105 and complains of abdominal pain on the fourth postoperative night that patient has blown his or anastomosis until proven otherwise. Other data suggests the patient's are more likely to be injured from the hand off (which by nature cannot be perfect) then by a fatigued resident. The work hours suggested will increase the danger to patients by increasing the number of hand-offs. I believe we must seriously examine data with respect to forced hand-offs and the implications that it has had on patient care.

Name: Josef E. Fischer
Organization: Harvard Medical School
Affiliation: individual

You have made every program develop a float system which doubles the transitions of care - we already a system that minimizes transitions of care

Name: W Johnson
Organization: U of A
Affiliation: individual

The idea of "strategic napping" is ridiculous - again this increases transitions of care as the "napster" takes
# Maximum Duty Period Length

## Comments not in Support

| Name: W Johnson  
Organization: U of A  
Affiliation | In a community hospital Family Medicine Residency, we have created solutions to work hours and provide a safe environment for our residents and patients. However these new shifts obstruct our ability to provide coverage for our hospital and will severely impact our ability to both provide care for our patients and education to our residents. This will decimate continuity of care and result in shift worker mentality in physicians. This is a poor solution and may not apply to problems that do not exist at hospital like ours. We believe this is a failed proposal. |
| --- |
| Name: Pam Davis  
Organization: Northridge Hospital Residency  
Affiliation: organization | I'm a little confused about this maximum duty period. I agree wholeheartedly that it would be better for patients and residents to be limited to 16 hours of duty, with at least 8 hours off in between. But why does this limitation apply only to first year residents? What magical transformation happens that allows second years to function after 28 hours of no sleep; while the previous year it was determined that, it was unsafe for them to work over 16 hours? The 16 hour limit should apply to all residents, not just first years. I have never talked to a single person outside of the medical field who felt that a 30 hour shift was reasonable. I don't think that shaving it down to 28 hours is an appreciable difference. Please rethink this section, and consider applying the 16-hour maximum shift length to everyone. |
| Name: Neal Goldenberg  
Organization: University of Wisconsin Family Medicine, PGY2  
Affiliation: individual | As work hours for residents’ decreases, we will be instituting more shift-type work for our residents instead of the old "on-call" structure. This is a good thing, as it is mimicking what Attending providers do in urban settings. However, I worry that we will start running into other work limitations that are specific to the Internal Medicine Program Requirements. Such examples are limitations on how many months of Night Float or ICU that a resident can do over their three years. If we reduce the amount of hours spent in the ICU on dedicated ICU months, can we increase the number of months residents can participate in the ICU? Or, can we define more clearly, if an ICU night float month counts as an ICU month, a Night float month, or both? |
| Name: Michael T. Morton, MD, FACP  
Organization: Exempla Saint Joseph Hospital  
Affiliation: individual | I feel that the new Duty Hours proposed will place an even heavier burden on residents and further take away from learning experiences. How do you propose we cover the remaining 8 hour time blocks?? We would have to have more people in-house every night, which would further stress home relations. I also fear that the increased patient hand offs during this time period and lack of continuity could potentially negatively impact patient safety. Please do not further restrict our learning time. |
| Name: Derek Gasper PGY2  
Organization: Hinsdale Hospital Family Practice Residency  
Affiliation: individual | This is really unacceptable. These are not medical students but are first year doctors, and as such should be able to work a 24 hour shift. They are already limited in their overall hours and that has certainly affected... |
| Name: Brian |
| Organization: University of Nevada School of Medicine |
| Affiliation: individual |
| I am a chief resident at UK. I feel the duty hours are a significant detriment to resident education. We are making a once proud hardworking profession and watering it down to shift work. I think further restrictions on duty hours will significantly detract from time spent with patients, will overburden residents who will have to cover more patients, will increase the number of opportunities for and-off related mishaps, create scheduling nightmares, place emphasis of medical care on things other than patient care, and lengthen residencies of all sorts by years. The decision here will continue the downward slide towards mediocre health care. |

| Name: Jacob Perry |
| Organization: University of Kentucky |
| Affiliation: individual |
| I believe the change of PGY1 only working 16 hours maximum straight is unreasonable and unnecessary. As an intern, some of the most valuable time in training is in the middle of night. I also think that this will have a dramatic impact on the work force of programs, where more of the work will fall to the more senior folks or will require costly hiring of midlevel's. 80 hours, with 24 max, 3-4 hours turnover is fine. We are training doctors. |

| Name: Robin Minielly, M.D. |
| Organization: |
| Affiliation: individual |
| the 16 hour rule for pgy1 residents effectively eliminates the need to learn (physiologically, psychologically, and habitually) to function under duress, at a time in the training/care continuum when that resident has the most backup and the least individual responsibility. To have to then learned strategies to maintain effectiveness during long duty hours in the pgy 2 year just delays the inevitable. There really is no succession plan for the training/care continuum if the duty hours are progressively constricted in the more junior members of the team, leaving more holes to fill by more senior members. The 16-hour rule will nearly double the number of pgy1 residents required to provide continuous coverage of a service. Who is paying? I am a physician in an academic setting who is providing more direct care to patients than ever before, as house officers find patient care too boring. Luckily, I love patient care. |

| Name: George Hoffman |
| Organization: medical college of Wisconsin / children's hospital of Wisconsin |
| Affiliation: individual |
| I think it will seriously hurt the interns learning by not allowing them to be in house for more than 16 hours. Also by bringing down the transition time to 4 hours will severely limit the number of didactic sessions the residents are able to attend. How does that help patients if the resident is well rested but doesn't know what they are doing? I also disagree with not having the resident attend their continuity clinic post call. If this occurs then we will have a very difficult time getting the numbers that are needed to give the residents adequate exposure to outpatient family medicine. |

| Name: Leslie Sleuwen MD |
| Organization: Hinsdale Family Medicine Residency Program |
| Affiliation: individual |
Maximum Duty Period Length

Comments not in Support

I am a PD of family medicine program. The new restrictions for PGY-1 will mandate night float, shift work. Other restrictions will also limit educational time. The net effect is that FM cannot deliver enough educational experience in our current 3 year format and will need to go to 4 years. This is great except that it will increase each residency's size 33%, requiring more space and more personnel resources. Who will pay?? This is a bad idea unless funding follows, especially when evidence of effectiveness is limited or non-existent.

Name: Stephen Flynn  
Organization: Fairview Hospital  
Affiliation: individual

I have just completed my intern year of a family medicine residency. I am very concerned about the changes proposed to duty hours. As an intern on call overnight, I never felt alone. A senior resident was always on call with me and attendings were always available by phone. While working on call 24 hours at a time can be tiring, I never felt too tired to make decisions. My best learning experiences came while on call. All of the residents I have spoken to agree with the above statements and are opposed to the proposed changes.

Studies have shown that increased hand-offs jeopardize patient safety. If interns are only allowed to work 16 hour shifts, the number of hand-offs will be increased, leading to possible omissions and threatened patient care. Also, smaller residency programs will not have the amount of residents necessary to staff the hospital with shorter shifts. If these programs are forced to close, the primary care shortage will continue to worsen.

In order to provide the best care for patients as well as the best education for residents, I urge you not to pass these proposed changes. The current 30 hour shift limit is sufficient to prevent physician exhaustion and any further limitations will jeopardize the education of all future physicians.

Name: Theresa Weerts  
Organization: Hinsdale Family Medicine Residency  
Affiliation: individual

I am about to start my 3rd and final year of a family medicine residency. Our community hospital program is an excellent program that balances supervision with increasing autonomy during the growth of a resident. I very strongly disagree with the severely restricted work hours recommend for PGY1s. During my PGY1 year, I learned so much on call during my 30 hour shifts that I would not have learned in an 8-5 work week. There is a tremendous amount of growth that occurs when it's the middle of night and you have to manage a patient with limited resources. I feel that the new recommendations will interfere with this growth and shut-down excellent small programs that do not have enough residents for a night-float system. It may be more beneficial to limit the number of patients managed by residents rather than limiting a shift to such few hours.

I feel that the amount of documentation required to allow a resident to stay beyond recommend duty hours to follow an interesting patient is excessive. I understand the need to set limits and avoid programs from having expectations that residents will always stay, but I believe the paperwork will interfere with the learning process. There have been multiple times when I was about to sign-out when a patient's condition rapidly changed, and I was glad I was available to oversee the transfer of the patient to a higher level-of-care because the oncoming resident would not have known what was going on.

Name: Angela  
Organization: Hinsdale Family Medicine Residency  
Affiliation: individual

The "strategic napping is strongly encouraged" comment is vague. There is little point in having 24 hour call if residents have to be cut loose to nap and it would be better to simply specify as such. Certain clinical services would not be amenable to strategic napping by residents, especially without interns available due to duty hours rules. Large programs will easily adapt to this via complicated rotation schedules and float coverage, but small programs with limited residents will face tremendous difficulty.
Name: Mark Rasnake  
Organization: UTGSM Knoxville, TN  
Affiliation: individual

The 16 hour limit for PGY 1 level residents does not make any sense. Certainly, PGY 1 level residents need immediate supervision at all times and they should not be expected to work more hours than upper level residents. However, there is no objective data available to suggest that limiting the work hours to 16 would improve the educational opportunity as compared to the upper level residents. The work restriction would cause friction within the resident groups. It would make weekend call schedules extremely difficult.

Name: Clifford Hayslip  
Organization: Program Director - OB/GYN - Pitt County Memorial Hospital / East Carolina University  
Affiliation: individual

I am a Gastroenterology PD. While this restriction will not affect our GI program directly, I believe it will affect the quality of medical residents that will be applying for fellowships in the future. I am opposed to the 16 hour restriction for 4 reasons:

1) There are no data to show that patient outcome and or safety will be enhanced with this restriction. It is conjectural that "16 hours + multiple hand-offs" is more conducive to good patient care than mildly sleep deprived physicians taking care of patients with which they are intimately familiar. 2) I question whether clinical education in enhanced. We may train physicians to be better at "handing-off" but at the expense of actual clinical experience. 3) I do not think this restriction is realistic in terms of training physicians for real life. While many physicians will eventually have jobs that involve shift work, many will practice in smaller communities where they will experience 24 hour duty and working under sleep-deprived conditions. 4) Lastly, I think this restriction fosters a culture that allows one to avoid "patient ownership."

Name: Martin Scobey, MD  
Organization: Carolinas Medical Center  
Affiliation: individual

This is a bit confusing and awkward. The intern is being treated like a med student (med students go home at 10pm). Why is intern any different than other residents. Internship needs to be intense so they are ready to supervise. This keeps them out of the hospital too much. They are already missing lots of procedures, resuscitations because they are being sent home to enforce duty hours.

Will need more interns and how is going to pay for this? no one wants to pay for interns that are not very available and may not end up well trained! Faculty are getting tired of this and wonder if it's worth teaching any more. No one protects faculty form the extra work that ends up in their laps and the increased sleep they lose as a result of this. BIGGEST concern is poor training outcomes, less and less intense training, more stress to get everything done in short amount of time. Are they expected to see the same amount of patients in less time? This stressed them out.

Name: Suzanne Wright  
Organization: Marshfield clinic  
Affiliation: individual

As a student planning on beginning my surgical residency next year, I am concerned how this 16hr limit will impact my training. In order to serve my overnight call duties and remain under the 16hr limit, I would have to begin my day in the afternoon, missing out on the vital operative time that is most heavily concentrated in the morning hours. I understand the need to limit fatigue among residents to improve both learning and patient safety. However this particular limitation could be a great hindrance to residents in operative specialties who need to be present in the OR in the morning and take call overnight.

Name: Bobby Gibbons  
Organization: University of Louisville
| Name: Kristen Blaker                      | Organization: Medical Student, Class of 2011, University of Louisville |
| Affiliation: individual                 |                                                                           |
| Comments not in Support                |                                                                           |
| As a future general surgery resident, I find that this stipulation is incongruent with an effective learning experience. As a surgery resident it is of utmost importance to participate in as many surgeries as possible. A 16 hour shift would greatly hinder this objective. To ensure patient care, interns would have to begin work in the late afternoon, thereby missing valuable OR experience. Less experience means poor training, which translates to poor patient care in the future. |

| Name: Mary Wagner MD                   | Organization: UMN-Methodist Family Medicine Residency                    |
| Affiliation: individual                |                                                                           |
| In terms of work hour restrictions—it is clear that there is a tension between getting enough experience-hours and preventing dangerous and counter-productive fatigue. The rules don't provide for any acknowledgement of variation, either in individuals or programs, despite the necessity of learning to assess this in future professional life. A better rule would be to use outcomes-based findings, such as requiring use of a validated sleepiness & fatigue scale to assess when work limits are reached. |

| Name: Donald Briscoe                   | Organization: Methodist Hospital (Houston) Family Medicine Residency     |
| Affiliation: individual                |                                                                           |
| The nap thing really doesn't work well logistically. In slower programs that might work. But in busy centers, it means putting on a 2nd resident that you don't need for at least a portion of the night—just to cover the nap period. Plus, then the 2nd resident can't return to duty for 10 hours after he/she goes home—which means the 2nd resident then misses morning on whatever they are on. I think we should cut out the words "strongly suggested" in the document in reference to naps and use naps as an example of ways to manage fatigue. |

| Name:                                                                 |                                                   |
| Affiliation: individual                                                                 |
| This is an unrealistic expectation that will ultimately lead to decreased patient safety. It will result in patients being cared for by physicians who don't know their history well, leading to more errors. It will result in patients being cared for by physicians working shifts who have no direct ownership over their care, leading to things being missed. It will result in more mid-level providers caring for patients, rather than physicians. It will result in less qualified physicians entering practice since they do not have the breath and depth of exposure that they need. This is a short sighted vision of patient safety. |

| Name:                                                                 |                                                   |
| Affiliation: individual                                                                 |
| It is also unrealistic to expect residencies to be able to accomplish these work hour requirements and still                                                   |
Maximum Duty Period Length

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<td>meet all the other RRC requirements required to graduate competent physicians. How are didactic lectures supposed to be done when residents are not physically present? How are continuity clinics supposed to be scheduled when residents cannot be there to see their patients? Did the ACGME take into account the health and safety of these patients who also need to be cared for by their physicians?</td>
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<tr>
<td>Finally, this unrealistic work hour requirement will increase the cost of medical care in this country and exacerbate the physician shortage already present in many areas. To meet this drastic work hour restriction residencies/hospitals will be forced to hire more providers (mid-levels and others), increasing the cost of hospital care. There will be economic pressure for residencies to consolidate into large residencies in order to have enough manpower to meet the shift work environment that this requirement essentially dictates. Already strained residencies in underserved areas will not be able to survive in this environment.</td>
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<td>I ask the ACGME to reconsider this requirement. There must be a more realistic level of work hour restrictions that meets all our goals of patient safety, resident wellbeing, and adequate preparation of this country’s future physicians.</td>
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<table>
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<tr>
<th>Name: Dr. Chris Kuhlman</th>
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<tr>
<td>Organization: Northridge Family Medicine Residency</td>
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<td>Affiliation: individual</td>
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<td>This seems odd to me. Interns are expected to work hard and overnight call is an important first step. There is a huge amount of learning to be done during overnight call. I disagree with this recommendation and feel that it will adversely affect learning. Interns should also be allowed 24 hrs + 6 hrs call.</td>
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<th>Name: Jsingler</th>
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<td>Organization: UC Davis</td>
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<td>Affiliation: individual</td>
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<td>Residents no longer have enough patient contact to have a sufficient breath of experience. All recommendations to limit duty hours should include one to extend every residency by 1 year.</td>
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<th>Name: John Berger</th>
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<tr>
<td>Organization: Children's National Medical Center</td>
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<td>Affiliation:</td>
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<td>While I agree with the need for work hour restrictions, I have several issues with the new proposal. The first is regarding the 16-hour restriction for PGY-1 level residents. This combined with the 10 hours between shifts makes it very difficult to allow for &quot;on-call&quot; experience necessary to be a competent junior or senior resident. For example, if hand-off to the inpatient team is at 7am, the PGY-1 residents on the team can never stay past 9pm, to allow 10 hours before they start up again at 7am the next day. As a recent residency grad, I can attest to the importance of needing to have experience working in the hospital overnight with supervision before being primarily responsible in that role as a junior or senior resident. Even if a night float system were to be instituted to give them this experience, they would lose the experience of rounds and continuity care in the afternoons with the patients as they would be required to leave typically in the middle of morning round! There is no explanation why there is a difference between the PGY-1 work hours and the other levels of training. I also feel that no continuity clinic after 24 hours of duty makes it very difficult for PGY-2 and PGY-3 level family medicine residents to get their required patient numbers for their outpatient clinic experience. In our program, we were always in the office post-call since there were no other duties we were allowed to engage in according to the duty hour restrictions (except for continuity care in the hospital). If call occurs every 4th night, that is 7 half days a month, or 84 half days a year, or up to 168 half days in their residency that they are not seeing patients in the clinic. If they typically see 8-10 patients each half day, that's over 1000 patient encounters they could be missing out on. Having worked the past 3 years under the current restrictions, I don't recall, neither do any of my colleagues, feeling that the restrictions were still too demanding where we felt our safety or that of our patients were compromised. And if they were, I feel our program had a policy in place that would deal with that on an individual basis. In summary, I feel that if a residency program takes the necessary steps to ensure safety and develops an empathic approach to resident fatigue, that the current work hour restrictions are far superior with regards to patient safety.</td>
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<tr>
<td>Name: Chad Osborne</td>
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<td>This is going to be very difficult for residency programs to be able to implement. Smaller programs will be at a great disadvantage and may be forced to close. This will only hurt patient care as there will be more hand-offs to residents who did not admit the patient and thus less familiar with their history. The most learning is done in the first 24 hrs of an admission in terms of diagnosis and workup. You are depriving interns of this essential learning opportunity.</td>
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<th>Name: Kuhlman</th>
<th>Organization:</th>
<th>Affiliation: individual</th>
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<tr>
<td>As a surgical resident I cannot disagree with the proposed intern hour restrictions strongly enough. The 80-hour workweek gutted surgical training and the studies to date have shown little to no improvement in patient safety. The ACGME's new proposal further weakens the ability of programs to train new surgeons. The rigid and simplistic approach to duty hour restriction as a proxy for improving patient safety misses the larger picture that safety lapses are nearly always a failure of systems, not of people. The focus on hours has led the ACGME far afield and distracted from the real battle that should be being waged: systems' reforms in hospitals. What duty hour restrictions have done is create an atmosphere of perpetual hand-off where residents cycle in and out of the hospital too quickly to either gain an understanding of how patients become ill or how they get better. It increases the likelihood of errors occurring at hand-offs (again, a systems' error) and creates the mistaken impression among patients and physicians-in-training that medicine is a 9-to-5 profession. With all due respect, the ACGME ought to remove itself from the governance of residency programs and remain an advocacy-only organization for residents. Its influence to date has been detrimental to residency training and contributed little the overall good of residents or patients. Its new efforts at duty-hour restrictions reveals a deep disconnect between its advisory board members and the day-to-day realities of those of us in residency training.</td>
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<tr>
<th>Name: Matthew Bengard</th>
<th>Organization:</th>
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<td>Limiting PGY1 work hours will severely limit education and force medicine into shift work and all but create nightfloat systems that will focus more on cross coverage than patient care or education. These residents ultimately will transition to future PGY1 trainees and will not have the clinical expertise to be ready for this transition. This proposed change will have a detrimental impact on the future of medical education.</td>
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<tr>
<th>Name: Eugene DePasquale</th>
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<td>Having PGY1 residents treated differently than their colleagues for the entire year seems not only disruptive but separates them, (they will have a different schedule than the other residents). Perhaps we should consider the 16-hour limit the first half of the year as the settle into the program and then they &quot;graduate&quot; to being able to have a similar schedule to their colleagues for the second half of the year.</td>
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<tr>
<th>Name: Laura Minikel</th>
<th>Organization: Kaiser Oakland</th>
<th>Affiliation: individual</th>
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<td>I think the new intern work rule limits are dangerous! It's unrealistic to expect someone to function on overnight call as a senior resident if they've never taken care of patients overnight. It takes practice and repetition to work those conditions. Moreover, as staff physicians, this will be the norm (working overnight on call that is). Call is an invaluable time for learning. As a resident I know that I learn much more on call than...</td>
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## Maximum Duty Period Length

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<th>Comments not in Support</th>
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<td>during the day. If I hadn't taken call as an intern, I never would have been ready to be a supervising resident.</td>
</tr>
<tr>
<td>Name: Thom</td>
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<tr>
<td>Organization: Pediatric Resident NMCSD</td>
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<td>Affiliation: individual</td>
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<tr>
<td>I think limiting the maximum number of hours that a PGY-1 works to 16 is short-sighted.</td>
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<tr>
<td>Name: Jennifer Jury</td>
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<tr>
<td>Organization: IU OB/GYN Residency</td>
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<td>Affiliation: individual</td>
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<td>I feel that having just 16hr shifts for the 1st years will decrease their learning experience and compromise the continuity of care. If anything, I feel the senior residents should have the shorter shift hours, and allow the interns to follow the management of a patient completely.</td>
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<tr>
<td>Also, &quot;strategic napping&quot; just isn't going to happen. If we are at work, we should plan to be working and usually, that's the case. Often on a call night, we might get 1 hr of sleep if we are lucky, but we cannot as much as we try, try to change the number of admissions and pages we receive during certain hours.</td>
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<td>I do agree that shorter duty shifts is important, but i feel that in the first year, interns need to see the continuity of following a patient through am rounds after developing a plan and getting the feedback and teaching from the attending. Also, while shorter shifts is good, it seems like it won't allow for as many days off, and we would lose the &quot;golden weekend&quot; which is good for families and a mental break.</td>
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<tr>
<td>Name: Anonymous</td>
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<td>Organization: Anonymous</td>
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<td>Affiliation:</td>
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<td>I am extremely concerned about the new duty hour regulations. They would increase risk to patient care and reduce learning and quality of life of residents.</td>
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<tr>
<td>1) Increased Risk to Patients: The new rules will likely require more MD to MD sign outs which means more miscommunications, and would require more covering of other teams' patients, which means the MD will be less knowledgeable about the patient. No matter how much we might think we can sign out, in practice we will never deliver the quality communication needed to ensure there is zero loss of relevant information, especially when we are being pressured to get out in time.</td>
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<td>2) Reduce Resident learning- Residents will not get near the amount of patient exposure and follow-through needed to learn the hefty amount of information needed within the year's allotted.</td>
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<td>3) With restricted on q2 call etc we will be less able to reschedule our call to accommodate our life's needs. We will be bound to the hospital and be forced to miss family occasions etc. This will be detrimental to quality of life.</td>
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<td>OUR CURRENT REGULATIONS ARE SUFFICIENT TO ENSURE SAFETY, EDUCATION AND QUALITY OF LIFE. Please reconsider implementing these rules as I feel they will cause unexpected repercussions.</td>
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<tr>
<td>Name: David Ezon</td>
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<td>Organization: Childrens National</td>
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<td>Affiliation: individual</td>
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<td>This requirement will force us to have a night time float which I have been resisting since my sart as Internal Medicine PD 2002. The float will miss formal ward teaching rounds, didactic conferences, and clinic. Based on our numbers, each individual will have 2 months of float total which will subtract from their formal education. In addition, the work hour restrictions will limit their clinical experience and result in more patient handoffs, which always fragments care.</td>
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Maximum Duty Period Length

Comments not in Support

Name: Harvey Friedman  
Organization: ST. Francis hospital of Evanston  
Affiliation: individual

The 6-hour post call maximum worked well, this enabled house staff to finish their work and attend noon conference before leaving. With the 4 hour maximum conference will no longer be possible for the post call resident. There are nights when the residents get good sleep but will still need to leave the premises before conference.

Name: Harvey Friedman  
Organization: ST. Francis hospital of Evanston  
Affiliation: individual

Why is this rule in place when PGY-2s are still subject to a maximum of 24 hours duty?  
This rule will seriously impede work scheduling in our residency programs.  
We must be very careful with these continued decreases in work hours because I believe that we threatening their educational experience of our physicians-in-training.

Name: John Ikonomidis  
Organization: MUSC  
Affiliation: individual

This is a terrible step backward in surgery resident education. All specialties are not the same and the PGY-1’s in surgery will miss out on OR experience as they will start shift’s in the afternoon and leave in the early morning. Surgery PGY-1’s should be exempt from this as they certainly can handle 24 hours shifts and don't want to miss the operative experience.

Name: William G. Cheadle  
Organization: University of Louisville  
Affiliation: individual

PGY-1’s whose duty hours are limited to no more than 16 consecutive hours is an awful idea. In a surgical residency, given the changes that programs will have to make to accommodate this, PGY-1’s will miss out on incredibly valuable operative time. If this passes, this will be an absolute travesty. I strongly feel that if this comes to fruition, medical education in the United States will in jeopardy. This is in no way beneficial for students, residents, or most importantly, patients. Please do not allow this proposition to pass.

Name: Brady Harris  
Organization: University of Louisville  
Affiliation: individual

There is no reason to limit the duty hours to 16hrs; 24hr call is a good educational activity, removes unnecessary transfer of care and excessive sign outs.

Name: jagannathan  
Organization: BWH  
Affiliation: individual

A 16 hour limit would mean that a PGY 1 resident on the in-patient service would EITHER make rounds with the team OR be on call at night, but not both. This increases the number of transitions and decreases continuity of care. It also makes it just about impossible to derive a meaningful call schedule for a small to medium sized residency program. The current standards are working well, no need to change.

Name: Tom Kincer, MD  
Organization: Montgomery Family Medicine Residency  
Affiliation: individual

So far there is no proof that errors or patient care has benefitted from the whole duty hours regulations. According to the IOM errors are still occurring, none of which have been attributed to resident fatigue. If we as physicians would just decide, a treatment works better with no data to support that decision we would be
lambasted in the medical community. What is the difference between a PGY-2 and a PGY-1 that one can work for 24 hours and the other cannot. All these regulations are creating is a new breed of doctors that upon completion of their residency training they have a sense of entitlement. They are entitled to earn large sums of money, not take call and not have to "work" for the patients nor the money they are being paid. The other issue with this is the extremely difficult burden you are placing on the health care system for patient care so the resident can rest comfortably in his/her bed for 8 hours while on call. The federal government is looking to decrease the reimbursement to hospitals for resident training. Insurance companies are decreasing reimbursement for patient care and the ACGME is placing a greater financial burden on hospitals that are going to have to hire more physician extenders to provide patient care.

Name: Frederick A. Gulmi, MD
Organization: Brookdale University Hospital
Affiliation: individual

No continuity after 24 hours means that a resident would do hospital rounds with the team on Monday and then if on-call Monday night, would essentially not come back to work until Wednesday. Because they could not do their continuity clinic on Tuesday morning and would be off Tuesday afternoon as well. Basically, in order for this to work, you would have to have two teams, the day team and the night team. Small to medium sized residencies just can't do this. This is a "hospitalist" mentality of shift work. I fail to see continuity in this model.

Name: Tom Kincer, MD
Organization: individual

Surely the 16 hour rule for PGY-1’s is going to cause the most difficulty for residencies. What is extraordinary about all of the proposed changes in CR’s is the balance: the added verbiage on professionalism and patient safety and supervision forces us to examine changes such as the 16-hour rule in context: Can we defend that a PGY-1 provides the highest quality patient care in his/her 24th hour of consecutive duty? Does this promote professionalism? Can we guarantee appropriate supervision of such a trainee at 5 am? Congratulations to the Task Force on a document that will challenge us to derive thoughtful strategies for implementation.

Name: Sharon Dooley (DIO)
Organization: Northwestern McGaw
Affiliation: individual

I actually think this is far more humane than previous guidelines, and appreciate the ability for a resident to stay beyond the guidelines in a special circumstance without being forced to lie about it. While I can't find any specific evidence to support these times, the idea that a less experienced resident would make more errors when fatigued certainly makes intuitive sense. In a time when medicine is more evidence based, however, it would be nice if our guidelines were as well.

In Family Medicine, with the number of IMG and less competent US applicants that we are receiving, quality is already dropping. I don't believe we can train a competent family doctor in three years with an entire year of call removed, which is essentially what the 16 hour rule would create. We certainly can't maintain the level of continuity of care that is currently expected, and will likely see an increase in errors related to hand-offs. This will be a huge financial burden for small community programs, some of which will likely close as a result. At best, if these guidelines are approved, family medicine residency training should be extended to 4 years. Without extra time, it will not be possible to meet the current program specific requirements for family medicine and adhere to these hours rules.

Name: Kate Neely
Organization: Forbes Family Medicine Residency Program
Affiliation: individual

I agree with not attending continuity clinic (outpt) after 24 hours of duty. Also, I think if there is a rule to not
## Comments not in Support

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<th>Name</th>
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<tr>
<td>Sharon Yegiaian</td>
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<td>Individual</td>
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<td>I think that you have the duty periods backwards. PGY1 residents should be the ones with longer work hours. The system you propose will cause untold misery as the PGY2 residents and above may have to work longer workdays than PGY1 residents. The senior level residents who supervise the junior level residents should be the ones with the most time off, not the least, because of their additional responsibilities in supervising patient care.</td>
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<td>Greg Brown</td>
<td>UNSOM</td>
<td>Individual</td>
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<td>In my opinion, you're trying to legislate &quot;safety&quot;. Part of residency is learning to work at all hours. I can tell you honestly that I have never worked harder or longer than I did AFTER I finished my residency. There were no caring attendings who were concerned with my sleep cycle, hunger, duty period, etc. Just sick people who needed my care. As a teaching anesthesiologist, I had residents who, at 9 PM, were finishing for the day and informing me that they could not be present the next morning for a 7 AM case due to the work hour restriction. What, you can't go home at 9 and get a solid 8 hours of sleep? I certainly can, and still do. You cannot achieve a perfect medical environment (happy, caring, rested, perfect providers who never make a mistake or have a bad outcome) by legislation or any other means. Sometimes you just have to use common sense.</td>
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<td>Gifford Eckhout MD</td>
<td>Trinity Mother Frances Health System</td>
<td>Individual</td>
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<td>I am not sure why changing the maximum duty length period is necessary. What evidence exists that the current 24 duty period for PGY-1 residents is not appropriate?</td>
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<td>Carlos Brown</td>
<td>UT Southwestern Austin</td>
<td>Individual</td>
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<td>I am a future surgery resident and I think that this will impair my ability to receive adequate training in my field. I also think it will impact patient care. The more transfer of care there is (shift changes) the easier information is lost.</td>
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<td>Jenny Bland</td>
<td>UL</td>
<td>Individual</td>
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<td>There is absolutely no data to support this recommendation. Further limitation of resident duty hours in any fashion will enhance the concept of shift medicine, remove any association of the physician to their patient, and increase hand offs which will increase medical errors and cause additional patient harm. The increase in hand offs has been proven through multiple investigations to increase patient risk, harm and cause physician error. On the other hand, NO studies have documented that decreasing physician work hours increases patient risk, harm, or physician error.</td>
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<tr>
<td>Dennis W. Vane, MD, MBA</td>
<td>Cardinal Glennon Children's Medical Center</td>
<td>Organization</td>
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Maximum Duty Period Length

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<td>The intern work hours restrictions are very difficult on smaller programs and likely will add to closure of smaller programs. As this process continues you will have a larger group of residents who have only worked in large groups and organization. They will be even more reluctant to serve in areas of greatest needs which are in sparsely populated locations. Also there are no faculty/staff work hour restrictions. Residents will work more as they progress. It will be difficult to know if they will be able to handle it as they will not be supervised by staff.</td>
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Name: Mike Chinn  
Organization: MAMC  
Affiliation: individual

I recently finished my intern year in family medicine at Mckay Dee Hospital in Ogden Utah. I am extremely concerned about the proposed restriction on intern work hours to 16 hours in a row. Our program is structured so that we take call every 4th day during call months. Our call is a 24 hour call and so we admit all of our own patients. This allows us to formulate a differential diagnosis for each patient upon admission, implement our plan, and then follow up on all of our orders/labs. Since we admit all of our own patients we are intimately familiar with their problems and their disease process as their hospital course unfolds. This process has been invaluable for my learning and would simply be impossible under the new work hour restrictions. Because our residency is located in a community hospital, we always get at least a few hours of sleep on call, and often get at least 4-6 hours of sleep. I support efforts to improve medical education but feel as though these new! Restrictions are being implemented for political purposes, are not based on sound evidence that they will actually improve care, and would seriously compromise the education of residents in my program. Perhaps even more importantly, they would negatively impact patients, as they would seriously undermine continuity of care.

Name: Brooke Drollinger  
Organization: Mckay Dee Family Medicine Residency  
Affiliation: individual

I am concerned with this part of the proposal for many reasons.  
-I think that intern year is the time to learn the most, and restricting interns to only 16 hours on would take away learning -This leads to many more transitions of care, which are not safe for patients, and it also provides less continuity for the residents with their patients -For a small program like ours, where we only have 18 residents, this would be very difficult to institute. We currently have a Q4 call system that is front loaded, and we are responsible for 2 call services. Making these new changes would require much more work from the upper levels. Also, we are a family medicine program. The problem with this proposal is it forces programs to do more call in the 2nd and 3rd years. For family medicine, that should be the time when 2nd and 3rd years are spending more time in clinic. In fact, there are many ACGME regulations that require a certain number of patients to be seen in continuity clinics. This new proposal would make this difficult to accomplish.  
-Our program, while intense, still has manageable call. We are often able to sleep on call, and we are not required to work more than 80 hrs per week when on a call service. The majority of our residents prefer a Q4 call schedule, which would not be possible with this new proposed change -I appreciate the 80 hour work week rule, and I know that there was probably a lot of resistance to that as well, but I really do believe that this change is not in our(residents) best interests. It will be too challenging for some residency programs, and will be a disadvantage to residents. Please reconsider this part of the proposal.

Name: Carissa Monroy  
Organization: McKay Dee Family Medicine Residency  
Affiliation: individual

My experience in residency was that 30 hours was difficult, but was not the cause of errors being made as far as patient care. It was due to sign-out miscommunication to other residents who were not as familiar with the patients. Reducing the number of hours would increase the number of times a patient care was transferred leading to more sign-out errors. The education I gained from the hard work I did as an intern was invaluable and was in direct relation to the number of patient hours I spent in the hospital. The other sad fact is that we learn from our mistakes and we make allot of mistakes as an intern from lack of...
## Maximum Duty Period Length

### Comments not in Support

**Name:** Marie Shelton  
**Organization:** Adventist Hinsdale Hospital  
**Affiliation:** individual

For single sponsoring institutions with only one small residency, the 16-hour limit on PGY1 residents will be most difficult for them to comply with. Since this recommendation is based on very limited evidence, I would ask the committee to consider allowing PGY1 residents to work 24 + 4 hours. The new requirements for increased available supervision should help compensate for any concerns about patient safety, and 24-hour shifts will better prepare PGY1 residents for becoming upper year residents.

**Name:** Robin O. Winter, MD, MMM  
**Organization:** JFK Medical Center  
**Affiliation:** individual

I think the duty hours should be 24 hours for all levels. Decreasing the PGY-1 residents to 16 hours will increase the needed number of transitions in patient care, which will decrease patient safety. There are some residents who can work for 24 hours and do well and others who do not do well. I think the mandate from the ACGME should be 24 hours with the caveat that the program director is responsible for assessing the residents and determining if individual residents are unable to work that long and have a shorter shift. Another alternative is to allow PGY-1 residents to have 24-hour shifts on Friday or Saturday, when they will be able to go home afterwards and completely rest until the following day, including a mandatory 12-hour rest period after a PGY-1 shift of 24 hours.

**Name:** David Berkson, MD, FAAFP  
**Organization:** Drexel University College of Medicine  
**Affiliation:** individual

Is there any data behind this move to a 16-hour workday? Has this been tested at all? It seems like a logical, evidence-based approach would be to roll this out in a few centers for 3-5y, and then see if these reduced hours are able to still produce physicians of sufficient caliber to meet the needs of the public. I am a first year resident, and am awfully glad that I am going to actually have an intern experience. I hope that the committee will consider a phased-introduction of these recommendations, in order to validate the supposition that a shorter workday will allow for higher quality learning that is the equivalent of the higher quantity model currently used.

**Name:** Bryce Peterson  
**Organization:** McKay-Dee Family Medicine Residency  
**Affiliation:** individual

Understanding of the "alertness management" section above requires that residents not be allowed to work 24-28 hours continuously! The standards need to recognize this scientific fact. In the real world, numerous successful lawsuits based on errors from employees forced to work as little as 16 hours overnight have already been won. These rules have already been shown to be malproductive in the courts, and this needs to be recognized in the medical profession as well. Please read this literature and make rules based upon what we know.

**Name:** Michael Bonnet  
**Organization:** Wright State U SOM  
**Affiliation:** individual

I absolutely agree with the addition of "in unusual circumstances, residents may remain beyond their scheduled period of duty to continue to provide care to a single patient..." Thank you for respecting our ability to make decisions to care for patients (our Hippocratic oath, the foundation of our profession).

I have not; however, been impressed with ACGME ROC handling of resident's honest reporting of duty hour
Maximum Duty Period Length

Comments not in Support
violations. The POINT of these rules is to facilitate feedback from residents to their programs, so that programs recognize problems and have an opportunity to correct them in a timely manner (and if that isn't the focus of these rules, it should be).

This past year our medpeds program was accredited, as it should have been. It is an EXCELLENT TRAINING program. Because residents function in 4 different hospital systems (a large county, private, VA, and Children's hospital), we are challenged to incorporate ACGMEs continually evolving standards into 4 incredibly diverse clinical environments. This is an ideal training program for a resident, to learn different systems. Yet ACGME standards / regulations / policies seem to favor smaller more homogenous programs and demand more of larger programs.

Residents in our program are ENCOURAGED to be honest about duty hours violations and concerns in residency education (again how it should be). At the VA this year (the largest VA in the country) we experienced a massive increase in patient volume (as have most VAs), fewer relative residents to cover the services (as a result of ACGME requirements for more ambulatory rotations/training), thus our program and chief residents were forced to improvise / experiment with many different call systems - so that would balance our service to our patients, our educational responsibilities, and clinical experience in the confines of our duty hours. In my supervisory role as an upper level resident, I violated work hours because of excess patient volume and a call system that wasn't working. I was honest, as were other residents in our program, because we knew our honesty would lead to change. AND IT DID. That specific call schedule lasted one month and one month only. The chiefs / program director made nearly instantaneous changes to the call schedule. The following month the call schedule was again revised and duty hours violations resolved. This is how the system is supposed to work. Was our program applauded for their incredibly timely / rapid response to resident concerns. NO WE WERE PENALIZED WITH A RETURN ACGME SITE VISIT 8 months after we'd be accredited. This creates a huge drop in morale for residents and our program.

Name: Kirsten  
Organization: MedPeds Resident  
Affiliation: individual

This duty-hour restriction is a nonstarter and does not make sense, particularly on surgical services. The days of tired interns prescribing interacting drugs are mostly over since computerized pharmacy and CPOE. In fact, the residents who make the most critical decisions on a surgical service are senior and chief residents (e.g. when to goto surgery, how to deal with operative changes, etc.) This restriction on intern duties further complicates the "handoff", since interns often are the continuity for the service out of the OR.

Name: Michael Lemole  
Organization: U AZ Neurosurgery  
Affiliation: individual

This proposal for maximum duty period length is a step in the right direction, but does not go far enough. The number of hours needs to be reduced from 24. The quality of patient care and medical errors are both negatively affected with these longer shifts. One cannot put a price on a patient's life, and forcing residents to be in the hospital for extended periods jeopardizes patient care. Another issue is ensuring that these policies are enforced. Many institutions find ways around the aforementioned laws. The committee should consider imposing harsher penalties on institutions that are found to be non-compliant with these important policies.

Name: Jonathan Bonnet  
Organization: Ohio State University Medical School  
Affiliation: individual

I think changing the duty hours to not exceed 16hrs for first year residents harms our education in lieu of helping. If first years are not permitting to stay for 24hrs they will miss sign out at either the start or end of their shift depending on what time they start and lose continuity of care with their patients. It's a critical step for first years to be a part of the team and if they are not permitted to stay for the duration of the shift, they
will not receive adequate sign out or be permitted to participate in formal sign-out, which is bad for both education and patient care. Furthermore because we are a small program we will have to restructure to night float and eliminate some of our elective rotations that have been a great experience.

Name: Lauren Shore  
Organization: Dartmouth  
Affiliation: individual

The overnight call is a key part of the educational process especially for an intern. Simply hearing about the admissions or consults that went on the night before cannot substitute for being there yourself.

Name: Adam Sunderland  
Organization: Henry Ford Orthopaedics  
Affiliation: individual

Comparing my son-in-law's recent pediatric training to my own, the most important problem with the 80-hour work rule that I have seen has been with transition of care. More handoffs mean more possibility of error (or lack of knowledge about the patient) by the new duty doctor. Limiting a shift to 16 hours invariably will lead to more transitions in caregivers. Interns should be able to function for 24 hours as well as a PGY-2 with the improved supervision afforded by the new rules. The intern is better served in seeing the new admission through the initial evaluation and initiation of treatment, and seeing the initial results of his treatment and stabilization. I understand the reason for the 80-hour rule, and support that limit, but I feel the 16-hour rule is a mistake.

Name: Daniel Geppert  
Organization: private practice  
Affiliation: individual

I'm not sure this is a good idea, limiting the hours of interns to 16 hours. The rules in this area have served to limit the hours spent by one person in the hospital, but has increased the number of people required to staff any one position. The work hour decreases have reduced the number of hours both working and learning in the hospital, which, I believe, has reduced the overall educational experience for most residents. I have completed a general surgery residency and during that time, the number of educational opportunities has decreased markedly. At the moment, there is a night float for interns, but the weekend days would not be covered in your proposed rules. This would require all interns to work at least 6 days a week, with more overall hours worked while on day services. I think the downsides of call responsibilities are outweighed by the opportunity to have more than 24 hours off during any one week.

If anything, the hours restrictions have made each individual's day-to-day job more painful as there are less people at work at any one time. This also leads to more redundancy during day shifts, with overall reduced learning. I'm not sure interns are so affected by being on call that they cannot do a 24-hour shift. If implemented, I think the backlash of scheduling will be more painful than having interns take call. Particularly in surgical specialties, this may be untenable. In the past 5 years, subspecialty interns have reduced their time on general surgical services to a point that we are not able to adequately cover individual services. The work ends up getting done, but satisfaction with the result has not been the same.

I hope you will consider changing this requirement back to the previous duty hour rule. It is not worth agonizing over call days to have everyone within 16-hour shifts. At present, interns are on call average 1 in 14 on day services. There are rotations where they are q 3-4, but these are usually "good" learning experiences by the judge of most residents. I don't perceive a problem with the current system to the point we need to change the rules. At some point we will get to the problem European countries are having where their education really suffers. (Archives of Surgery article, June 2010.)

Name: Philip Carrott  
Organization: Rhode Island Hospital  
Affiliation: individual
Maximum Duty Period Length

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As a current resident, I am concerned about the maximum duty period length. I am concerned about residents not getting the same amount of hands-on learning that is currently allowed, especially the interns who are needing the most hands-on learning. To make up for time lost, the number of shifts will have to be increased. Changing intern work schedules to shift work will increase patient turnover, which will inevitably increase errors and negatively affect patient safety. Having enough house staff to cover all of the shifts will prove to be difficult as well. As long as residents know their fatigue limits and know that it's ok to pass up on a procedure and let the next team on call do it, I don't know why the hours have to be shortened.

Name: Alicia Cleaver
Organization: John Peter Smith Hospital
Affiliation: individual

16 hrs max should be for everyone.

Name: Tyler
Organization: anesthesiology
Affiliation: individual

Only concern with the 16 hour roles for PGY1, this will direct more programs to due something like night float system which by itself carries a continuity of care issue which is a patient dissatisfied. Could you address this in the proposed change? Thanks

Name: Ahmad Kilani
Organization: Fairview Hospital
Affiliation: individual

Can you please provide the evidence in support of this change? It is very counter-intuitive to think that entry-level residents that tend to be performing less critical tasks should have stricter duty hour restrictions. This will only serve to place more work burden on higher level residents already making more critical patient care decisions that would likely benefit from lower levels of fatigue NOT higher levels.

Name: Jesse
Organization: University of Arizona
Affiliation: individual

These comments are mine alone and do not represent the opinion of Saint Louis University School of Medicine or any other of its faculty members. I am commenting on the concept of “strategic napping” and limiting hours to 16 for interns. Not only is this idea a farce but I ask if you are contributing to the dumbing down of a generation of physicians who are going to misunderstand illness, lack insight into how patients acutely progress when ill and find themselves totally unprepared to deal with a profession that until now has been one of humble self-sacrifice. Most 26 year old or 28 year old interns are capable of losing a night or two of sleep. Those who are not can specialize in pathology. The fact of the matter is we are sending a message to our physicians in training that medicine is just a job (“pay attention to that clock!”). Ultimately, the public will also catch on. There will be nothing noble or special about our cherished profession. Our profession will be populated by physicians who are ill prepared for long hours, and ill suited to truly understand how patients get sick and how to deal with stressful situations. Are you pushing this agenda on members of our military who go on missions? Do the Navy Seals or 82nd Airborne require “strategic napping” when on the battlefield? How about the two tennis professionals at Wimbledon who completed that historic fifth set this year… should they have had a “strategic nap” at say… 40 games? Should the 24-hours at LeMans be changed to the 2 hours at LeMans? The fact is, interns, residents, and fellows and gee, even attendings work hard. We signed up for this profession and we understood that hard work was part of the contract. We work hard on behalf of our patients, staff, and trainees and in return, we are provided a modicum of respect. Medicine cannot be practiced by a clock; medicine is an avocation and it is an art. If it takes you 17 hours to get the job done, so be it. Why is it that the older physicians are working longer hours than the residents? The studies that purport to show that physicians are impaired with more than 16 or 18 or 20 hours of service are flawed because they do not compare their results to the consequences of paring down those hours. I fear for the future of the profession: its spirit, its innovation, its sacrifice, and its ability to
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**Name: Paul J. Hauptman**  
**Organization: Saint Louis University School of Medicine**  
**Affiliation: individual**

I disagree with limiting 24-hour call to second and third year residents. As a female resident with children, I cannot fathom working 16 hour days, six days a week. I would never see my son, who is only up for twelve hours during the day. Working 24-hour call shifts and shorter workdays the rest of the week helps me maintain balance between work and family. At our program, we do get some sleep while on house call (3-6 hours), and I feel this call schedule (approximately q5) is MUCH less of a burden than doing a night float system and working 16 hour days. In fact, one of the reasons I chose this program was to avoid a night float system.

**Name: Jennifer Vesely, PGY 1**  
**Organization: U of MN Family Medicine (Methodist Hospital)**  
**Affiliation: individual**

While many of us in surgery are in favor of more rest and time for reading for the Residents as well as improved quality of care, studies have shown that medical errors occur not during the early hours (2 am, 3 am, etc), but rather at 'quitting' time. In other words, decreasing duty length without strengthening continuity of care may not show the benefits that this proposal designs.

**Name: Sean Benoit, MD**  
**Organization: HUH, Philadelphia**  
**Affiliation: individual**

I applaud the effort to attempt to reduce errors due to fatigue, but again must say that unless the same restrictions are in affect for practicing attendings, it doesn't seem that these regulations are going to do anyone any good. In most cases when a resident is sent home to sleep, the only people "available" to continue to coverage will be the attendings - who still are expected to work full days after being up all night. Unless we require health care organizations to set the same limits on everyone's work and we offer funding to enable them to survive, we can't restrict the coverage for residents. I also don't understand the 16 hours rule for interns vs. the 24 hour rule for second years - it would make more sense to require increased supervision rather than more sleep - I don't want an intern who has never spent the night in the hospital to turn into a second year and be expected to be a supervisory resident without ever having spent the night in the hospital before. I think we are headed in the right direction with these efforts, but would suggest that we look at health care as a whole and not just during teaching years.

**Name: Deborah Edberg**  
**Organization: Northwestern McGaw**  
**Affiliation: individual**

I have grave concerns over this duty length stipulation. It reduces the amount of time a resident can spend with THE SAME PATIENT continuously. Consequently, a resident will likely not see firsthand the impact of their own choices in treatment of a patient nor will they be able to see firsthand the natural history/development of an individual patient's hospital course. These are valuable lessons that they will have learn, but how? Seeing 100 different patients with chf for 24 hours at a time may not be nearly as valuable a learning moment as seeing a dozen chf patients throughout the course of the night and the next morning as they deteriorate, get treated and then turn around at recover. Not all chf patients are the same, and because of that, not being able to see the same chf patient for instance throughout his first 48 hours of stay (the most dynamic period of a patient's inpatient stay) may be detrimental to their education. Furthermore, it makes it very difficult to learn teamwork, as was mentioned above as one of the primary goals. If residents are going in and out of the hospital but not spending time together, it is difficult to learn teamwork. I fear that these hours lengths will make the resident's much less likely to spend significant time together and much more likely to be "ships passing in the night."
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Name: Pete ying  
Organization: anonymous  
Affiliation: individual

I applaud your efforts at recognizing special circumstances in which staying over the allowed limit of hours may be beneficial to the trainee. However, I was disappointed to see the new 16-hour restriction placed on PGY-1 trainees. I have noticed recently that many residents are more focused on the clock rather than patient care, particularly when "post-call". I am only a couple years removed from residency training myself; however, the evolving environment in medical education has been more focused on hours performed rather than improvement in critical thinking and improving technique. I too remember the difficulties in battling fatigue, however we must be careful not to train physicians that are unable to recognize that the hospital never closes, and that their expertise may be needed at all hours., not in 16 hour windows. Patient safety must come first, but we also must be very careful of the message that is being sent to young physicians as they enter a field that is quite demanding of time.

Name: Jason Mohr DO  
Organization: Pulmonary Fellow  
Affiliation:

1) In family medicine, there are going to be times when a resident's "private" or "continuity" patient goes into labor at an inconvenient time. In real life, this happens, too, and we deal with it, nap during the labor as much as we can, and cope. I see that we can "document the reasons" for remaining to deal with these patients--but we need to acknowledge that some of these reasons are going to be relatively routine.

2) Maximum of 16 hours in a row with nothing the day before or after, in effect, if you look at the requirements for sleep, means that if the resident is on any weeknight, they lose two full days of potential didactics. We can tape all our lectures and make them available online (or we could, if we had all the tech resources--has anyone mentioned that these recommendations are making things more expensive?) for residents to catch up on later. The residents also lose out on available time for rotations with specialists or other practical one-on-one teaching we would have done during the day. But a lot of the experience of medicine is learned with the admissions at night--there are different experiences that residents get, with different medical problems, during the day and at night. Also, the residents do need to be in the hospital at night to get the practice of handling "middle of the night" in-hospital telephone calls, so we don't want them to just not be on call so that they can have their day-time learning.

With the 16-hour limit and the no-work for at least 8-10 or so hours before and after a call night, a typical "community hospital" size family medicine residency with 6 interns would have difficulty covering the basic hours of weeknights, weekends, and days, for one family medicine inpatient service. Most likely, quite a few hours would have to be covered by some sort of hospitalists or moonlighters, and given the hourly limits on moonlighting, this would not be residents. It is possible that the faculty would cover the "extra" hours, but unless these faculty wanted to volunteer to do this additional work without additional pay, the average community hospital family medicine residency, which has been justifying its existence to its host hospital at least in part by covering an inpatient service, will be much more expensive to the hospital, and it is my fear that many residencies will close. Unfortunately, many of the residencies that are most likely to close are the ones in medium to small towns, providing service to relatively rural populations, and producing residents more likely to serve rural populations. Other residencies at risk are those serving inner-city populations, where there are high Medicaid and self-pay populations.

Name: Rebecca Beach  
Organization: Rebecca Beach  
Affiliation: individual

I applaud the committee on the work that was done. I think the work that was done is clear, manageable, and overall will have a positive impact, in particular the supervision definitions. I do have concern regarding the selecting out of R1's for the 16-hour rule. I am concerned for the increased hand-overs that this creates, the ten-hour break time required after such a shift (essentially converting this to a 14 hour maximum), and
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The workload that will now be shifted to others within the program. One of the indirect results of this shift will be fewer consecutive weekend days off for all residents, and more weekend and night work for senior residents. My assumption is that part of the reasoning for this is to put the seasoned residents in the situations that require more intuitive response. Without previous experiences, there is less intuition to rely on, part of the reason I am a fan of the supervision definitions newly created.

**Name: Jeff Haney**  
**Organization:** Santa Rosa Family Medicine Residency  
**Affiliation:** individual

The 16-hour work limit for interns is problematic in many ways. Interns will work additional hours per week to cover the loss of consecutive hours worked; they will miss out on learning opportunities, esp. in surgical specialties; this may lengthen the period of residency for many specialties due to the decreased number of hours worked. While we have all had bad nights, 24-hour calls typically offer at least some amount of sleep, and we have trained our bodies to be able to function for 24 hours at a time. Myself and literally all of the residents that I have discussed this issue with feel strongly that this change will be detrimental to our training in multiple ways.

**Name: Margaret**  
**Organization:** Memorial Family Medicine Residency Program  
**Affiliation:** individual

As a 37 year old recent graduate from a surgical residency, I find this information insulting and naive. Who is going to pay for the "physician extenders" or extra residents that will be required to fill these last 8 hours. where is the time for checkout? Namely, WHO IS GOING TO TAKE CARE OF THE PATIENTS? this is without a doubt going to extend the length of time required by programs to graduate surgeons, general, neurologic, orthopaedic, and urologic. Good luck getting qualified persons to go into those fields when you are looking at 7, 8, 9 years AFTER 4 years of medical school. I cannot wait to hear the "patient safety" and "quality of care" discussions that are held then. Are the trial lawyers writing these rules because they are the ONLY group whose quality of life will improve with these rules? Perhaps those who are going into training should get some say in this instead of the bean counters that have been removed from patient care for my lifetime!

**Name: Patrick**  
**Organization:** none  
**Affiliation:** individual

This policy will DRAMATICALLY affect our residency program structure. As first year interns we are on-call, in-house, approximately q 5 for a 24 hour period and then are usually in clinic for post call 6 hours the next day seeing continuity patients and attending afternoon conference. As on-call, in house residents ,we respond to codes and acute status changes, providing stabilization for the patient and contacting the hospitalist of these changes as soon as possible for he/she to assume care. This role was one of the things that enticed me to this program, but I don't see how we can maintain this schedule if the new duty hours take into effect next year. For obstetrics, we take 24 hours shifts q 3 or q 4. Again, this is going to have to be totally redesigned to accommodate the changes. Based on this structure, we provide a valuable service for our hospital. I'm not sure whom our program will enlist to fill in for the missing interns. I'm concerned that we may lose fac!

Faculty if the faculty are required to stay in house with us. I'm also concerned that I am going to have to work twice as hard as a second and third year resident because I have to fill in for the interns, which is a little disappointing considering our program (as well as many others across the country) is designed to get progressively easier as time goes on. Finally, I am concerned that the hospital is going to have to spend more money to fill in for the interns, and the value of being affiliated with a residency program would be diminished–worst case scenario, they would get rid of our program.

We are a small, 6 residents per class residency program, and I am concerned about how we can change our program to meet the requirements based on our small size. Plus, I can't help but feel it will hurt our recruitment this fall, considering that these proposed changes are up in the air, and it will take awhile to
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develop a new curriculum and relay these changes on to our applicants. It was not that long ago that I was an applicant and programs that had a lot of proposed changes up in the air were lower on my list because I didn't like the uncertainty.

I also find it interesting that home call is considered separate from that of in-house call. Our senior residents have home call in which they are woken up as many if not more times than we interns are, and yet, they work full days the next day without post call time off. Granted they have more experience under their belt, but I just don't understand the rationale between the differences of home call vs. house call.

I will also add that I imagine it is going to be increasingly difficult to meet all of our family medicine requirements with the new changes, and it is only going to hurt the education of future physicians.

I understand that these developments are ultimately in the best interest of patient safety. However, I don't understand why blanket requirements across the board are required. Our program is successful because they have many layers of oversight, and we have excellent patient safety despite our q5 in-house call schedule. I personally think that programs that have lower safety records should be forced to evaluate their work hours and structure based on their individual circumstances.

These changes, I'm afraid are going to hurt our program, because 1) they are going to take effect too soon to adequately re-design our curriculum 2) they are going to change the structure of our already successful curriculum 3) and they may lead to uncertainty that may affect recruitment. If these changes must be made, I would think that a couple years would be necessary to allow the required changes changes to be made.

Thank you for taking the time to listen to my concerns.

Name: Hilary Hammell, DO, PGY -1
Organization: University of Minnesota - Methodist FP residency program
Affiliation: individual

I am confident a PGY-1 Psychiatry resident can take 24 hour call with direct supervision after 6 months training especially since commonly a post-call resident in Psychiatry can transition care of his/her inpatients very quickly eg. Over minutes the morning he/she would be finishing the on-call shift. This advancement of responsibility is consistent with the duties, responsibilities expected of a PGY-1 resident currently, and to relinquish such places them in a professional position less than a fourth year medical student on an inpatient elective.

Name: James B. McLoone, M.D.
Organization: Banner Good Samaritan-Psychiatry
Affiliation: individual

As the program director of a 6-6-6 FM residency, restricting the PGY-1 residents to a maximum 16-hour duty shift would have a negative educational impact upon my PGY-1 residents by forcing us to choose between earlier hours with rounding opportunities and overnight experiences with good educational experiences. The evidence supporting this change appears to be weak. If the PGY-1 duty hours were identical to the PGY-2 and above, even if the 4-hour "hand off" time were not included for the PGY-1 residents, this would help us satisfy our educational needs.

Thank you for your time and consideration.

Name: Robert Langan, MD
Organization: St. Luke's Hospital Family Medicine Residency, Bethlehem, PA
Affiliation: individual

As program director of an unopposed community based university affiliated urban 6-6-6 FM program, the PGY 1 -16 max hour work/day will be the death of our program. We serve 67% of the indigent population of our city as a mission of our catholic hospital. As a result of the mission and lack of reimbursement for their mission to serve the underserved, we are dependent on Medicare GME monies for the existence of our
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residency. We generate 1/3 of each graduating class who continues this mission for our hospital. Unfortunately, we are dependent on the small attending staff for their education. There is a service obligation but not excessive in order to have the medical staff educate my residents for free. Our program is 50 points above the national average in training score so the med. staff does a great job. However the 16-hour PGY 1 rule will leave our services uncovered on weekends in order to meet requirements of 16 hours, I will be forced to break the 1 day per week (averaged) free of duties regulation as there is not enough interns to cover weekend call with 6 PGY 1 residents. This would require 2 teams of 2 interns and one senior resident each weekend. I have to choice. One is to leave service uncovered and lose the teaching of the small medical staff or hired more interns of which the hospital cannot afford without GME money which we know is not coming. So what's you solution. Too, lose a good program in primary care delivering care to the indigent who meets all duty requirements at present with outstanding education or meet the 16-hour requirement and risk lower the educational benefit of this hospital. Also isn't it discrimination to have 16 hours for PGY 1 and 24 hours for PGY 2 on the same team providing the same call. How do you think this is going to work in practice? You have no evidence that PGY1 perform better with 16 hours verse 24 without affecting their education or improving patient safety.

Name: Richard T. Martin MD
Organization: Sacred Heart Hospital Family Medicine Residency
Affiliation: individual

Prior to medical school, I was taking master level biology courses, working as an electrician during the day, and had a few side research projects on the side. I never worked less than 16 hours a day. The current 24/6 rule is needed, but further studies are needed to fully evaluate whether an arbitrary cutoff of 16 hours is needed. Patient safety is not being improved with the current rules and with handoffs every few hours more mistakes will be made. This is a profession, not a 9-5 job, residents/fellows understand this, and we do not want these changes. It is not fair that we have to fight and take care of our patients in the time constraints currently given. There is no data to back up any of the IOM claims.

Name: James Proctor
Organization: UAB Department of Cardiology
Affiliation: individual

While I'm certain this has been brought up before, it is worth restating that these changes are systematically discriminatory in their effects; small programs with fewer numbers of residents will be disproportionately affected, while larger programs will have more flexibility to comply by simple virtue of numbers. Our incoming intern class will need to be roughly 50% larger than previous classes, at a bare minimum.

I should also mention that the timetable for these changes is faintly ridiculous. We will find out about the final version of the changes (and therefore what number of interns we will need in order to comply) just as we are beginning to receive the first applications for this year's match? This lends itself to two interpretations: either the ACGME is completely lacking in reasonable foresight (a deficiency I expect in New Orleans and other developing countries, but not from a national accrediting body), or the timetable was concocted in such a way as to preclude time for substantial countervailing evidence to be assembled opposing the rationale for these changes. Forgive my cynicism if I suspect the latter.

I have vented my spleen, as I am sure was your only purpose for this “period of comment”. Deliver your new rules, and I will assume the appropriate position.

Name: Todd Washko, MD, FAAP
Organization: Tulane University School of Medicine
Affiliation: individual

I am a psychiatry resident at the University of Arizona. This year I am the chief responsible for making up the call schedule. Our program has always been very conscientious about following the duty hour rules, even though we take home call and the rules don't really apply to us in the same way. We are a small program, with very limited funding, and while I understand the reasoning behind limiting interns to a 16-hour shift, with the size of our program, it will actually increase the number of days we each have to work and add
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extra burden for all our residents by necessitating a short call system. To this point, we have been able to avoid doing so, and have worked things out so that interns take less call through night float, get more weekends off, and subsequently have less fatigue and better quality of life. With these proposed changes, they work more weekends and longer weekdays, and those changes persist throughout the residency. Please don't implement this change.

Name: Melanie Fillmore  
**Organization:** University of Arizona Department of Psychiatry  
**Affiliation:** individual

Residencies currently struggle to provide all of the education that is required in the amount of time available. These requirements will make it difficult, if not impossible to prepare residents for the demands of practice. In addition, I believe that the duty hours requirements decrease the professionalism that is expected of physicians, without any evidence of improved patient safety. There does not appear to be adequate evidence behind these changes to the entire system of medical education. In addition, any possible evidence would not explain the differences in the handling of duty hours according to year.

Name: Rudolph Krafft  
**Organization:** St. Elizabeth Health Center  
**Affiliation:** individual

The 16-hour continuous duty requirement will further degrade the problem of continuity of patient care. Duty is actually the wrong term, since it is an educational period also. Rather than setting a time limit, there should be an activity limit beyond a certain hour of continuous duty. For example, residents should have restrictions on unsupervised clinical activities after being on continuous duty for some period of time (16 hrs for example), but can continue to be on duty and performing supervised clinical activities or education during the latter hours of any duty shift.

Name: Paul Vespa  
**Organization:** UCLA  
**Affiliation:** individual

As an internal medicine/pediatrics residency program graduate prior to the 80 hour rule, and as an attending physician at an academic medical center, I believe that limiting intern responsibility to 16 consecutive hours is a big mistake. The majority of learning during residency occurs when you are on-call. The majority of work admitting patients occurs between 4PM-2AM. You learn by working in residency, rounding with your attending, and following your patients over time. The current workday starts at 6:30 AM or 7:00 AM. Attending rounds are in the morning at 8:00 AM or 10:00 AM. If an intern starts at 7AM and leaves at 3AM the following day, how are they going to follow the progress of their patients? They are not and this will affect learning. Are we willing to extend residency programs due to the decrease in learning? Not to mention the shift work mentality which already occurs at many hospitals I've worked at...i.e. pass it on to the next guy on-call or up. In private practice there is no one looking over your shoulder limiting you on how many hours you work. You are often working over 100 hours a week easy. What the ACGME should do, since there is worry about night back-up issues for sleep-deprived interns, is require significant attending physician backup for the interns/residents. How that occurs is up to the ACGME.

Name: Stephan Philip  
**Organization:** Ventura County Medical Center  
**Affiliation:** individual

Having recently completed my PGY-1 year, I do not agree with limiting duty periods for PGY-1s to just 16 hours. Nothing is gained in the first of year of residency that changes the amount of hours the resident can complete. You don't develop the ability to work longer without getting as tired. It simply does not make sense to limit the duty period in this way and may jeopardize the duty hour requirements of the other residents who will be forced to cover for this extra time.

Name: Max
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**Organization:** UMC  
**Affiliation:** individual

This will mean that our interns will come to work at 4 PM on a call day thereby increasing transition nodes. This is the line that is being crossed that should not be crossed. I am not sure what pressure has been brought to bear to give this up to whom? Is there someone in the government who is going to swoop down do something drastic if we don’t give away interns taking call. I truly believe that call is an important part of surgical residency training. Any residency training. Especially if we are going to practice in an environment where attending doctors have no duty hour limits.

**Name:** Earl Norman  
**Organization:** MSU/KCMS  
**Affiliation:**

Duty hour requirements of this sort imply that only the fatigue of interns is important. Why not implement the IOM standards where EVERY resident has 16 work limitations. Just because you finish internship you suddenly do not become better at coping with sleep deprivation and alertness management.

If you want to implement this sort of change, you will be effectively forcing all hospitals to adhere to a structure preset by the ACGME, which removes the beauty and elegance inherent in the current system where each program has its own unique features.

**Name:** Amit Vora  
**Organization:** Brigham & Women’s Hospital  
**Affiliation:** individual

As a current resident, I feel these duty hours are too limiting to my specialty (PM&R). Most of our learning is during the day hours as our specialty is mostly outpatient. (However, we do have inpatient units in which we care for patients and take in-house call for). In a small program, to comply with these restrictions, we would have increased transitions and work odd hours. For example, the current schedule to go into effect if these rules were to take affect would require some residents on inpatient programs to work 1/2 days (8 a.m. to noon) 2 times per week. I am really unsure how you are supposed to “know” your patients when you hardly seem them 2 days during the week. In addition, on those half days (8 a.m. until noon) you would reappear at work at midnight that same day and work to 5pm the next day. This fits the 10hours off b/t shifts however it in effect has you working for 2 days with minimal sleep. In effect, it will have us working such odd shifts to cover the hospital that our education would be severely compromised, patient care would be severely compromised, and my own safety getting home after the 2nd day of work would be compromised. I don’t think working 30 hour shifts is a blast but it is doable especially in our field where you generally get to lay down at night (Note I said lay down. Sleeping in a hospital with overhead announcements all night long is a rare feat even if you are not being paged). I think the “old days” of medicine were on one extreme of the spectrum as far as abuse to the residents and danger to patients. However these new regulations go to the other extreme making it difficult to cover the hospital and receive training. In addition, it is dangerous to patients as the number of transitions increase and it certainly will not help residents in our program get needed sleep. I think the ACGME really needs to rethink the impact these restrictions will cause. Either some programs need to be excluded or in general, these restrictions need to be advised.

**Name:** none  
**Organization:** none  
**Affiliation:** individual

I imagine during the nap that the resident would have to turn off her pager. Thus, someone else would have to be responsible for the care of the patients. There would need to be a sign out before and after the nap period. This seems unnecessarily complex. A well designed shift schedule with (day float/ night float: 12h: 12h) would be more reasonable. We should learn from our nursing colleagues and other medical professionals. They use shift work regularly to deliver effective patient care. They have formal and structured transitions of care. They have measures to prevent provider fatigue. No one doctor is so important or integral to patient care that only she or he can continue to provide appropriate care. A 12 hour
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shift is more than ample time for a resident to appreciate the continuity of care and the natural course of an illness and its treatment.

Name: Guido
Organization: none
Affiliation: individual

The napping period is impossible to schedule without involving other residents which further increases night responsibilities and is directly counter to try to increase patient safety by decreasing fatigue. For some residents, they feel more fatigued after a few hour nap. Finally this strategy is going to entail 2 more sign offs per resident team at the front end and back end of the nap, further increasing the chance of a patient safety issue because of something that was not transmitted. I think this napping verbiage should be eliminated from the document.

Name: xx
Organization: xxx
Affiliation:

I work in a 6-6-6 family medicine residency program. It would be extraordinarily difficult to have the PGY1 personnel to make this happen. Many FM residencies are smaller programs that are community hospital based and will have a lot of difficulty initiating these proposed reforms.

Name: Jennifer Good MD
Organization: Altoona Family Physicians Residency Program
Affiliation: individual

For interns to work less than 24 hrs in a row, this means no one can take overnight call. In order to accommodate the new regulations with the same number of available residents in a call pool, each resident would be on call nearly every day (if not daily), night float interns would have to take an extra night a week. Interns are most often those who do off service rotations. Therefore the call pool is down to 2-3 in many programs. Being on call every day, ie working nearly 28 days in a row is terrible for morale, leaves no time for outside life and would personally make me a very unhappy person who would potentially change careers. I cannot imagine being unable to have any given weekend completely free. As an upper level, being unable to take call fri/sun on occasion (still averaging q3 over a month) you would never in 4 years have a "golden weekend." This is detrimental to mental/emotional well being of residents . These regulations do not provide enough benefit to patients to sacrifice a life outside of work completely. Please consider my opinion as it reflects that of many of my co residents.

Name: Lauren Siff
Organization: tufts medical center
Affiliation: individual

I think the restriction of call to 16 hours for PGY 1’s is unreasonable since they have taken oernight call as medical students. PGY 1’s have access to advanced PGY residents and physician staff for advice and guidance. I am boarded in sleep medicine and there is nothing in the literature to support this guideline. There is evidence that suggests naps of short duration can be restorative for attentiveness and cognitive function and that is not addressed as an opportunity.

Name: Kathleen Yaremchuk, MD
Organization: Henry Ford Health System
Affiliation: individual

I think this new restriction is ridiculous and unnecessary. As a doctor that has just finished residency in IM, this will severely hamper smaller programs abilities to exist. Often there are not enough residents at a smaller community-based program to comply with these rules. I feel this is likely a part of the ACGME’s goal; to squeeze out smaller community-based programs because of a bias toward university based programs. These new restrictions will only make residents lazier, less prepared for the real world, and decrease educational opportunities. I can't believe that the people coming up with these ridiculous rules are
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physicians themselves. It is a disgrace. None of the current rules have even had a demonstrable effect on patient safety or care. The new rules are laughable and sad. We are going to be churning out a bunch of less qualified and babied new doctors. Thanks a lot...

Name: Ben Compton
Organization: BHS
Affiliation: individual

This will seriously detract from resident learning. There is much to be said about the experience of admitting a patient, seeing their labs come back, getting them stabilized, getting the consults and truly "seeing a patient through" which simply can't happen numerous times in 16 hours. It will impair patient care by increasing the number of handoffs between residents. It will also punish small community programs who will struggle to restructure their programs to comply with such a drastic change in hour restrictions. I am VERY concerned that my training is going to be at risk with these changes.

Name: Ashley Wentworth
Organization: McKay Dee FM Residency
Affiliation: individual

It seems odd that on June 30th a first year resident could only work a 16 hour shift, but on July 1, a day later, as a second year, could suddenly work a 28 hour shift. Is the issue really the year or ability of the resident to fatigue less or is it really the supervision of the resident during the time that they're on? Will they really be well prepared to be in a supervisory capacity their second year if they work so little their first year? My fear is that most residents will be assigned outpatient rotations their first year in order to meet this requirement and will be inadequately prepared to meet the challenges of the second year.

Name: Elizabeth Johnston
Organization: University of Nebraska Medical Center
Affiliation: individual

Thank goodness the 24-hr issue is being addressed, however it should NOT only impact interns!!! Upper level residents often have more responsibilities and thus more stress. A fair/balanced 16hr rule FOR ALL RESIDENTS is needed! PLEASE!!!

Name: Anonymous
Organization: anonymous
Affiliation: organization

The intern-training year is the most critically important year. Duty hours should not be restricted to 16 hours. There is no documented or scientific evidence that proves that limiting shifts for PGY 1 to 16 hours will accomplish anything meaningful. Except perhaps to limit their real-world education experience and put residencies in danger of having to eventually lengthen the number of years spent, to make up for the shortfall in education that shift limitations would impose. Strategic napping, while subjectively useful, also has no proven and well documented scientific studies that show any benefit. As well, not allowing continuity clinic participation after a 24 hour shift, while it sounds good, has no basis in proven fact for accomplishing anything. We as clinicians are practicing evidence based medicine. It is only right that any new rules for resident should also be evidence based.

Name: Arthur Morrow, DO
Organization: Altoona Family Physicians Residency
Affiliation: individual

The new duty hours will produce a generation of physicians who are inadepth in the care of patients in the real world. Patient continuity and care will be significantly compromised as well. This seems like a very bad idea and I do not think that either patient care or the quality of resident has improved with these measures.

Name: Thangam Venkatesan
Organization: Medical College of Wisconsin
Maximum Duty Period Length

Comments not in Support

Affiliation: individual

Asleep at the switch

The new proposal for work hours for doctors in training would have them take naps. I took naps, when I was a baby. I will again, when I am an old man. Young doctors should have the energy to keep going, no matter what. They should be able to function in all manner of situations. They should be awake to see it when their patient gets sicker than he was when they first admitted him. They should learn how to function when tired, because being tired and stressed is a situation that will recur, again and again, in real life, when they are real doctors who don’t have ACGME work hour limits to protect them.

First year residents will be on-call for LESS time than their seniors. The younger people, the physically stronger ones, will do LESS work than their seniors. This is upside down, and irrational. Younger people have the strength and stamina to stay awake, to work hard. To limit their time is to baby them, a bad way of preparing them for the real world.

Name: Eric Cohen
Organization: Medical College of Wisconsin
Affiliation: individual

As a chief medicine resident, I am concerned that limiting the maximum duty period length prevents junior physicians from seeing disease processes develop in the acute setting. I learned most from spending the first 24-30 hrs with my new patients, diagnosing them, formulating a plan, executing a treatment strategy and following the patient's response to my intervention. As we transition to shift work, I fear that residents will miss that critical learning window. I am also concerned that residents will need to lengthen their training in medicine residency in order to achieve competency in the core medicine curriculum. Lengthening an already unpopular training program such as internal medicine will contribute to the shortage in internists. I acknowledge this is a difficult decision with no "right answer." thanks for your time.

Name: Ellen Eaton
Organization: Stanford
Affiliation: individual

I understand and appreciate the desire to ease the burden on PGY-I residents, but this rule will have the unintended consequence of increasing the clinical burden and call responsibilities of upper level residents, who will now have to take on an even greater share of the duties. It is naive to believe this major alteration can be made without any change in funding for programs to hire or re-direct current faculty/staff for the purposes of clinical coverage. Additionally, this proposal could cripple smaller programs, and potentially have the effect of decreasing the number of programs (and thus, eventually trained physicians) willing to participate in the accreditation process.

Name: Steven Herron
Organization: University of Arizona
Affiliation: individual

With all due respect- you must be joking. I am not an old codger doc who thinks these young whippersnappers have it too easy and back in my day...etc. I am three years out of residency and I think this is ridiculous. We are turning our young physicians into shift workers at a time when "mid-level providers" are arguing their equality. Policies like these help make their argument. To some degree it has to be difficult-or anyone could do it.

Name: Ryan
Organization: LSUHSC
Affiliation: individual

Hi. I'm a new PGY-2 at UT southwestern pediatrics in Austin, TX. I would like to share my feelings about the new duty hour requirements.
Maximum Duty Period Length

Comments not in Support

First, I think I speak for most small to medium sized programs (less than 40-45 total residents) to say that with the new 16H continuous rule for PGY-1’s and the new 24H continuous rule for PGY-2's puts so many limits on continuity of patient care, that we are all having to work more TOTAL hours to cover rotations with call responsibilities in order to keep the hospital staffed with adequate residents to admit as provide care for old patients.

One obvious downside to this is that we are basically being turned into hospitalists as we are having to cut back on subspecialty and outpatient rotations to provide adequate hospital coverage.

Another downside is that there is no longer a way to have the intern who admitted any given overnight patient there to round on a given patient. This is such a great learning opportunity that is now being missed.

Another downside is that senior residents are having to perform morning duties in the hospital like writing notes in order to cover for the intern who cannot be there due to new work hour restrictions. This takes time away from supervising interns and helping to closely monitor higher acuity kids. This is extremely dangerous for children and is harmful to the education of senior residents who need to learn supervisory skills.

Finally, I ask myself why a rule designed to limit fatigue would actually force us all to work more TOTAL hours in the hospital in order to provide adequate coverage. The increase in hours mostly owing to more time on night float. Essentially you are forcing us to either get more residents (won't happen, especially in an economic downturn) or work more total hours. I did the math. It's right.

Please reconsider the 16H and 24H rule. You are KILLING small programs.

Name: Corey Fish
Organization: UT Southwestern Pediatrics
Affiliation: individual

I don't understand why PGY1’s are limited to 16hour shifts. I found my 24 hour shifts as an intern helpful in understanding how my morning plan affected physiology and may need to change by the evening. You also have time to see how the immediate postoperative period evolves. In addition, for the sickest patients, I could provide better care since I knew the patient well, knew the patient's trends, and could make decisions based on 1:1 experience with the patient.

Name: Lucia Madariaga
Organization: MGH surgery
Affiliation: individual

1. Please consider the long term effects of this restriction. Fewer duty hours in training means less experience for physicians going out into the community. Would you rather have physicians making errors while they are supervised by an attending, or when they are themselves attendings?

2. Consider that there are humane training programs out there that do not need these restrictions in order to provide interns with adequate rest. I fortunately never had to stay awake thru the night during my internship. Our residency was designed with our mental health and well-being in mind, and the workload is manageable. These restrictions will force a change to "fix" my training program's system, which is not broken.

I am now a 2nd year resident. I felt that my intern year was very educational without requiring me to sacrifice the sleep I needed.

Name: Kelly Jeppesen
Organization: McKay-Dee Hospital Center
Affiliation: individual

The rationale behind this guideline eludes me. I am currently transitioning from R1 to R2. My 30-hour calls last year were harrowing and I always felt that my brain was trying to swim through mud in my post call
### Maximum Duty Period Length

**Comments not in Support**

morning. This was terrifying when I was trying to take care of a decompensating patient with pulmonary embolism I had admitted the previous night. I knew what I wanted to do, but I just could not get it together to write the orders correctly so pharmacy would send up the correct drip. In my fatigue, it took rewriting the order five times. I was not in a situation where I could attend to details. This is only one example of many. I applaud the reduction of the R1 shift to 16 hours. What I do not understand is the presumed fundamental change in the neurobiology of the R2 brain that makes him/her more resistant to fatigue than R1s. If shifts that are greater than 16 hours impede patient and resident safety during intern year, how can they be safe during R2 and beyond years?

Also, it is not enough to strongly suggest that residents ought to take naps. Programs are not in a position to negotiate with hospitals given the current condition of state medicaid budgets, etc. Hospitals cannot accept work hour reductions that are not mandated. Strongly suggesting changes is only a way to protect the ACGME in the media, it does not really address a fundamental problem adversely affecting patient and resident safety. It’s cynical and disingenuous.

**Name: Flavio Casoy  
Organization: UCSF  
Affiliation: individual**

I have several concerns about limiting 1st year residents to a 16 hour call stretch.

1. With smaller shifts of continuous in-house call, comes an increase in the number of transitions of care between providers. Research has shown that medical errors are much more likely to occur in the transitions of care between providers. Poorer continuity of care (and therefore, quality of care) for patients will be a result of the proposed changes.

2. With smaller shifts, the volume of patients that an intern sees is likely to be reduced. This reduces their level of experience and thus makes them more likely to commit errors as a higher level of resident based on having less experience.

3. As far as I have heard, the changes that were made in 2003 (which I feel are appropriate) have not reduced the number of medical errors. What is the evidence that further restricting duty period lengths would decrease the number of errors? I submit that it would not, because there would be a compensatory increase in errors due to the increased number of pass offs of patients between doctors. Moreover, it would harm the resident's education by giving them less experience overall.

In summary, I feel that the proposed changes to the maximum duty period length would not decrease errors, and would have a deleterious effect on the education of the residents.

**Name: Emily Poff  
Organization: McKay-Dee Family Medicine Residency  
Affiliation: individual**

I don’t believe that the work hours should be different for different resident levels. It will breed resentment and other issues. All residents should be having the same experience as far as work duties go.

Cutting out the ability to go to continuity clinics post-call could have a severe impact on smaller programs and such problems should be taken into account when making these sweeping changes.

**Name: Laura Rosenfield  
Organization: UNSOM  
Affiliation: individual**

I understand and accept that the new duty hour rules will be going into effect no matter what comments you receive. I have major concerns about the effect these rules will have on resident education. I believe if these rules are going to go into effect, that the pediatric residency length MUST BE INCREASED TO FOUR YEARS. The increase of one year will offset the loss of training pediatric residents will be receiving with the new rules and would allow us to continue to graduate residents with equal skills and knowledge as has been
## Maximum Duty Period Length

### Comments not in Support

the case for many years. I hope you really listen to those of us who train our residents and this comment period is not just for show. Thank you.

**Name:** Dr. Doug Ziegler  
**Organization:** St. John Hospital & Medical Center  
**Affiliation:** individual

Single-residency programs with 18 or fewer residents will have difficulty setting up a night-float system which will be required. Also, it will be hard for Fam Med programs to meet the Family Practice Center patient #s with such a fragmented (as we see it) schedule, so the RC-FamMed will have to consider modifying those #s (as well as expectations for in-patient #s) to realistically meet them.

**Name:** James Richard  
**Organization:** Summa Barberton Family Practice Residency Program  
**Affiliation:** organization

I don't think that is a good idea because interns are ready to work hard in the beginning, after that they may wear off and if they don't do these calls, they may never learn to handle emergency situations. I am myself an intern and strongly oppose this idea of 16 hours.

**Name:** RITU MADAN  
**Organization:** Creighton University  
**Affiliation:** individual

Instead of limiting 1 PGY1 to 16 hours, why not require 2 interns be on call each night while the first intern is working the second could be sleeping, then, after 6 hours the second intern can begin duties this way there would be no need for post call days.

**Name:** Felix Grucci III  
**Organization:** UPH  
**Affiliation:** individual

VI. G. 4.a) and b). The maximum duty period lengths of 16 hours for PGY-1 residents and of 24 hours for PGY-2 residents and above are both illogical and impractical.

The proposed changes are illogical because residents of PGY-1 and PGY-2 and above status obviously require the same amount of sleep/rest. In many training programs, their work loads are nearly equal. In others, due to additional responsibilities, work load is greater for a PGY-2 or above resident than a PGY-1 resident.

The proposal is impractical because having different duty periods for PGY-1 and PGY-2 and above residents would be disruptive to patient care and teamwork (fostered in section VI.F), especially in hospitals that employ one resident-one intern teams. Having different duty hour periods for the two members of the team would increase transitions in care, which should be minimized as per the proposed guidelines (VI.B.1.), and would reduce the effectiveness of the team.

We propose duty periods of 24 hours for each team member regardless of PGY status, plus an additional 6 hour period for transitioning care in order to ensure safe handoffs.

Minor Comments:
1. Section VI.A.6. and the very next section, VI.B.1. appear to contradict each other. The former encourages transitioning to a ‘rested provider’ while the latter encourages assignments that minimize transitions in care. Clarification is needed.
2. Section VI.D.5., line 738. The word ‘resident’ should be changed to ‘patient’.
3. It is laudable that the ACGME recognizes that in unusual circumstances residents may choose to stay beyond their duty hour period to care for a critically ill patient or for other reasons listed under VI.G.4.b),(3). However, it should be made clear that the need to document this to the program director need
Maximum Duty Period Length

Comments not in Support

not be done on the day of the occurrence, as this would defeat the purpose of extended hours. It would appropriate to permit the resident to document such occurrences within a reasonable time period (e.g., 7 days) to the PD.

Name: Mark Feldman, MD and Sonya Merrill, MD, PhD
Organization: Texas Health Presbyterian Hospital of Dallas
Affiliation: individual

Regarding the requirement to "document" reasons for remaining to care for a patient beyond a 24-hour shift. Does anyone really think that requiring residents to document MORE will help us get out of the hospital on time? It is hard enough without having to justify yourself every 20 minutes. If you want us to work more efficiently (because there is never going to be less work to do), help us DECREASE the amount of excessive documenting and justifying, instead of increasing it.

Regarding limiting PGY 1 shifts to 16 hours. This shifts the burden to upper level residents to cover overnight activities. Poll the residents. I am certain most people would rather get the hard times over with sooner. Furthermore, I think this will lead to an increase in the errors by upper level residents, as now they will be overburdened in place of the lower levels.

Name: wuest
Organization: BCM
Affiliation: individual

This is killing medical education. It is imperative that interns be allowed to work so they can learn. With proper supervision, a 24-hour shift can be incredibly educational. Also, the ACGME has mandated that programs minimize the number of handoffs; however, this new regulation flies in direct contradiction.

Name: Jess Thompson
Organization: Texas Childrens Hospital
Affiliation: individual

I don't think this necessary- I don't think anything magical happens between PGY1 and PGY2 that makes you able to stay up for 24 hours and be effective. I think it takes practice. My first few overnight calls were exhausting and I couldn't think straight. But after doing it over and over I can go all night and don't get that delirious feeling anymore.

How do you propose napping while you have a pager strapped to your belt that goes off every 60 seconds with questions about tylenol?

This is a great rule. I have always thought it was stupid to go to clinic until noon after working all night- I look and smell bad and the patients can tell I'm not at my best.

Name: Jennifer Wagner
Organization: Baylor Orthopaedics
Affiliation: individual

The 16 hour PGY1 duty hour restrictions are problematic for several reasons:

1. This will drive some small surgical programs into extinction when they count on class sizes of 1-2 residents per year. PGY1 residents are required to be in overnight call to allow the program to function. Closure of these programs will hurt access to surgical care.

2. This a cloaked commentary on our medical school education. This move essentially reduces a PGY-1 resident to a 5th year medical student.

3. It is unclear how an intern is less able to handle the fatigue of work hours compared to more senior level residents. There is clear evidence that interns make more mistakes. The issue becomes what is the root
Maximum Duty Period Length

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cause. Is it fatigue or lack of experience? Without evidence based analysis of the impact of a 16 hour duty period, this recommendation is unfounded and simply a mandate.

3. The 16 hour PGY-1 restriction will pretty much mandate a night float system which many programs are ill equipped to provide due to a resident shortage. This risks putting more senior surgical residents on call and will subject them to the 24 hour requirement. This will then effect their ability to perform the required number of surgeries as their case volume will decline. This has a domino effect resulting in more poorly trained surgical graduates.

4. The restriction of post call hours from 6 to 4 hours is troublesome. This reduces didactic opportunities, morning surgical cases, etc. thereby reducing the quality of surgical trainees.

5. The term continuity clinics must be clarified. Are these resident run clinics or standard clinics in which a resident assists in seeing a staff's patients? In terms of patient safety and the surgical patient, the less acute patient is seen in clinic and will be less susceptible to the effects of a fatigued resident. Also the care is typically directly supervised by an attending. Any restriction to these clinics could be detrimental to trainee's education.

6. For any of these recommendations to be possible, funding will have to be provided from sources to cover the lack of hours now provided by residents.

7. The ACGME should be commended for allowing the flexibility to allow for the caring of critical patients in unique circumstances.

Name: Joshua Broghammer  
Organization: University of Kansas Medical Center, Department of Urology  
Affiliation: individual

I do not think 16 hours is adequate time to learn how to be excellent physicians. 16 hours will not allow me to follow my patients enough to learn about management of patient care. Please do not institute this 16 hour rule. It does not make sense and it makes our education as residents futile.

Name: Golnaz Alemi  
Organization: UNSOM  
Affiliation: individual

Having experienced the current ACGME requirements for 3 years, I believe the maximum duty period length should remain the same. As most scheduled surgeries take place in the morning, 30 hours of continuous duty allows me to participate in the DAILY rounds of my patients as well as surgeries for patients that I’ve been working with at outpatient clinics. I would like to be able to BE THERE for my patients.

In addition, having an additional 6 hours of clinic experience after 24 hours of duty remains a valuable and safe clinical experience. Should exhaustion or sleep deprivation render a resident unsafe, which I have yet to see happen, we are strongly encouraged to speak up to be relieved of clinical responsibilities - without fear of retribution.

Name: Jessica Fu  
Organization: UNSOM OB/GYN Residency  
Affiliation: individual

A 24 hour duty maximum is realistic and prudent. It allows for appropriate learning and continuity, but does not lead to over fatigue. A 16 hour maximum for interns, however, is too short a time and will be detrimental to their learning. It will also put a greater burden on the upper level residents to cover those hours that will be left uncovered by the change and will detract from moonlighting hours which provide excellent learning opportunities.

Name: Wyatt West
### Maximum Duty Period Length

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<tr>
<th>Comments not in Support</th>
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<tr>
<td><strong>Organization:</strong> McKay-Dee Hospital Family Medicine Residency</td>
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<td><strong>Affiliation:</strong> individual</td>
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<td>We owe it to our patients to make sure the change in duty hours will improve patient care and not worsen it due to increased number of handoffs or other unknown issues. It most likely will increase costs at most institutions which would be very discouraging if we are not improving care. We need studies on these changes before implementing them, or at least after implementing them if we have no other choice.</td>
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<tr>
<td><strong>Name:</strong> George W. Brown M.D.</td>
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<td><strong>Organization:</strong> Atlanta Medical center family medicine residency program</td>
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<td><strong>Affiliation:</strong> organization</td>
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<td>An exception should exist that a resident performing an operation under supervision should never have to leave a case before it is finished unless the resident or attending physician believes that he is unable to complete it due to sleep deprivation.</td>
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<td>Limiting intern shifts to 18 hours is incompatible with the goal of avoiding handoffs, which pose a much greater risk to patient care than an additional 6 hours of work. In effect, this requirement means that no surgical intern can be on night call after working during the day, which means that no patient will ever be cared for at night by a resident that has had a chance to participate in team rounds, procedures and discussion of care objectives during the day. The natural flow of a work day is 24 hours, and medical school prepares interns to work this length of time.</td>
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<td><strong>Name:</strong> Timothy Millington</td>
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<td><strong>Organization:</strong> MGH</td>
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<td><strong>Affiliation:</strong> individual</td>
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<td>Instituting 16 hour restrictions on interns increases handoffs, which we know increase medical errors. I fail to see how this effort to reduce errors by guarding against fatigue will result in a net decrease in errors. This system pushes a night-float system, which places a disproportionately large strain on smaller programs like ours, 3-3-3, that simply do not have the resident numbers to meet the requirements of call and education. When a resident is on night-float, they cannot simultaneously participate in clinic, electives, etc. To replace current inpatient months with 50% night-float would also be a detriment to education as most of the didactics and resident presentations occur during the day.</td>
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<td>I propose making the PGY-1 hours equal to PGY 2 and 3.</td>
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<td><strong>Name:</strong> Andrew Morris</td>
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<td><strong>Organization:</strong> MAHEC Hendersonville FMRP</td>
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<td><strong>Affiliation:</strong> individual</td>
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<td>I find that these proposals are placing fatigue over patient care. It seems very hard to imagine that several medical errors will be made during frequent hand-offs, which is what is bound to happen if a 16 hour cap is implemented. Furthermore, it is taking away valuable educational experiences for the interns, as they will no longer be able to follow a patient through from presentation to completion. I find it difficult to believe ACGME is content with creating disjointed, poorly managed patient care.</td>
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<td><strong>Name:</strong> Lindsay French</td>
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<td><strong>Organization:</strong> Baylor College of Medicine</td>
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<td><strong>Affiliation:</strong> individual</td>
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<td>I am quite concerned about the newest duty hours-related rules and restrictions that have been recently proposed by the ACGME. I am in the middle of my general surgery residency. I begrudgingly came into training in the middle of the 80-hrs era. These were not regulations for which I asked. Instead, myself and fellow residents felt that the restriction of our ability to work, learn, and care for patients imposed by the ACGME was unfair, short-sighted, and reactionary. The 80 hour rule is arbitrarily set, as best I can tell. In an era of &quot;evidence based medicine&quot; and best practice guidelines, it seems that these rules were placed without any evidence to their merit. I have not seen any evidence since the initiation of the 80 hour work</td>
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### Maximum Duty Period Length

**Comments not in Support**

Week which shows that patient care has improved. So instead of taking this opportunity to revise their regulations, the ACGME has further restricted my ability to practice and care for patients, again with seemingly little evidence or scientific basis.

The right to be left alone, the right to push oneself to the greatest extent of their abilities, all to take care of the sick and dying: these are the things that we ask for as residents in training. I did not ask the ACGME to restrict my access to patients; I never will. I am concerned that the increased regulations, beyond the previous 80 hour week and 4 days off in 4 weeks, will further hinder my ability to care for patients. Restricting an intern's hours to 16 in a row effectively banishes the surgery intern to a year of rotating night float and odd shift hours. He or she will see a decrease in the number of opportunities to begin sharpening their operative skills early in their training. Overnight call is an essential part of training. Making decisions on your own, organizing your time, and prioritizing your efforts are all skills that are honed by the intern on call, watching over his or her ward for an entire day. Any graduate of an approved medical school here in the United States should be capable of such a feat and allowed that opportunity. By taking away the ability of programs to average calls so that they may not exceed 1 in 3, the ACGME has wrecked many carefully thought-out schedules, crafted over the last few years by exasperated program directors in an effort to conform to the whims of the ACGME.

The ACGME is making these rules purportedly in an effort to protect both residents and patients. Well, I have never asked for their protection and certainly do not seek it now. I am however asking them to protect my patients: Protect them from a world of shift-workers, clock-punchers, physician extenders, and cross-covers. Allow them to be under the care of a dedicated physician, unencumbered by rules and regulations. Allow them to be cared for by a professional who has dedicated their mind, body, and soul to this wonderful calling, as that professional sees fit.

Name: Michael Egger  
Organization: University of Louisville  
Affiliation: individual

I think PGY-1 duty period length should remain as it is. Interns are usually supervised during their shift by a senior resident anyway and are less likely to make detrimental decisions to impact patient safety. Plus, they need these shifts to prepare them for long shifts as a senior resident and for adequate learning.

Name: Adrienne Zavala  
Organization: WVU Rural Family Medicine  
Affiliation: individual

I think first yr residents need more than 16 hr as this is there learning periods

Name: zoovia aman  
Organization:  
Affiliation:  

I'm strongly against this 16 hour guideline. I feel that 24 hours is an appropriate standard, but 16 is just excessive. Although I'd love to make overnight call history, this just isn't practical. It means that the PGY2-4s will be working more and sleeping less. Our interns won't be able to contribute their fair share of the work load with 16 hours, and the rest of the residents will be burdened with it. Isn't the PGY2 working twice as many 24 shifts to compensate for the PGY1’s restrictions more dangerous to patients? I want to help interns as much as possible (I am one currently) but not if it means punishing the other residents.

Name: Christopher Sorensen  
Organization: MIHS - psychiatry residency  
Affiliation: individual

24 hour shifts are what many attendings do so it is good to keep this here.

Name: Dan  
Organization: CMMC
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<td>I think restricting residents to less than 24 hours of continuous duty is disruptive to their development as practicing physicians, unproven in the matter of improving patient care outcomes and will significantly reduce their experience during an already strained schedule of training. As a program director of more than 20 years I agree with limits on continuous duty and have found the current limits to be mostly adequate though our residents usually come off duty around 28 hours maximum.</td>
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<td>Finding a reasonable way to get call experience for a PGY-1 within the curriculum schedule for core first year rotations will significantly reduce hours spent in training on a weekly schedule (routine work hours are when training experiences happen for these rotations and that is when the preceptors are rounding and doing procedures). Allowing an at least 24 hour duty session for PGY-1's will only require them to miss rotation during the post call period but even that restriction will result in significantly less hours-with-preceptor each month when compared to the current 30 hour limit.</td>
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<td>I feel certain that patient care competencies will suffer from this restriction and little if any improvement in care will be documented. In the long run within a 3 year FM residency we will be graduating less experienced physicians who will be less prepared to give quality care (and probably won't want to work as hard as you have to in order to be a good doctor).</td>
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<tr>
<td>Name: Marion Sims MD</td>
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<td>Organization: St. Vincent's East FM Residency</td>
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<td>Name: Stephen Hulker</td>
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<td>Organization: MAHEC</td>
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<td>Name: Kaoru Miyazaki</td>
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<td>Organization:</td>
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<td>Name: Funda Sonuparlak</td>
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<td>Organization: Maricopa County</td>
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<th>Name: Marion Sims MD</th>
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<tr>
<td>Though fatigue may increase at 16 hours, patient care will be jeopardized to a greater extent by the increased number of hand-offs and discontinuity of care under the new guidelines.</td>
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<th>Name: Stephen Hulker</th>
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<tr>
<td>Further shortening maximum duty hours for Interns will increase the risk of miscommunication between caregivers as more hand-offs will be required. It also seems to unfairly shift a greater amount of work to upper level residents. I do not agree with this proposal. More appropriate would be to build mandatory nap hours into every overnight call for residents.</td>
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<th>Name: Kaoru Miyazaki</th>
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<td>I don’t understand the increase in duty hours from 1st to 2nd year of residency. If the intention is to reduce fatigue related errors, wouldn’t senior residents need at least as much rest. Maybe more if they have the additional responsibility of supervising PGY1’s?</td>
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<td>I recently graduated from a pediatric residency and feel these new requirements in general will jeopardize patient care and education of residents by creating too many hand-offs and decreasing continuity of care.</td>
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<tr>
<td>The graduated duty hours requirements for interns and then longer for senior residents do not make much sense. If anything, the less time one has been in residency, the less sleep deprived they will be.</td>
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<td>Creating an effective maximum time on duty of 28 hours (24 on-call plus four to finish up) will not positively impact sleep and safety for residents and instead will only make it more difficult to educate residents during the crucial post-call day. You will also end up with more hand-offs possibly even before attending rounds on some patients.</td>
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## Comments not in Support

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Timothy J. Warren, MD</td>
<td>Private Physician</td>
<td>individual</td>
</tr>
<tr>
<td><strong>I am a R1 and I honestly believe that 24h of work is not too much for me. Exceeding 24h is a different story, but 24h itself is a perfect amount of time to learn efficiency and thoroughness in patient care. If we were to switch to 16h days, there would be many more sign outs and more information lost between sign outs--not great for patient care.</strong></td>
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<tr>
<td>May Shung</td>
<td>UCLA obgyn</td>
<td>individual</td>
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<td><strong>This is the area that I have the most problems with. As a matter of background I completed med school in 1989 and residency in Family Medicine in 1992. I have been a program director since 2004. In my first year of residency I was on call every third night for 4 months straight, Weekends off consisted of call on Friday night and then leaving after rounds about 11 am, 36 hour call shifts were the norm. I fell asleep on several occasions at traffic lights on the way home. With my manual transmission car I had a couple of occasions where I would slip into the car behind me. Thankfully I never had a serious accident. The hours at that time were dangerous! This is the other extreme. Now the hours are dangerous because first year residents particularly in short three year residencies will not learn how to work with a little duress. This is required and needs to be done with appropriate supervision. You cannot have this happen for the first time as an attending or when you are the supervising resident. You need to have this happen when you are supervised. It is dangerous for patient care and does not allow residencies to model the experiences which are necessary to have safe transitions from residency to attending. The present hours are good. No need to change!</strong></td>
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<td>Thomas H Miller</td>
<td>SIU Quincy Family Medicine</td>
<td>individual</td>
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<tr>
<td><strong>I do not support these changes. Errors in medicine are not only made secondary to fatigue, but also from &quot;hand off&quot; errors. 16 hours will increase the number or &quot;hand offs&quot;, &quot;checking out&quot; errors. Instead of limiting hours, can we not limit the number of admissions or duties that are time consuming (versus on call coverage calls) in a 24 hour period? Education will also be compromised. More exposure, more education and learning.</strong></td>
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<tr>
<td>Catherine Varney, PGY-1</td>
<td>McKay Dee Family Medicine Residency</td>
<td>individual</td>
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<tr>
<td><strong>I strongly oppose this proposed change in maximum duty period length, and question the data on which this change is based. A 16-hour shift is an inconvenient length of time, which will force many programs to assign 12-hour shifts instead. Due to the increased number of shifts, residents will be required to work at least one weekend shift every weekend, rendering the &quot;golden weekend&quot; a thing of the past. I don't think one can overstate the importance of golden weekends on the emotional and psychologic well-being of residents. It is infinitely more valuable than the inconsequential 8 hours per shift residents would gain from this change.</strong></td>
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<tr>
<td>Brianne Romeroso</td>
<td>UCLA</td>
<td>individual</td>
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<tr>
<td><strong>I believe that our UCLA OB/GYN residents and interns benefit from a full 24 hour call as it permits for management of laboring patients in a longitudinal manner such that we are able to have time to follow through/obtain results from our management practices. Shortening the call interval would be at a detriment as it limits our management options and ability to carry through with caring for patients.</strong></td>
<td></td>
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</tbody>
</table>
### Maximum Duty Period Length

#### Comments not in Support

**Name:** Susan Park  
**Organization:** UCLA OB/GYN  
**Affiliation:** individual

As a PGY1 in a program that has 24 hour call, I believe that limiting duty periods for PGY1 to 16 hours will severely interfere with interns participating in continuity of care. It will also decrease the flexibility that is built into the way we currently schedule our calls. We will no longer be able to offer full weekends off as well as extended 3 day weekends and holidays as we do by having some residents work 24 hour shifts.

**Name:** Kristen Whitaker  
**Organization:** UCLA  
**Affiliation:** individual

The proposed PGY1 resident work hour restrictions will result in potentially less time in the FMC and on other rotations, and a resulting less clinical experience for the PGY residents. That will potentially delay their ability to supervise the next year's PGY 1 residents. Increasing their hour limits after 6 months may allow for a more orderly transition to PGY2 work hour rules. I am concerned that these work hour rules will communicate to the resident that medicine is a shift-based model of care; that will have a deleterious impact on the quality of care and patient safety because of the lack of follow-up of patients through their clinical course and frequent handoffs in care.

**Name:** David Wakulchik MD  
**Organization:** Aultman Hospital  
**Affiliation:** individual

- This forces us to have PGY 1 night float coverage, without exception. The number of residents required to provide patient care in such a system is greater than current.

- The "strong suggestion" of strategic napping essentially means that intermediate level residents CANNOT work 24 hours. This really forces the night float model to be used for all PG levels.

- "Strategic napping" is meaningless without someone available to provide the patient care that the napping person would have provided. This requires more residents.

- The current transition time is 6 hours after a 24 hour on-call. By decreasing the transition time from 6 hours to 4 hours, they've made it almost impossible to have residents take overnight call and stay for conferences or rounds.

- The prohibition on continuity clinic after 24 hours on call mainly impacts Family Medicine residents, which were allowed to have continuity clinic in the morning after 24 hour call. The requirement for continuity of patient care is almost impossible to meet if residents have 24 hour call and can’t go to clinic after call.

- These continuous duty hour limits, while well-intended and defensible, will have significant unintended consequences:
  1) In order to have residents available to work at night, fewer residents can be assigned to daytime clinical rotations. Many educational components of residency take place during the day (attending rounds, didactic conferences, clinical conferences, Grand Rounds, etc) and will be missed by residents assigned to night duty.
  2) The need for residents to be assigned to night float-type duties will decrease available time for residents to do electives and research.
  3) Night float duty is heavily clinical and oriented toward service, with fewer opportunities for education. GME prioritizes education over service.
  4) Limiting duty hours will necessitate a greater number of transfers of patient care. Inpatients are generally very acutely ill and often unstable. Transfer of patient information from one physician to another is a vulnerable process. Changing the system to increase the number of care transfers could have a negative impact on quality of care and patient safety.
## Maximum Duty Period Length

### Comments not in Support

5) the profession of medicine requires an idealistic commitment to the care of patients. It sends the wrong message to upcoming physicians that the number of hours they continuously work is more important that the patients they care for.

**Name:** Marie Trontell, MD  
**Organization:** UMDNJ-RWJMS  
**Affiliation:** individual

I strongly disagree with the 16-hour rule for first year residents.  
1) If we are allowing any residents to work 24-hour shifts, residents should learn to function for a 24-hour shift during 1st year, when they have the supervision outlined in the supervision section. Otherwise, the residents will have only worked 16-hour shifts, then will enter second year and may be doing their first 24 hour shift without the backup that would be provided by direct supervision.  
2) 16 hour duty periods is not really call. It is shift work, It will create very challenging schedules for our and other residency programs, including an increased number of handoffs, and will foster a shift-worker mentality in first year residents.

**Name:** Alison Samitt  
**Organization:** Maine Medical Center Family Medicine Residency  
**Affiliation:** individual

Resident Duty Hours

The new duty hour limitations will prove especially problematic, particularly the 16 hour shift limitation for PGY1 residents. (An alternative might be to increase the hour limit after 6 months rather than one year.) We think small programs (6 or fewer PGY1 positions) and single-residency institutions will have difficulty complying with the new rules. This might result in the closure of a significant number smaller programs, reducing the number of family physicians we train each year.

The ACGME and the RCFM have steadily increased the requirements for the educational component of residency training, while at the same time reducing the number of hours in which to deliver this education. Something has to give. We feel the new duty hour rules will result in less time in the family medicine center (FMC) or less time on the clinical rotations – or both. If the time comes out of the FMC, it will be difficult to achieve the mandated number of patient visits, especially in the PGY1 year. If the time comes out of the rotations, residents will not be as well prepared in the content areas of the rotations as they are now.

The new rules also exacerbate the shift mentality our directors have been observing in the last few years. Residents don’t readily take ownership of their patients – they just work their shifts – similar to the Emergency Medicine model. We believe the new rules will decrease continuity of care, increase the problems generated by frequent hand-offs, and have an over-all negative effect on the quality of our patient care, rather than improve care and patient safety, the outcome which we all really seek. It is, we believe, the antithesis of the patient-centered medical home model. It has been said that if you have more than one doctor, you don’t have a doctor. Under the new rules, we’re afraid many of our patients won’t have a doctor.

**Name:** Anthony J. Costa, MD  
**Organization:** NEOUCOM  
**Affiliation:**

As an administrative chief resident who makes the call schedule and is very familiar with the working hours of residents, I feel limiting intern shifts to 16 hrs will be detrimental to their professional AND personal well-being. Call shifts are the time when a lot of acute learning occurs. We evaluate patients in the emergency room, do emergent surgeries, and in general get to learn how to manage a patient from admission through her hospital course. On Labor & Delivery in particular, the joys of Obstetrics are truly felt when you admit a patient, follow her throughout the course of her labor, and help her deliver her baby. By only working 16 hrs shifts, a lot of that continuity would be lost. Our relationships with our patients would be adversely affected, as the patients would be seeing new faces more often. Change of shift is also the time most errors are made, and in this system there would be more shift changes.
Maximum Duty Period Length

Comments not in Support

Interns would also be affected in their personal lives. We would not be increasing the number of interns in our programs, but would be limiting the length of their shifts. In effect this means most interns will have to work every weekend (b/c if they are only working 16 hr shifts, there would be more people working each weekend). What this means is there would never been a full weekend off. As interns and residents, we cherish our “golden weekends” (sat/sun off), as this is the only time we can truly be off (and not post call or precall).

Working 24 hr shifts are fine as we do them as members of the team. Everyone takes turns working (including the intern). Please do not make the mistake of changing the duty period length.

Name: Akta Patel
Organization: UCLA
Affiliation: individual

Evidence shows that fatigue increases after 16 hours but patient care may be more jeopardized by increased hand-offs of care that this standard would cause.

Name: Mike Coladonato, MD
Organization: MAHEC
Affiliation: organization

As a recent residency graduate, I can say from experience that the current duty hour restrictions are more than sufficient to protect resident wellness and alertness, and the further restrictions proposed would negatively impact the educational experiences available from a traditional in-house call. Further, such restrictions would increase the number of transitions in care and negatively impact patient continuity while engendering a shift-work mentality that opposes the values of primary care.

Name: Jessica Handel, D.O.
Organization: St. Elizabeth Health Center Family Medicine Residency
Affiliation: individual

The 16 hour time limit for intern call hours does not seem reasonable. The first and second years in our program would have so many more shifts during the year if this was made into "law". Our program does an excellent job at keeping track of our hours and making sure that we do not suffer from fatigue, however if the first years could only do 16 hour shifts they would have to work more frequently (and it would impact the second years at certain sites who have intern call) and they would seemingly never get a "golden weekend" which seemed necessary in the first year to help keep us rested and sane. Could this be an option? Maybe residents could opt out of this regulation?

Name: Erica Oberman
Organization: UCLA
Affiliation: individual

I disagree with the proposed 16 hr limit for R1’s. It will for one limit their schedule, where they will be on call almost every weekend now, instead of having "golden weekends" and a longer stretch of holidays off. Our residents are very upset about this, since they feel that 24 hr call is not that difficult and they also enjoy a social life outside of medicine. These rules are too restrictive. In addition, I feel that R1's need to know what it feels like to work 24 hrs in a row. They will likely do that if they go into private practice, and if they do not like the lifestyle, they have a chance to switch to another specialty (ie not OBGYN) early on. I don't think the 16 hr rule is fair to R1s.

Name: Cecilia Wieslander
Organization: UCLA
Affiliation: individual

I have serious concerns in regards to the 16 hr limit for shifts for PGY1. In the area of OB/Gyn I feel this will significantly curb the ability of PGY1's to have continuity with laboring patients. In the first year, our
## Maximum Duty Period Length

### Comments not in Support

Residents have significant support and resources to tackle fatigue at the workplace. All of our PGY1s are well supervised by more senior residents and attendings and are supported with the workload already. Having a 16 hr limit on shifts makes it very unlikely for PGY1s to accurately learn the proper management of labor as they may never see a patient admitted in active labor and see them deliver. Unless patient's arrive within the first 4-5 hrs of their shift, they will chronically be picking up patients in labor or delivering patients they did not admit.

Having a 16 hour limit also makes it virtually impossible for the PGY1s to have a complete weekend off, even with the help of senior residents filling in. Although I see the purpose is to avoid fatigue, however there are already resources in place and the availability of complete weekends off is both helpful in preventing fatigue as well as fostering positive mental health in a year which is notoriously very difficult.

I would encourage the ACGME to consider other alternatives, including scheduled, required napping within a 24 hour shift.

**Name:** Stephanie Evans  
**Organization:** UCLA Ob/Gyn Residency  
**Affiliation:** individual

It is blatantly inconceivable to believe that decreasing work hours will produce quality future physicians, unless the assertion is that those of us who worked without restriction were completely inefficient. Simply put, the residents' experiences during training do not equate to ours due to the limitation in hours alone. While I support fatigue management interventions (having performed during sleep-deprived status), I firmly believe that the length of residency programs will need to increase as work hours decrease.

The idea of a nap has come under much scrutiny. I am unaware of any data that support the idea that napping in the hospital is at all refreshing or restful. Quite the contrary, when tied to one's beeper, it matters not about where, when, or the amount of sleep prescribed, one does not achieve a period of rest because of a heightened sense of awareness, like sleep on a battlefield. Trainees should either be in the hospital working or simply leave altogether. A nap in the middle of one's shift requires an additional transition of care; this is in direct opposition to decrease the number of hand-offs and will undoubtedly result in inefficient patient care.

**Name:** Joshua Lenchus  
**Organization:** University of Miami  
**Affiliation:** individual

I disagree with the proposed 16 hr limit for R1’s. It will for one limit their schedule, where they will be on call almost every weekend now, instead of having “golden weekends” and longer stretch of holidays off. Our residents are very upset about this, since they feel that 24 hr call is not that difficult and they also enjoy a social life outside of medicine. These rules are too restrictive. In addition, I feel that R1's need to know what it feels like to work 24 hrs in a row. They will likely do that if they go into private practice, and if they do not like the lifestyle, they have a chance to switch to another specialty (ie not OB/GYN) early on. I don't think the 16 hr rule is fair to R1s.

**Name:** Cecilia Wieslander  
**Organization:** UCLA  
**Affiliation:** individual

The language of "residents" here vs. interns should be clarified. My original review of the document would allow 16hrs.+4 for interns, but another interpretation is that only 16hrs. are allowed (without time for transition, change over, etc.). While PL-1 interns should have more supervision and other considerations vs. more advanced residents, it is not clear (or evidence-based) why PL-1 interns should not be allowed to have a +4 hour transition period.

This period (4hr. transition) is important for patient safety, education, and other opportunities. This proposal will effectively promote night float, night shifts and asynchronous schedules which have literature.
Maximum Duty Period Length

Comments not in Support

Name: Jerry Rushton
Organization: Indiana Univ. Pediatrics
Affiliation: individual

I am fully supportive of all of the other proposals, and the principles ACGME has forwarded. HOWEVER, the main overarching challenge is implementation date of July 2011- this should be the START of implementation, but it is unrealistic to mandate a full redesign of residency in <9months. ACGME should use this period to encourage programs to all begin implementation, with piloting on many services and reporting on results, outcomes and experiences in the first 12-24 months before full-scale implementation on every service.

Residency operates within complex systems, and the ACGME timeline will create a rushed approach where educational principles (and even potentially safety/quality) will be strained as systems already budgeted and planned for July 2011 cannot meet this deadline. While we all recognize the IOM report and public/regulatory interests and pressures, those same groups will not be satisfied with a rushed, poorly planned, and executed transition to what may be one of the biggest changes to GME in decades.

The ACGME was late to provide programs with the necessary details and was delayed from the ACGME original timeline. September vs. Spring and < 9mos. vs. > 15 mos. makes a huge difference.

The limitation of PL-1 interns to <16hrs. should be viewed in proper context: this is an EFFECTIVE 25% REDUCTION IN AVAILABLE FTE for the ENTIRE RESIDENCY PROGRAM. In order to work within this schedule and redesign, it is not as simple as having faculty and others step in. Most of us support the overall efforts; however based on current literature, pilot examples, and other information, this shortened timeline will likely limit effective results and outcomes for the first several years. The competency Outcomes ACGME project was implemented over several years, and there should be strong consideration for a phased implementation, or transition period with more reporting to understand the effects, since the literature on duty hours is so limited and mixed. This is a major distinction from wanting to delay implementation, or not respond to IOM and other regulatory organizations. I hope that ACGME will reconsider the timeline and weigh this with the many significant potential unintended effects that the timeline will needlessly create.

Name: Jerry Rushton
Organization: Indiana Univ. Pediatrics
Affiliation: individual

The 16 hour limit is a mistake. These residents are no longer students. they are physician residents. What they need is experience, not more time to read; go to lectures; etc., What they need is to see and manage patients. By implementing this 16 hour limit, the ACGME is enhancing the service obligation, as well. On a resident team, there is going to be one person to take call; one to take care of patients during the day; and another who will be gone because he/she is post call. This is also going to result in residents who will have poor preparation to lead a team as a senior resident. There will be very little left of the team. Thus, they will leave residency poorly prepared to be team leaders as attending staff.

Name: Greg Thompson
Organization: Gundersen Lutheran
Affiliation: individual

I am currently a PGY-2 Psychiatry resident and would like to comment on the proposed changes to the resident duty hours for first year residents. I do not believe this is a good idea, and I feel this will only hurt the resident’s ability to have continuity of care with their patients. Obviously there has to be coverage 24/7, and at our program we already have a night float system, but this proposal will ultimately increase the amount of night float shifts a resident will need to work. I also believe I learned a lot more from those 30 hour calls that I worked as a first year; allowing me to learn how to manage my time more efficiently, spending longer with the patients I saw and not rushing through an encounter, and having a great amount of
Maximum Duty Period Length

**Comments not in Support**

time allotted for teaching medical students. Would there be more money available to residency programs to hire more residents to assist in covering the times that were previously covered by the first years? Also this will enforce the second year residents to be forced to work more calls and decrease the time spent in specific rotations designed for second years (such as C/L Psychiatry, Geriatric Psychiatry, and Adolescent Psychiatry at our program). Also I believe this will actually prevent residents from being prepared for practicing after residency under stress and fatigue, which is often the case after residency is over. It also increases the potential for other patient-error events, considering the rest of the residents will be picking up more hours and getting less sleep and still continuing on with their upper level duties, not to mention the fact that the hospitals are already understaffed. Overall, I believe the proposed changes will negatively effect the residency experience for not just upper levels, but also the first years, as they will not be able to develop as physicians the way previous physicians were able to.

Name: ZK, MD  
Organization: PGY-2  
Affiliation: individual

The language of "residents" here vs. interns should be clarified. My original review of the document would allow 16hrs.+4 for interns, but another interpretation is that only 16hrs. are allowed (without time for transition, change over, etc.). While PL-1 interns should have more supervision and other considerations vs. more advanced residents, it is not clear (or evidence-based) why PL-1 interns should not be allowed to have a +4 hour transition period.

This period (4hr. transition) is important for patient safety, education, and other opportunities. This proposal will effectively promote night float, night shifts and asynchronous schedules which have literature demonstrating negative impact on educational opportunities, sleep/fatigue, etc.

Name: Jerry Rushton  
Organization: Indiana Univ. Pediatrics  
Affiliation: individual

I hope and pray the new ACGME proposal does not pass because it will completely transform the residency program that I belong to. When looking into programs last year, I chose this program for many reasons, one being the way the PGY1 through PGY4 curriculums were setup, including its work hours. If I knew ACGME was going to transform this residency for the worse, I would have not even applied to this program. (yes, I realize it will affect all residency programs, but each program will deal w/the changes in a different way.) I was looking forward to my PGY2 year next year and the different specialties of interest that I would have been able to experience, and having a well rounded training so I can better decide if one of those specialties are for me. With this new change, I will be spending more time picking up calls, that the PGY1s used to work, instead of getting a well-rounded training that I deserve and so desired. I understand that safety is the main reason for changing the hours of PGY1’s but I think safety will still be an issue due to the lack of continuity of care and the decline of preparation for the real world where ACGME rules do not apply. Outside of a residency, I will still need to make important decisions w/little sleep and a lot of stress. With the cut in hours, these difficulties will be new to me and there will be no attending looking over my shoulder then. Also, my program is already under-staffed; will you be adding new residency spots to all programs? I can’t imagine the stressful conditions of next year with the same number of residents having to do more shifts because of the new rules. I also feel that the several overnight calls I’ve already had this year have been beneficial to my learning so far. I can’t imagine not having this priceless experience as an intern. I guess, I will get my fair share of intern year though considering next year will be even more stressful with this new ACGME rules and it’s ill effects on my program. I think ACGME should pass the rule that an attending should be in house for call to increase safety. However, I believe there should be a grace period in the institution of this ACGME law for changing intern hours if it does pass, because otherwise the program I belong to is going to completely change for the worst.

Name: Dr. Aisha H.  
Organization: PGY1 resident  
Affiliation: individual
Maximum Duty Period Length

Comments not in Support

I hope and pray the new ACGME proposal does not pass because it will completely transform the residency program that I belong to. When looking into programs last year, I chose this program for many reasons, one being the way the PGY1 through PGY4 curriculums were setup, including its work hours. If I knew ACGME was going to transform this residency for the worse, I would have not even applied to this program. (yes, I realize it will affect all residency programs, but each program will deal w/the changes in a different way.) I was looking forward to my PGY2 year next year and the different specialties of interest that I would have been able to experience, and having a well rounded training so I can better decide if one of those specialties are for me. With this new change, I will be spending more time picking up calls, that the PGY1s used to work, instead of getting a well-rounded training that I deserve and so desired. I understand that safety is the main reason for changing the hours of PGY1’s but I think safety will still be an issue due to the lack of continuity of care and the decline of preparation for the real world where ACGME rules do not apply. Outside of a residency, I will still need to make important decisions w/little sleep and a lot of stress. With the cut in hours, these difficulties will be new to me and there will be no attending looking over my shoulder then. Also, my program is already under-staffed; will you be adding new residency spots to all programs? I can’t imagine the stressful conditions of next year with the same number of residents having to do more shifts because of the new rules. I also feel that the several overnight calls I’ve already had this year have been beneficial to my learning so far. I can’t imagine not having this priceless experience as an intern. I guess, I will get my fair share of intern year though considering next year will be even more stressful with this new ACGME rules and it’s ill effects on my program. I think ACGME should pass the rule that an attending should be in house for call to increase safety. However, I believe there should be a grace period in the institution of this ACGME law for changing intern hours if it does pass, because otherwise the program I belong to is going to completely change for the worst.

Name: Unanimous Dr's
Organization: GME
Affiliation: organization

Evidence shows that fatigue increases after 16 hours but patient care may be more jeopardized by increased hand-offs of care that this standard would cause.

Name: Daniel Frayne, MD
Organization: MAHEC
Affiliation: individual

I am concerned that first-year housestaff will end up working duty periods with unusual hours with loss of opportunity to interact with peers and faculty at vital program activities such as conferences and seeing continuity patients. I am also concerned that night float will be used more with the attendant increase in transitions of care. Night float is unpopular with housestaff due to the isolation, decreased face-to-face teaching, and disruption of circadian rhythm with multiple nights worked consecutively.

Name: Susan Vanderberg-Dent, MD
Organization: Rush University
Affiliation: individual

As a PGY-1 Neurosurgery Intern, I feel I would be especially affected by this standard. I don't believe that a 16 hour work limit will adequately prepare us for the graduated responsibilities of more senior resident. A huge part of the intern experience, in my opinion, is to get us acquainted with the workings of the hospital and get us physically ready for the more strenuous upcoming residency. I can't think of any validated, study-oriented rational that would support this proposed standard. While there are many things I agree with and some things I don't in these new proposed standards, this is the standard that I agree the absolute least with. I agree that residents should practice alertness management strategies and be self-aware, but I don't believe that there will be a negative effect on our cognitive and effective ability after 16 hours. Through undergraduate and graduate study, the majority of us have gone through many, many days of >16 hour work days. On a personal note, regardless of clinical work or not, I average 14-18 work days without, as far as I can assess, a negative effect on my life of my work.

Name: Walavan Sivakumar
### Maximum Duty Period Length

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<th>Comments not in Support</th>
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| **Organization:** University of Utah  
**Affiliation:** individual |
| I would strike the 24 hour provision. Really the idea of "strategic napping" is bordering on farcical. The best course of action would be a 16 hour shift offset from their PGY-1 to provide coverage without fatiguing your PGY-2’s and beyond. |
| **Name:** Karl Hurst-Wicker  
**Organization:** Marshfield Clinic  
**Affiliation:** individual |
| Duty hour restrictions have completely changed the face of residency. The benefits of shortened duty hours with respect to the mental and physical well being of house-staff, as well as their ability to properly conduct the activities of daily patient care, is without question. However, the unintended consequences of these and any further restrictions have yet to be seen. A feared consequence of the limited work-week is the poor translation to real clinical practice. Surgeons trained in this environment may not have the dexterity to weather a particularly difficult call schedule that they may incur as a practicing physician.  
For instance, due to duty hour constraints a resident is often not be able to reap the benefits of an ill-timed diagnosis, protracted workup, or extensive pre-operative resuscitation. A “hand off” may be required before the definitive operative treatment has been performed, an option that might not be feasible or available outside the confines of surgical training.  
More apropos to residency training is the total hours that are available for individuals to hone the necessary skill set to become an independent physician. The current 80 hour cap significantly limits the overall clinical and operative experience over the course of a 5 year program. This reduction is to hopefully be ameliorated by more efficient training, by the use of adjuncts such as surgical simulation and direct outcome measures that have already been instituted. However, with further encroachment, it is doubtful that any of these measures can ensure the superior level of training that is expected of graduating surgical residents in the United States.  
The current proposition to limit call for interns is based on data demonstrating that a significant number of adverse events can be prevented by ensuring that interns are well rested. From the perspective of our program, these findings demonstrate the end result of a fundamental system error, not an individual’s transient fallacy. At our institution, junior level residents are heavily supervised; all decisions regarding patient care are reviewed in a timely manner by more senior residents. While junior residents are encouraged to engage in progressively more independent thought and decision making, there is always oversight and supervision reflecting their level of training.  
Our intent with this letter is to emphasize what most programs already engage in to curtail preventable medical errors. Unfortunately, no system can preclude the types of adverse events that have brought about the call for further duty hour restrictions. However, we feel that the source of such events cannot be left to the discretion of an inexperienced junior resident, irrespective of how well he or she may have slept the night prior to taking call. |
| **Name:** Jack Rostas  
**Organization:** University of South Alabama General Surgery Residents  
**Affiliation:** organization |
| The 16 hour limit for PGY1 will make it impossible for PGY1’s to attend didactic sessions, clinic, or rotations when on a night-float system (which appears to be the only way to implement the 16 hour rule). I have a few concerns with this: 1) For Family Medicine, how will I ensure adequate FMC numbers - I’ll have to schedule more FMC hours, taking away from rotation time, 2) The quality of medical students, whether US trained or not, is decreasing. Their sense of accountability and dedication to their patients and profession is notably declining over the past several years. This 16 hour limit will further that atmosphere, 3) I certainly hope that all States that allow a physician to be licensed after one year of training will change their requirements to be two years of postgraduate training. I don't see how any physician would be remotely competent after one... |
Maximum Duty Period Length

Comments not in Support

year of training with these new rules.

Name: Brenda Fann, MD
Organization: Rush-Copley Family Medicine Residency
Affiliation: individual

First, we commend the ACGME on the systematic, thoughtful, multidisciplinary approach taken to identify both the data and the issues relevant to current and proposed work hour regulations. We share the goal of balancing a professional commitment to patient well-being and intensity of clinical exposure while assuring adequate rest and personal reserves to ensure patient safety and attain educational benefit from patient encounters. We are pleased that issues of patient hand-offs, supervision, and graduated level of responsibility are included in the latest regulations. We also applaud the efforts of the task force to recognize that upper level trainees such as fellows must begin to transition to the level of self-regulation and self-monitoring expected of faculty members. Likewise, the recognition that there can be exceptions to strict limits on lengths of shifts in circumstances that demand continuity for an individual patient, family, or educational opportunity as long as such exceptions are rare and monitored by the program is an important addition that we support.

We wish to raise a few additional points.
1. The guidelines state that “…residents must prepare to care for patients over irregular or extended periods in certain specialties…” This reflects the very nature of critical care medicine, where patient needs may demand that providers work longer hours than are typical of other specialties. This comment is placed in the document in the context of the provision mandating at least 8 hours off between duty shifts, but we assert that similar flexibility must be afforded in maximal length of shifts and frequency of days off. We believe that programs must have the flexibility to permit shifts of 24 hours plus 6 for transition (the current standard) and to permit averaging for in-hospital, on-call frequency. Allowing averaging of on-call frequency for these more advanced trainees more closely mimics the flexibility of faculty scheduling to which they will soon be transitioning, and enables either more concentrated academic time for scholarly pursuits or greater continuity of care on daytime service for patients, while still minimizing overly demanding schedules.
2. The best intensivists must be able to anticipate the trajectory of illness; this is only feasible if one has seen the longitudinal progression of disease in real time. The ability to consider and incorporate previous experiences into clinical practice (the essence of Practice-Based Learning) is an additional justification for the flexibility as requested above. Moreover, we assert that strict and artificial truncations of time subvert these educational goals.
3. Learners must take accountability for their own education, and learn the skills of deliberative practice wherein one reviews and reflects upon one’s actions. This is best done by permitting trainees to take part in the discussions of the consequences of their actions. These discussions take place during rounds, an additional rationale to permit the flexibility described above for the specialty of pediatric critical care medicine.
4. Minimizing and optimizing handoffs of care is essential to assure safe and effective patient care in the pediatric intensive care unit. We enthusiastically commend the ACGME for including discussion of the impact of work hour restrictions on patient hand-offs, and we strongly encourage the organization to maintain a leadership position on this issue.

In summary, as a specialty, we aim to train engaged and energetic physicians whose practice supports the primacy of patient care and patient safety and who are prepared for the demands of attending level practice. We support continued examination of work hour guidelines so as to provide an environment fostering professional commitment to patient well-being and safety, robust clinical exposure, adequate rest to promote personal care of providers, and a culture of thoughtful reflective practice.

The signatures below represent 51 of the 62 accredited programs in pediatric critical care medicine.

Name: Denise M. Goodman, MD, MS
Organization: Fellowship Program Directors in Pediatric Critical Care Medicine
Affiliation:
Maximum Duty Period Length

Comments not in Support

Duty hour restrictions have completely changed the face of residency. The benefits of shortened duty hours with respect to the mental and physical well being of house-staff, as well as their ability to properly conduct the activities of daily patient care, is without question. However, the unintended consequences of these and any further restrictions have yet to be seen. A feared consequence of the limited work-week is the poor translation to real clinical practice. Surgeons trained in this environment may not have the dexterity to weather a particularly difficult call schedule that they may incur as a practicing physician.

For instance, due to duty hour constraints a resident is often not be able to reap the benefits of an ill-timed diagnosis, protracted workup, or extensive pre-operative resuscitation. A “hand off” may be required before the definitive operative treatment has been performed, an option that might not be feasible or available outside the confines of surgical training.

More apropos to residency training is the total hours that are available for individuals to hone the necessary skill set to become an independent physician. The current 80 hour cap significantly limits the overall clinical and operative experience over the course of a 5 year program. This reduction is to hopefully be ameliorated by more efficient training, by the use of adjuncts such as surgical simulation and direct outcome measures that have already been instituted. However, with further encroachment, it is doubtful that any of these measures can ensure the superior level of training that is expected of graduating surgical residents in the United States.

The current proposition to limit call for interns is based on data demonstrating that a significant number of adverse events can be prevented by ensuring that interns are well rested. From the perspective of our program, these findings demonstrate the end result of a fundamental system error, not an individual’s transient fallacy. At our institution, junior level residents are heavily supervised; all decisions regarding patient care are reviewed in a timely manner by more senior residents. While junior residents are encouraged to engage in progressively more independent thought and decision making, there is always oversight and supervision reflecting their level of training.

Our intent with this letter is to emphasize what most programs already engage in to curtail preventable medical errors. Unfortunately, no system can preclude the types of adverse events that have brought about the call for further duty hour restrictions. However, we feel that the source of such events cannot be left to the discretion of an inexperienced junior resident, irrespective of how well he or she may have slept the night prior to taking call.

Name: Jack Rostas
Organization: University of South Alabama General Surgery Residents
Affiliation: organization

- Duty periods of first year (PGY 1) residents must not exceed 16 hours in duration (VI.G.4.a))
  o Response – this will prevent PGY-1 residents from taking what is now participating in what is now considered “in-house call”, and will force implementation of shifts. The float team will be subjected to a new set of stresses due to regular inversions of the work day. Night float has its own inherent problems. Switching from an AM to PM day to a PM to AM day results in disruption of circadian rhythm and is associated with impaired performance until one is acclimatized. Does ACGME have any plans to help accommodate issues surrounding issues associated with the “float shift” concept?
- Intermediate-level and senior residents (PGY 2 and above) may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents, as professionals, to use alertness management strategies to maintain alertness in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and during the hours between 10PM and 8AM, is strongly suggested (VI.G.4.b))
  o Response - The concept of strategic napping during the hours of 10PM-8AM rest period may be difficult in the absence of a night float. This will create additional manpower demands and introduces the previously noted problems that may be inherent in the float shift concept.
- In unusual circumstances, residents may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extension of duty are limited to reasons of required
### Maximum Duty Period Length

#### Comments not in Support

Continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must: a) appropriately hand over the care of all other patients to the team responsible for their continuing care; b) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director must both review each submission of additional service, and track both individual resident and program wide episodes of additional duty (VI.G.4.b).(3))

- **Response** – The nature of appropriate educational experiences remains somewhat vague. Would this include or exclude conferences?

<table>
<thead>
<tr>
<th>Name: Bradley Marple MD</th>
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<tr>
<td>Organization: Otolaryngology RRC</td>
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Having blanket statements on "time limits" one is to work is not a sound and practical rule. For many institutions, limiting the intern shift to 16 hours will not work, or will cause so many patient care transitions of care that patient safety will be compromised even more.

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Having interns have less time in the hospital will force night floats onto all programs in the country, decrease the number of physicians at night and decrease educational opportunities. Also for smaller programs this may force more senior residents to work longer and take more call and take away focus on education and running the services and being prepared for more complex surgeries. This will also actually increase the number of handoffs of care, have more patients taken care of by less physicians. Also, this may also impact ICU staffing and preclude interns from taking ICU call or fully participating in rounding, etc the next morning, thus losing the opportunity for feedback.

Just as with sports the more patient interactions, surgeries, ability to round with senior residents have an immeasurable learning opportunity that would otherwise be lost.

As a resident who started medical school rotations w/o 80h workweek and saw the steps taken by programs to manage this with the current standards, I do not feel the need to fix or change a system that is not broken and more importantly, we have not had the time to measure the impact of the changes that were just made a few years ago on training. How can we change the system without data supporting the need for changes, not creating a system to measure the impacts of these changes, and finally assuming that all health care systems will be able to with less than a year of preparation absorb the impact of these changes.

It is also troubling that focus is placed on interns who in surgery usually have the least amount of direct responsibility for patient care. The loss of the work force would further shift work up the ladder as it already has and further create an unattainable learning curve as an intern progresses through residency.

Although I applaud the desire to create better working environments, there are far more things that the ACGME can do for residents in terms of reimbursement, lobbying for loan deferments regardless of income with interest forgiveness, making sure that hospital provides benefits to make the time spent in the hospital more productive.

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<tr>
<th>Name: Kelly Olino</th>
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<td>Affiliation: individual</td>
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I'm a PGY1 doing q4 overnight call on wards and I can't express how important this is to my training. When we are interns we are expected to be inexperienced and have ample backup support, senior residents and attendings. When we are PGY2s we are often the senior resident. I feel it would be terribly stressful and unsafe for patients if my first overnight calls or night shifts were during my PGY2. This early cross cover and night shift is essential to our training. I would even go so far as to say medical students should get ample exposure, as I did at Georgetown SOM. The ACGME hour restrictions are helpful but if we go so far as to prevent ample experience during each year of residency, we will have to prolong residencies, which would be terrible for patients, physicians and community alike. We have a physician shortage, especially PCPs, we can't afford to prolong residencies at this time.
### Maximum Duty Period Length

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<th>Comments not in Support</th>
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| **Name:** | **Organization:** Sparrow Pediatrics  
**Affiliation:** individual |
| The 16 hour restriction will have a major impact on smaller programs, such as mine. 2nd and 3rd year residents are going to be required to do more work to take up the slack from interns not being available. This will cause an even greater risk to patient safety because now the senior resident will have to do all of the admissions and will be tied up doing an admission that may be in the ER and an existing patient on the floor may require immediate attention or worse may code and the senior resident is not available because they are having to do the interns job. |
| I strongly disagree with the 16 hour rule. |
| **Name:** Laura White  
**Organization:** Marshall University Department of Internal Medicine  
**Affiliation:** individual |
| No continuity clinics after a night on call is an excellent change. In regards to the reduced PGY-1 work shift, I feel that that 16 hours is too short of a shift. The shifts should remain at 24 hours for all PGY levels. |

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Common Program Requirements VI.G.4.b.(1) With the 24 + 6 current rule changing to this 24 + 4 rule, the structure of many educational/didactic programs must change. Clinical discussions and didactics that historically occurred during the noon hour will disappear. Didactic instruction is required by the FMRC, but must now occur in a different time. Other time frames are more likely to disrupt a clinical rotation that provides hands-on patient care. Asynchronous didactics via the internet are an option, though the value of program identity, team function, faculty/resident communication and shared experience that occurs as residents and faculty gather over a meal/conference will be lost. Convenient opportunities for residency business meetings will also vanish.

Common Program Requirements VI.G.4.b.(2) In Family Medicine, and in compliance with FR RC VI.E.3.a), it has been commonplace for residents to attend to a continuity clinic session within the Family Medicine Center the morning after a 24 hour call ending at 7 a.m. The 24 + 6 rule allowed for this practice. The new proposals stipulate a 4 hour hand-off period option, and further state that “Residents must not attend continuity clinics after 24 hours of continuous in-house duty.” The FM RC already has a rule that a resident must be on a block rotation a minimum of 5 half-days per week (FM RC II.A.4.s). In a traditional 10 half-day week, there are only 5 half days left for other activities including on-call, in-patient and community-based experiences and sessions in the FMC. In our system, one 24 hour in-patient ‘on-call’ session will now negate 4 half-days; 2 that occur during the 24 hour on-call period, and 2 more that occur on the post-call day when the resident will be off-duty. This only leaves 6 half-days to accomplish the entirety of continuity clinic within the FMC and a block (e.g. inpatient or outpatient) rotation. The math simply will not work. Rotation experience or patient numbers in the FMC continuity experience will suffer as there are simply not enough half days to accomplish all of the requirements.
Maximum Duty Period Length

Comments not in Support

Name: Paul Callaway, MD  
Organization: [1201911142] University of Kansas (Wichita)/Wesley Program  
Affiliation: organization

I'm unsure how an intern is to learn required skills in the 16 hr day you propose. In addition if an intern has inadequate training in his/her first year the years following are likely to be the same. Further, I wander who is going to pick up the additional hours to be covered. I'm certain that the money/funding is not in place for additional residency positions. I suppose this means the upperlevel residents will have to pick up additional hours in an already extremely limited 80 hr work week. I feel that it can not be done with out completely eliminating overnight call. Which may not be a bad thing except for the continuity of patient care will likely suffer. Which is an excellent point, how is this suppose to better patient care? I see it hurting patient care because this will require multiple hand offs in a day. I sure the ACGME is composed of a panel of "experts" but I believe they are out of control (16hr shift and a nap). As a surgical resident I don't plan on being a resident my entire career but I think if the ACGME has their way surgical residency will have to be extended by years. This is a shame because it is already too long at 5-7yrs depending on the program. If these rules go into effect I would hope that the surgical community would choose to leave ACGME and establish their own recommendations. Don't think that I enjoy working long hours and staying up all night, because I don't, but is is a necessary evil during residency especially surgical residency. Part of learning surgery comes from being available and if you are "taking a nap" or working 16 hr shifts you are not available to be in the ICU or the OR. I have 5 yrs to learn everything I need to know about surgery. I need to be available when ever a learning opportunity presents itself.

Name: Chris Kitchen  
Organization: Marshall University  
Affiliation: individual

I think 16 hr duty hour limit for first year PGY1 residents is not enough. It should be atleast 20-24 hours, as they need to get exposed to extended duty hours, in order to be able to work these hours as a second year. I agree, after 24 hr on call in hospital, they should not be allowed to see new patients or do their continuity clinics. Also by making 16 hr rule, residents in smaller community hospital programs will have to have a night float system & they may have a lot of difficulty in providing coverage as well. as their are not enough residents to provide multiple night float services in multiple hospitals they are covering. Too many hand offs are going to create more confusion.

Name: saba faiz  
Organization:  
Affiliation: individual

Limiting intern shifts to 16 hours will result in a wider knowledge gap between PGY1s and PGY2s, and will limit interns to even fewer exposures to patient management. While I agree with limiting the number of extended duty periods for all residents, the elimination of them altogether for PGY1s is detrimental to their training. Part of medicine, as is pointed out in the recommendations, is patient care responsibility and taking ownership of an ill patient's need. By eliminating extended shifts for PGY1s, the risk of setting a precedent throughout the remainder of their professional career is real.

Elimination of extended shifts for PGY1s will only worsen the issue regarding patient safety, as the number of patient handoffs between trainees will inevitably increase.

There is great value in evaluating and treating a patient on initial presentation and then again multiple times over the course of the next 24 hours. This value is shared by both the patient and the medical trainee.

Name: Michael Curren  
Organization:  
Affiliation: individual

Despite the evidence shown in one study of pediatric ICU PGY-1 residents that shift lengths greater than 16
Maximum Duty Period Length

Comments not in Support

Hours increase the risk of error. I believe that limiting the PGY-1 shift length across all programs at this time is premature. This represents a broad generalization of a very specific set of individuals doing specific tasks to a much more diverse group of residents. Not only that, but the time and resources that will have to be poured into changing the current structure of residency call and coverage will be vast, only to find out that the effect is not as great as we had hoped. How frequently do we see landmark studies overturned as more knowledge is gained? Why change so much based on so little information? I agree that the evidence is compelling, but it tells us that we need more information about “real-world experience.” I am a product of duty hour restrictions, having started my residency in 2003. I can tell you honestly that I resented having to log my duty hours every day as this took precious time away from my family and from learning. I strongly feel that had my intern calls been limited to 16 hours I would have lost out on memorable learning experiences. I would have lost that close sense of teamwork with my resident as we were on call together each time, getting to know each others’ strengths and weaknesses. Staying up on call one night is not so traumatic in the mind of most interns; going out in practice and covering call for an entire weekend, or even a whole week is daunting. How do we prepare residents for that? This is not the time to change the PGY-1 maximum shift so drastically.

For the most part I completely agree with the remainder of the tenets.

Respectfully and sincerely,

Name: Justin Whitt
Organization: Ball Memorial FMR
Affiliation: individual

80 hours works well and the fatigue is never overwhelming. 60 hours is too drastic of a swing to the short time line. This change will casue poor patient care due to decreased continuity.

Name: Jay Koonce
Organization: MUSC radiology
Affiliation: individual

Comments on the proposed ACGME Requirements

The 16 hour rule for interns is problematic. Yes, they are the least experienced member of the team but this rule is designed to keep them inexperienced. Adequate supervision of the interns should be able to overcome potential mistakes made by a tired intern. Sixteen hours, instead of the more usual 24, potentially decreases the junior resident’s investment in care and certainly decreases continuity which results in more frequent hand-offs.

Another concern of only 16 hours is the question of whether interns will have enough time to learn. Medicine has exploded with data in the last decade and has become increasingly sophisticated. Most residents struggle to learn more and more data in less and less time (and programs struggle to teach more data with less time). Reducing direct patient care again will only exacerbate this problem as long as length of program remains the same. Many European countries have very limited weekly duty hours but their residents also remain in programs for many more years than do U.S. residents.

The 16 hour rule certainly does not reflect reality for many practicing physicians, particularly in rural settings. In fact, it doesn’t reflect the reality of what senior residents will be asked to do but now interns have not developed the skills necessary to care well for patients after 16 hours and provide teaching for younger colleagues and students. With this in mind, many programs will out of necessity find themselves shifting call usually completed by interns to the senior residents which in turn will be more burdensome for the seniors but potentially quite necessary to ensure adequate time and numbers of patients for optimum learning. Of course, smaller programs will be more adversely affected than larger programs.

The proposed ability for a resident to continue to provide care for a single patient beyond the duty hour limits is certainly welcomed by residents and faculty. However, the proposal that each of these events be written up and then reviewed by the program director is burdensome and unnecessary but does probably ensure
## Maximum Duty Period Length

### Comments not in Support

| Name: Judy A. Benson, MD  
Organization: Internal Medicine Residency Spokane  
Affiliation: organization |  
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Dear ACGME,  

The rationale for recommending this radical shift in PGY-1 duty hours is not clear to me. I'm concerned that in forcing programs to adopt a schedule based entirely on shift work will compromise both patient care by increasing the number of provider transitions and medical education by limiting PGY-1's exposure to various patient problems. Some of the most valuable learning during my intern year came on overnight calls, and I'm afraid of what would be lost if we eliminated those experiences.  

Sincerely,  
Gaelan  

| Name: Gaelan  
Organization: UPMC Medical Education Program (Resident)  
Affiliation: individual |  
--- |  
I am of the chief residents in internal medicine at the University of Pittsburgh Medical Center, and I disagree with the proposal to limit interns to 16 hours of duty. The transition from intern year to PGY-2 year is in many ways more difficult than the transition from medical student to intern, and implementing this change will further distinguish interns from residents and further contribute to the difficulty in becoming a PGY-2. Also, while a balance is important, there is a significant educational value in following a patient for 30 hours. Too many 30 hour calls is detrimental to education and training, but too few is also a detriment. In my residency, the patients and learning experiences that I continue to carry with me are those in which I worked overnight, had the opportunity to see the case evolve and respond to those changes, and then round with the attending in the morning to clarify what had been done well and what should have been done differently. I am grateful to the ACGME for limiting the work week to 80 hours, but I think that eliminating the 30 hour in-house call goes too far in an effort to protect residents' education and if implemented, will ultimately detract from it.  

| Name: Jennifer Corbelli MD  
Organization: University of Pittsburgh Medical Center  
Affiliation: individual |  
--- |  
At a meeting of PD's, general agreement that the new requirements were good and in the right direction with emphasis on flexibility.  
Some commented that about the 16 hours for PGY1's and were in disagreement as they were least involved with decision making and always under close supervision. Also, they are not any more or less prone to fatigue and that they could miss "teachable moments".  

The most relevant issue is SUPERVISION.  

The other issue about fatigue mentioned by a PD: "management of their time before, during and after clinical assignments:" ?? if they have a sleepless baby at home. Therefore very difficult to enforce.  

When a resident is too tired to go on, must take a nap. The logistics and implementation of this is very difficult.  

No more than 6 consecutive nights on night float: this is too any. Should be limited to a maximum of 5 and not more that 3 weeks in a row.  

DIO at our institution called a meeting of PD's and residents and fellows to be present at a talk by Dr. Steve Amis. Excellent presentation with lengthy discussion and PD/resident input and comments. Overall the
### Maximum Duty Period Length

#### Comments not in Support

reaction was very positive emphasizing supervision, flexibility and personal responsibility of individual residents to work within the proposed limits.

**Name:** Brian Cohen  
**Organization:** Albert Einstein College of Medicine and Montefiore Medical Center  
**Affiliation:** organization

I believe this decrease in hours will cause more transitions in care, which puts the patients at risk. The change will also decrease the amount of patients that interns follow from beginning to end of a hospital course, leading to less educational value.

**Name:**  
**Organization:**  
**Affiliation:** individual

I vigorously disagree with the no overnight shifts for interns rule for a number of reasons.  
1) It makes it impossible to schedule shifts. How does one schedule 16 hour shifts? Will we be asking an intern to come in at 2AM to relieve an intern that has hit his 16 our limit?  
2) It does not protect patients. If the logic is that interns are too tired to not make mistakes on a long shift, why allow residents (or attendings for that matter) to work longer shifts? Now residents will need to work even harder on overnights since they won't have an intern to help shoulder the burden. Moreover, residents will have never experienced overnight shifts as interns and will therefore be less prepared for them. This rule also creates difficulty in handoffs. If the intern is sent home at 2AM and the next intern comes in at 6AM, they won't be able to have face to face signout.

As a current intern, I applaud all the ACGME has done including the 80 hour work week. However, this recommendation will not improve patient care and hurt resident/interns' education. Please do not enforce this provision.

**Name:** Rory Makielski  
**Organization:** University of Pittsburgh  
**Affiliation:** individual

Only 25% or less of residents are covered by the new hour restrictions - if working >16 hours is unsafe, why are 75% of residents or more exempt? This is just political posturing really, and the senior residents will be forced to take on even MORE responsibility and extra call while exhausted since the interns will have to leave at the end of the day. This is a step in the wrong direction and a very flawed policy. Either 16 hours or less is necessary for safety or not. I'd rather see no changes than negative ones.

**Name:** Alyssa Thompson, MD  
**Organization:** UC Health  
**Affiliation:** individual

Depending upon how you want to look at it, the 16-hour limitation will have the effect of increasing either medical school to 5 years or the residency to one extra year. This rule also appears to make the assumption that all residency training is created the same -- which is simply not true. Surgery residency training, for example, takes longer. That's why programs are five years. From my perspective of 30 years of training residents, you'd simply have to lengthen the residency to 6 years and write off the PGY-1 as a SubI.

**Name:** Steve Dougherty  
**Organization:** Texas Tech  
**Affiliation:** individual

I believe restricting PGY-1s to a 16 hour call will be detrimental to their experience of training and especially continuity of care on a service. For our services this will end up being more time at the hospital for shorter periods of time and less consecutive free time at home. The interns in our residency are the work-horses and this change will have a chain effect on the current R1 and R2s and even faculty with increasing their work loads. I also think that this will push us to require 4 years of training since R1s will basically function as
# Maximum Duty Period Length

## Comments not in Support

a MS-5. I believe there are other ways to promote safety without having this work hour restriction (spacing 24 hour calls to no closer than q4 or 5) that would work better for continuity on services such as OB, for consistency with sleep schedules, and to obtain sufficient clinic time.

<table>
<thead>
<tr>
<th>Name: Phyllis You, R3</th>
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<td>Organization: Family Medicine Residency of Idaho</td>
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<td>Affiliation: individual</td>
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I don't see how having interns on for 16 hours at a time is 1) Going to allow them to learn enough to be competent R2s or 2) Going to allow them to be more rested than with a typical call schedule. ACGME should consider that there will be more call frequency due to the need for pt volume and less contiguous hours of rest, not to mention more transitions, leading to more fatigue and more medical errors.

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<th>Name: Amy Drumm</th>
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Evidence does show that fatigue increases after 16 hours but patient care may be more compromised by the increase in hand offs that this standard would necessitate. In my experience, many more errors occur as a result of communication errors during hand offs than by duty hours exceeding 16 hours.

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<th>Name: Lisa Ray, MD</th>
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<td>Organization: MAHEC FP Residency Program</td>
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<td>Affiliation: individual</td>
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The rationale for not having PGY1 residents work 24 hours is flawed. All it does is postpone the time when the resident is forced to think for him/herself. In the current system, an intern is forced to do it when there is a more senior MD (usually a resident) around to supervise and catch the mistake. In the new system, we will have a more advanced resident who has not had to think through the issues, being on site without a more senior resident also on-site. So we have gone from a situation where there is an intern and senior MD on-call to one in which there is a senior MD without the needed experience with no on-site supervisor.

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<th>Name: Nuri Farber</th>
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As the literature shows, the current duty hour mandates have not increased the amount of time residents spend sleeping, nor have they improved patient care outcomes. For this reason, it is unclear how more stringent duty period requirements will contribute to resident rest and the quality of care. In particular, the new requirements will:

- Increase the number of handoffs, in direct contradiction to the ACGME’s objective of improving patient care.
- Interfere with the transition from PGY-1 to PGY-2 responsibilities in programs that have 24-hour call, as the PGY-2s will never have experienced this.
- Require the recruitment of additional PAs, NPs, attendings, and/or PGY-1 residents, and thereby impose a severe and unnecessary financial burden on institutions.

In addition, if programs need to expand in order to meet these requirements, it is unlikely that most RRCs would be able to handle the volume of approvals required for additional recruitment in the 2011 Main Residency Match.

We ask that the ACGME remove the proposed requirements for maximum duty period length until the impact statement has been published and analyzed.

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<th>Name: Scott H. Barnett, MD</th>
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<tr>
<td>Organization: Mount Sinai School of Medicine</td>
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<td>Affiliation: organization</td>
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### Comments not in Support

This is a ridiculous proposal. Residents are becoming less and less like true physicians and like students. To be honest, medical students would be spending more time in the hospital than interns. Continuity of patient care is of utmost importance. With the current hour limits that are currently in place, I have seen too many incidents in which patient care has suffered due to poor communication. It is my assumption that communication problems are bigger than too many hours at work. Of course, we should have done a better job in the past in regards to residents' hours, but this is going too far. There is already a physician shortage in the country. We are relying more on midlevels to provide cares and faculty are bearing more of the load. For example, I have been on call since 7am yesterday and will be here until 6pm tonight. I will have operated on 7 surgical patients, rounded on > 20 ICU patients twice, evaluated/resuscitated 7 trauma patients and now doing office work. The burden is being shifted to attending. We are producing residents that will not be able to function in the "real world". Also, the financial cost is being thrust upon Departments and Hospitals to provide for coverage during these "lost" hours. Society can't have it both ways.

**Thanks**

**Name:** alan tyroch  
**Organization:** ttuhs-el paso  
**Affiliation:** individual

This change in duty hours would diminish the current team dynamic as it would likely leave a senior resident on by themselves with the intern leaving. Interns will feel as though they are abandoning their senior. We currently have a night float 5 days a week, with only Friday and Saturday as overnight calls. Adding additional night float coverage would require a significant expenditure to our program in faculty coverage or additional residents.

**Name:** Charin Hanlon  
**Organization:** Charleston Area Medical Center  
**Affiliation:**

As a general surgical resident, a field with an approximately 20% rate of attrition that was NOT changed by work hours reform, I am highly concerned that allowing exceptions to duty hour rules such as here (ie able to stay past the end of duty period in "unusual circumstances") will lead to resident abuse. It is easy to see the opportunity for coercion by the program to stay and do more work well past the end of your shift, especially since all you have to do to make it acceptable is document this for the program director, who may be the VERY PERSON forcing you to stay late as it is. Please eliminate these loopholes that will lead to my fellow residents and me being open to abuse and exploitation.

**Name:** Leonard Armstrong  
**Organization:** University of Minnesota  
**Affiliation:** individual

The proposed regulations include language (IV G 4 a) limiting PGY-1 residents to 16 hour duty shift with (IV G 5 a) minimum 8 hours (ideally 10) hours free of duty between shifts. This has some significant negative implications on residency training programs in the USA including:

Inability to learn from the initial diagnostic studies and response to therapy: The first 12-24 hours of an inpatient admission are often filled with essential diagnostic testing and therapeutic interventions. Much can and should be learned from this initial period of clinical care. Asking an intern to leave in the middle of this period will give them less opportunity to learn about the success or challenges of their assessment and treatment plan. Without this direct observation PGY1s will learn less clinical care and retain less about their patients and their disease processes because of this lack of participation.

Inability to maintain a team structure: Team structure is critical during the PGY1 year. Working as part of a team is integral to the 21st century physician, and observations made during internship about team leadership styles and team functions almost certainly will influence a physician's leadership ability in the future. Further, intern education and supervision will most likely be more efficient and individualized when done with a resident physician who is familiar with intern's abilities and knowledge base. Fragmenting a team, by requiring the PGY1 to leave early will jeopardize both of these strengths in the learning climate of
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the team. The current proposal allows residents to have a 24 hour duty period (followed by 14 hours rest). While it is possible that some programs may limit residents to 16 hour duty shifts to keep the team structure, it is more likely that programs will allow residents to work 24 hour shifts. This means that the day after admission -- a key time reinforce lessons learned from the initial treatment plan and promote life-long learning -- will be supervised by a resident or attending physician who has both limited knowledge of the case and learner.

PGY1 and higher level trainees will care fewer cases than ever and receive less medical education.. When a residency has a cap or not on patients, the time constraints will not permit residents to care for as many patients as is currently possible. With a shorter workday simply less cases can be admitted and cared for by the trainee. The trainees will also have less time to interact with teaching faculty and attend education conferences. Residency durations will not be lengthened so each resident will receive proportionally less training. Having less training at the end of their residency, means they will possess, less clinical skills. Residents already complete residencies with less clinical skills than physicians who trained a decade or more ago because of have cared for fewer patients. The ACGME proposed regulations ignore the fundamental medical pedagogical principle that case-based learning essential and cannot be replaced by any amount of reading, online or otherwise.

In short, the proposed duty hour restrictions on interns will have potentially significant negative effect for training physicians in America. Pilot studies at the University of Pennsylvania have revealed that this process results in clinical chaos has ensued from such a schedule with frequent changes in clinical coverage. This was actually presented at the national ACGME conference in 2010 but seems to have been ignored in the process of proposing the new regulations.

As regards patient safety, there is no evidence that these regulations will enhance patient safety. The few studies regarding patient safety and work hours that were positive were done before the 80 work hour rule was implemented and are not applicable to this particular set of changes. The number of handoffs will increase and opportunities for missed communication will be increased.

Recall:

"During a small part of this study, I served as attending physician on the ICU during both the traditional (control) schedule and the intervention schedule. Although the interns were more awake and made fewer serious mistakes during the intervention schedule, they often knew very little about the patients who had been admitted the night before they came on duty."


Moreover this change will result in further reducing the professionalism of the trainee by the implicit message that the practice of medicine is truly shift work and that the first priority is the physician getting to enough rest, not that the patient’s healthcare comes first. Does the ACGME really want to start all physician trainees with that message of that physician’s needs come first? It is unlikely that this is the intention but it is likely to have that unintended effect. Physicians trained in such an environment are likely to expect shift work when they become attending physicians and access to trained physicians will be lessened by such a practice on a national scope.

Both our recent interns and our current chief residents noted that a complete and thorough internship is crucial to the educational growth throughout residency and that the reduced duty in the proposed new regulations will impair that maturation and growth process during the PGY1 year.

In the past, the ACGME made changes that while, sometimes difficult to implement, overall, they enhanced the educational environment. Now the ACGME appears to being coerced by the Institute of Medicine committee and poorly informed patient advocacy groups into making changes that will harm the education of physicians in the USA and the care of patients. A careful and thorough study should be conducted in a few
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programs to fully and carefully evaluate the effects of such changes in training requirements would have on patient safety, educational effectiveness, and clinical training before it becomes a national policy.

Name: Arnold R. Eiser, MD
Organization: Mercy Catholic Medical Center
Affiliation: organization

The reponse of our residents to the PGY-1 changes has been fascinating - they are concerned that the 16 hour limit ("your shift is up, go home") will not only take away from education, but importantly (as one of our GMEC residents put it) "infantilizes the interns" - by clearly noting that they are different, and that even with the direct supervision now required of them, that they are treated as medical students currently are - that they leave at a certain time as their input, experience and work is not necessary to patient care.

Name: Staci Fischer, MD (DIO)
Organization: Rhode Island Hospital/Brown Medical School
Affiliation: organization

The proposed 16 hour restriction is a terrible idea. I am a new intern this year just coming off a medical ICU rotation, in which I had three 30-hour shifts. During those shifts, I got more procedures than any other time that month, and am now signed off on several of my Internal Medicine residency requirements. This restriction will foster a generation of PGY-2s that are unprepared in more ways than one. I am now prepared to supervise interns next year in certain procedures, which certainly would not have happened had I not been overnight. I also now know the rigors of the 30-hour shift, without the responsibility of having to supervise anyone. It is cruel to throw a new PGY-2, who is nervous enough about their responsibility as a resident, into a demanding situation that they have never experienced.

Additionally, this will affect me directly. As an intern, one looks forward to PGY-2 year as being less stressful time-wise, although it is more stressful responsibility-wise. I am now as an intern working longer hours than the resident, and next year I'll be a resident working longer hours than the intern, but with added responsibilities? That doesn't seem right. Coddling the interns for one more year doesn't change the fact that they'll be overnight and overworked as residents, fellows, and attendings. Overnight shifts and long hours are something we all go through. 16-hour shift restriction is not the solution.

Name: Kelly Ross
Organization:
Affiliation: individual

I am concerned that the proposed rules categorically exclude post-call continuity clinic after working 24 consecutive hours.

Family medicine is unique from other medical specialities. In order for 2nd and 3rd year FP residents to obtain real-world experience, many residencies are affiliated with private practices or resident clinics that function as a family practice. As a senior family practice resident, my calls are typical for a family physician that does both inpatient and outpatient care. I answer phone calls from our practice's patients at night. I answer pages from nurses on the floor. I consult on our patients in the ER who may need admission. And sometimes, I sleep through a quiet night. Currently, the following morning, I go to post-call clinic. While at times post-call clinic seems to be a hassle, it is a good learning experience and helps me get to my clinic numbers required by the ABFM.

It seems there are going to be some exceptions for certain specialty residencies to go past the maximum duty period length. The reasoning is that senior residents need to be prepared to go into independent practice. I think an exception for senior family practice residents to perform post-call clinic goes along the same line. That's what private practice family physicians do.

Name: Chi Young, MD, R3
Organization: Virginia Commonwealth University Family Practice Resident
Affiliation: individual
PGY1 residents should be allowed to rotate with the other residents on the team to minimize transition. While endorsing the 16 hour shifts as the preferred length of shifts, the 24 hour shift is necessary to facilitate weekend coverage. We ask that this be reconsidered to allow PGY1 residents to work with their team on weekends.

Name: Mark B. Woodland  
Organization: Drexel University College of Medicine  
Affiliation: organization

My residency consists of 16 residents, the main services that we cover with 24hr inpatient coverage are OB and inpatient medicine (adult, pediatric, and newborn). Our inpatient service consists of a 4 week-long, 5 days/week night float during our PG-1 and PG-2 years. Though difficult, this is a coming of age, and is useful even in the first year. Additionally, our OB coverage is a 24 hour on-call block- reducing this to 16 hour maximum duration would result in increased frequency of call likely resulting in increased burn-out, despite overall fewer hours. I believe the proposed next step in limiting duty hours is not only inconvenient, but increases hand-off (jeopardizing patient safety) and increases burn-out for short but frequent call (jeopardizing resident well-being). Additionally, there are no hour limits after graduation - being pushed and trained to be adept even when tired (though not needlessly exhausted) is a useful role of residency. The proposed further hour restrictions are overly restrictive.

Name: Farrant Sakaguchi  
Organization: Pocatello Family Medicine  
Affiliation: individual

I came from a very difficulty residency program and I believe in making life for residents more livable, HOWEVER

Not allowing interns to work more than 16 HOURS in a row is INSANE. This is just going to keep the most ignorant from educating themselves. The ignorant will stay more ignorant and be unprepared to teach the next year when they are second years, be unable to handle a call schedule that is new to them, and will be much less able to take charge in emergencies when their interns are looking to them for guidance.

I watch the new doctors my practice hires and I am weary of their poor work ethic, their inability to deal with the normal stresses of normal call. They are ill prepared, less experienced (I do not mean book learning, I mean hands on), and entitled. They expect to be paid the same for less work, and we know that the future of medicine is not going to involve better reimbursement no matter what. Medicine is hard work and trying to make it "easier" in this way is not going to help these docs deal with real life when they are out on their own.

I am fearful of the generation of MD's who will take care of me when I am no longer able to take care of others.

Name: Dr Lucia A Fouts, MD FACOG  
Organization: Women's Health Advantage.  
Affiliation: individual

We have a family member who is presently a 2nd yr. resident, having completed his grueling internship year in June. He is at a major hospital in Boston. Having completed his first year, and knowing that his second year would be equally as demanding, if not more than his first year, he could see the light at the end of the tunnel for years three and four. This was what they were told at orientation.

However, with the proposed changes, the word filtering down from their superiors is that because the interns cannot work as many hours as interns have in previous years, the third and fourth year residents will have to pick up the difference and work the same insane hours that they have done for the internship and second year. So for those who will, by next June, already have "served their sleep deprived time" for two years, they are the unlucky ones who have to continue that schedule for two additional years. That seems very unfair. We think there should be some way to "grandfather clause" those doctors who will have already done this for two years to be exempt from any additional hours they might have to be on duty because of the
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proposed hours. Years three and four give them a ray of hope to be able to catch their breath and maybe have personal/family time that residents in their third and fourth year are, in many cases, currently experiencing.

We have often wondered what the medical community is accomplishing by having these doctors working such long hours. From our conversations with him, it is difficult for many to make good decisions which may impact the well being of a patient at the end of a long busy overnight shift without any sleep (in his hospital, sleep on the night shift is pretty much nonexistent!).

We would encourage the decision makers in this proposed change to consider identifying ways in which those who have already completed their first and second year (by June, 2011) will not have to repeat the same exhausting hours that they have already done for two years.

We applaud the possibilities that you are proposing, but not at the expense of the second year residents who will be entering their third and fourth year in June, 2011 and 2012.

Thank you for giving us the opportunity to comment on the proposed changes.

Name: M. Elwell
Organization: 
Affiliation: individual

Reducing Intern duty hours to 16+4 daily will effectively eliminate intern call and devastate my program and many others. My program is currently thriving, having actually grown from 6 to 7 slots last year with an active continuity clinic and healthy hospital service for our patients. We abide by duty hours religiously and take frequent naps on call. We are not sleep deprived.

If these rules are implemented, we will not be able to maintain our hospitaling service. At 7 residents per year, we are too small for a night float, nor can upper levels complete their clinic obligations and cover intern calls. We may also need to stretch Family Medicine to 4 years from 3 to ensure clinical exposure, further deterring medical students from choosing primary care.

This change may destroy us.

Name: William Luster, MD
Organization: East Jefferson General Hospital/Tulane S.o.M. Family Medicine Residency
Affiliation: individual

Those those concerned;

First of all, I would like to offer my support and encouragement for those seeking to improve the quality and safety of patient care, as well as the well-being of medical and surgical housestaff. I think that there has been tremendous progress to this end in the past 10 years, and am hopeful that this drive will continue. However, I would like to express some reserve regarding the proposed ACGME changes to the current duty-hour structure; specifically, the “16-hour rule.” The benefit of admitting a patient and following him/her throughout the first day of admission was crucial to my development as a senior resident. This is a sentiment I have heard repeatedly echoed by my colleagues, PGY1 through PGY4. More importantly, I am concerned that such drastic changes might only serve to further fragment patient care and continuity in an environment where quality depends on such factors.

If conclusive data through further research can demonstrate that a 16-hour work limit is crucial to the safety of our patients and colleagues, I will undoubtedly offer my support. In the mean time, I urge those involved to strongly consider the detrimental effects of mandating arbitrary limits on a community that may not benefit from such changes.

Thank you for your time and consideration.
Comments not in Support

Best,
Joe Simonetti, MD
University of Pittsburgh Medical Center

Name: Joseph Simonetti, MD
Organization: University of Pittsburgh Medical Center
Affiliation: individual

I have real concerns about the ‘16 hour rule’ for interns, as it will force more transitions in care, already
acknowledge by the ACMGE (and many other bodies) as a risk to patient safety. I also find it concerning
that interns will be singled out as somehow ‘different’ from all other residents, incapable of working long
hours and essentially ‘glorified medical students’. This sends the wrong message to both intern trainees and
their more senior counterparts; are interns somehow not ‘true doctors’? How are these individuals incapable
of working more than 16 hours on June 30, but on July 1 they are capable when they become PGY 2s? I
strongly support 24+4 or 24+6 for all trainees as a better option. With increased supervision and
appropriate fatigue recognition/education and remediation, 24+6 will be safe for all trainees and patients.

Name: Mary Klingensmith
Organization: Washington University in St Louis
Affiliation: individual

I am the program director of a 40 resident general surgery residency at a large university hospital. I am very
concerned about the implementation of the intern 16 hour shift restriction from both an educational and
practical standpoint. Surgery is a complex discipline that does not work in shifts. Patients need continuous
care and attention at all hours of the day and night. To learn surgery also requires that a resident
understand all aspects of a patient’s care. These restrictions will take our interns out of the hospital and limit
their exposure to patients and vital clinical situations. Their understanding of patient care will be further
fragmented.

Our current call schedule for 2010/2011, has interns covering 479 twenty four hour shifts. The services
most affected are trauma and the cardiac and surgical ICU’s. I have already formed an internal task force to
develop strategies to cover these shifts. Unfortunately my department and institution are unable to provide
financial support for physician extenders and/or house physicians. To cover these shifts we will likely need
to pull residents away from our affiliate institutions. This will result in a loss of their exposure to community
surgery, an exposure we believe has value. We will also likely need to expand our night float system. This
will put interns in house at night more often. Their time in house during the day will be further reduced.

I ask that you strongly reconsider this recommendation. At the very least, give us more time to find sound,
educational options for coverage. Covering 479 twenty four hour shifts with no increase in financial support
or resident complement is a herculean task that will take some time beyond July 2011.

Name: Karen Chojnacki
Organization: Thomas Jefferson Universtiy Hospital Department of Surgery
Affiliation: individual

As the PD for a small surgery program (3 categoricals per year), this 16 hour limit for interns will severely
limit coverage on weekends. We currently have night float for our interns, and weekends are covered by
two other interns (we have 3 urology prelims). Changing to 16 hour shifts not only will require 3 interns per
weekend, with it's requisite extra "handoff", but instills the "shift" mentality to surgical interns that we as
educators are trying to avoid. Caring for patients on a ward or unit is not the same as in the ER. (shift
workers). There is excellent supervision with 2 senior residents. Having an intern without the knowledge of
the patients that continuity provides will render them more of a burden to the team, and make them more of
a glorified third year medical student. This is a major disaster.

Name: Harold Welch, MD
Organization: Lahey Clinic
As Internal Medicine residents of a community teaching hospital in Baltimore, we wish to communicate our concerns regarding the new proposed duty hour restrictions published in the July 2010 in the NJEM.1 We are specifically concerned about the new duty hour restriction of 16 hours per shift for interns, which we believe is based on the results of two studies published in October 2004 in NJEM. 2, 3 Both of these studies were part of a larger study entitled, “The Intern sleep and patient safety study.” We reviewed this set of data and have the following critiques of this study and these two resulting publications:

1. The sample size (n=20) was very small and a single academic medical center was involved. The results obtained from the study may not apply to different clinical settings. In particular, community hospitals, with different patient volumes, intensity of care, availability of technology and support, have different cultures and approaches.

2. There was no direct mortality benefit to patients in interventional schedule group when compared to group of residents who were assigned to traditional on-call schedules. In fact, there was more mortality (14.5% of total unit admission) compared to traditional schedule group (12.7% total no. of unit admission), although the difference was not statistically significant.

3. There was a significantly lower patient load in the interventional schedule group (No. of patient-days was 909) compared to traditional schedule group (No. of patient days was 1294). This difference might have resulted in work intensification in traditional schedule group, thereby causing more attention failure and medical errors in that group.

4. Two interns experienced dramatic decreases in attention failures when switching from the traditional schedule to interventional schedule. These two individuals may have significantly skewed the data. The other participants in the study did not respond in such an impressive fashion. Because of the small sample size, it is possible that the statistical difference achieved between the traditional and interventional schedules was the result of a few outliers.2

5. Physician observers were used for detecting errors, and it was accepted in the paper that observers were in short supply. Indeed, if errors were missed, it would have been among the interventional group. Specifically, four interns were working simultaneously in the interventional group, whereas three interns were working in the traditional schedule group. It is entirely conceivable that there is a greater chance of overlooking or missing serious errors when trying to observe four interns busy at work rather than three.

6. The study only evaluated trainees at the intern level. If one extrapolates this data to more senior level residents, it is not clear why PGY-2 and PGY-3 residents may work 24 hours shift, but interns are limited to 16 hour shifts. Why should we expect the human physiology to suddenly change for the better when residents transition from the PGY-1 year to the PGY-2 year?

The impact of this new regulation on our program cannot be over-estimated. At present, we have an intern aligned with a supervising PGY-2 or PGY-3 resident working together as an overnight team every third night in our critical care unit. This unit is considered the pinnacle rotation in our program; we universally feel that we derive the most educational benefit from this rotation. Due to a comprehensive system of checks and balances involving nurses, pharmacists, and critical care specialists, our error rates are well below national norms. Overall, we are very concerned that this very small study, conducted in a single academic center, will potentially compromise a very positive educational experience in our program. Additionally, on a national level, this requirement has the potential of costing $610 million to $1,740 million,4 at a time when the U.S. is pressured to reduce health care costs, especially for interventions that yield questionable benefits for patient safety.

In our view, duty hour restrictions should not just focus in the absolute number of work hours, but also incorporate initiatives in the interest of patient safety. We advocate that there be funding for better pilot programs and more robust studies that include analysis of cost benefit, diversity of clinical settings, evaluation of the effect on the quality of resident education, and measurement of the adequacy of resident exposure to breadth of disease states and pathology. There should be consideration of more comprehensive solutions, such as stress reduction, improved patient safety protocols, and decreasing the intensity of workloads. We humbly submit that the reflexive response to reduce duty hours for interns to 16 hour shifts is short-sighted, poorly based in quality evidence, and at present ill-advised.

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Name: Satish kabera
Organization: Good Smartian Hospital
Affiliation: organization

I am the program director of a 40 resident general surgery residency at a large university hospital. I am very concerned about the implementation of the intern 16 hour shift restriction from both an educational and practical standpoint. Surgery is a complex discipline that does not work in shifts. Patients need continuous care and attention at all hours of the day and night. To learn surgery also requires that a resident understand all aspects of a patient’s care. These restrictions will take our interns out of the hospital and limit their exposure to patients and vital clinical situations. Their understanding of patient care will be further fragmented.

Our current call schedule for 2010/2011, has interns covering 479 twenty four hour shifts. The services most affected are trauma and the cardiac and surgical ICU’s. I have already formed an internal task force to develop strategies to cover these shifts. Unfortunately my department and institution are unable to provide financial support for physician extenders and/or house physicians. To cover these shifts we will likely need to pull residents away from our affiliate institutions. This will result in a loss of their exposure to community surgery, an exposure we believe has value. We will also likely need to expand our night float system. This will put interns in house at night more often. There time in house during the day will be further reduced.

I ask that you strongly reconsider this recommendation. At the very least, give us more time to find sound, educational options for coverage. Covering 479 twenty four hour shifts with no increase in financial support or resident complement is a herculean task that will take some time beyond July 2011.

Name: Karen Chojnacki
Organization: Thomas Jefferson Universtiy Hospital Department of Surgery
Affiliation: individual

Fellow program directors have correctly pointed out various unintended consequences of progressive duty hours restrictions, including delayed maturation and the probable need to lengthen training in order to compensate for lost experience. Let's think about it a different way. As I stated at the APDS business meeting in San Antonio, there is currently a major missed educational opportunity for physicians in the United States--namely, the MS-4 year.

The ACGME's proposal will effectively abolish overnight call and consign all interns in all programs to night float. This will oppose two of the guiding principles of the ACGME task force: (1) minimizing handoffs with their potential for error, and (2) reducing the tendency of physicians to adopt a shift-worker mentality. In smaller programs, it will turn interns into nocturnists for a significant portion of the year.

Currently my 8-intern class takes overnight call approximately once a week and "short call" until 7 pm once a week. They do not find this to be onerous. They go home after call and do not return until the next day. The current PGY-1s express concerns that the next intern class will not have this experience. They believe, as I do, that dumbing down the first year will delay the real start of their clinical maturation until PGY-2--at the very time they are trying to learn supervisory skills, laparoscopic technique and critical care, to mention only a few.

A better proposal would increase the readiness of new PGY-1s to assume clinical responsibility. That isn't happening consistently now. Many current residents say that, although they paid full tuition, the educational component of the MS-4 academic year occupied only 6 to 8 months and most of that was not very rigorous.
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The rest was an expensive vacation.

I suggest that all MS-4s have a common pre-internship experience to prepare them for residency training. This would require sub-internships in surgery, medicine, family medicine, critical care and elective specialties, plus skills labs, spanning 9 to 10 months. There should also be a required "coda" course (as at UCSF and some other schools) that brings together all graduating MS-4s to learn in detail about the many things that can harm patients in the middle of the night such as shock, hemorrhage, sepsis, MI, PE, aspiration, acid-base and electrolyte problems, iatrogenia, etc. All medical students should be BLS and ACLS certified as a condition of graduation. Thus, all new MDs would be ready to enter their first day of residency training at a level commensurate with at least mid-internship under the current curriculum. This could be accomplished at very minimal cost.

These views are those of an 11-year veteran surgical program director (me) and not necessarily representative of the views of Kaiser Permanente.

Name: J. Craig Collins, MD, MBA, FACS
Organization: Kaiser Permanente
Affiliation: individual

There are no data that establish the need to restrict the continuous duty hours of SURGERY PGY-1s to 16. This change will be highly disruptive to the education of the PGY 1s, delaying their clinical maturation, particularly in regard to the management of urgent and emergent surgical conditions and perioperative developments. It will disrupt the experiential learning of the surgery resident, which requires exposure to the full course of the care of a patient. It will prevent equal integration of the PGY-1 into the team. It will adversely affect the education of all the other residents, since it will increase the time spent in night float rotations, which classically have a larger proportion of less educational activities. It will prevent attendance at educational conferences. It will disrupt the team function by off-cycle shift start times. It will adversely impact the quality and safety of patient care by dramatically increasing the number of care transitions. There are so many disadvantaged to this structure that is difficult to know where to start. And most frustrating, the data used to justify this ARE NOT specific to the field of surgery. It is inappropriate to initiate such a profound change in the role of the PGY-1 residents without field-specific data that establish the educational rationale or patient safety rationale for such a change. If the ACGME has concluded that students finishing medical school are not qualified to take supervised call, then it is well past time to address the deficiencies of the medical school curriculum. The educational goals of residency training are enormous and residency time should not be dedicated to making up for the inadequate preparation received in medical school.

Similarly there are no data justifying the reduction of the 24+6 duty hours to 24+4. This change will further limit the opportunity for residents to stay after overnight call to participate in educational conferences, particularly skills labs for surgery residents, and will increase care transitions.

Finally, while strategic napping and reporting/monitoring of each decision to stay beyond a scheduled duty period for compelling reasons of patient care are reasonable principles, effective monitoring (if it can even be achieved) will place such a heavy administrative burden on programs and program directors as to make it impossible. This demand would further divert the program's attention away from educational activities.

Name: Linda M. Reilly MD
Organization:
Affiliation: individual

It would be great if a footnote to references demonstrating that 16 hours has been shown to reduce errors (the NEJM 2004 Harvard study) were included. Otherwise, the work hour duration seems somewhat arbitrary.

Name: Shelley Schoepflin Sanders
Organization: Providence St. Vincent Medical Center
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Affiliation: individual

Do you honestly think that residents will be able to strategically nap? I think that if the time isn’t scheduled out... then likely they will be working through that strategic nap period.

Name:
Organization:
Affiliation:
I am a PGY-2 resident in a family medicine program of 5 residents per year (15 total) in Oklahoma.

Looking back at my intern year, I am resolute that I would not have learned as much as I have by being in the hospital for only 16-20 hours per day and call period. I think this requirement will devastate intern year education, and lead to more unprepared residents entering their second year of training. The 16-hour requirement has the potential to destroy programs as small, or smaller than mine. There are several family medicine programs in Oklahoma with only 2-3 residents per year. I am unsure of how they would be able to accommodate these new requirements. With the push to train more primary care physicians, is it really the goal of the ACGME to wipe out residency programs that train such physicians by these onerous requirements?

The 16-hour timing is also very odd. Consider if I was a PGY-1 on an inpatient hospital service who was on call that night with this requirement. I could arrive at 6 AM at the hospital, and work until 10 PM for my 16 hours, or until 2 AM for the additional 4-hour transition period. My relief resident would be coming into the hospital at 10 PM, and I would be leaving at 10 PM to 2 AM. I think this would have the potential to cause more resident fatigue, as residents would be switching during nighttime hours.

If a night-float system were in place in our program of 15 residents, it would probably cut out at least one to two months of our resident education in sub-specialty areas, further hindering my readiness to practice medicine.

I am also unsure of why a period of 24-28 hours is that much different than the current 30-hour duty period for an upper-level resident. Did any research show evidence that those extra two hours made a statistically significant difference in medical errors by residents? I am also confused why residents will no longer be permitted to see non-urgent patients in continuity clinics after a call period. Is there data to show significant medical errors are being made on the outpatient basis as well?

I am happy to see that there can be exceptions made for residents who wish to stay to see interesting procedures or patients after their maximum duty period is up. However, this is small consolation for the damaging effects these new requirements will have on many residency programs in this country.

Name: Kyle Schauf, MD
Organization: Great Plains Family Medicine
Affiliation: individual
Fellow program directors have correctly pointed out various unintended consequences of progressive duty hours restrictions, including delayed maturation and the probable need to lengthen training in order to compensate for lost experience. Let's think about it a different way. As I stated at the APDS business meeting in San Antonio, there is currently a major missed educational opportunity for physicians in the United States--namely, the MS-4 year.

The ACGME's proposal will effectively abolish overnight call and consign all interns in all programs to night float. This will oppose two of the guiding principles of the ACGME task force: (1) minimizing handoffs with their potential for error, and (2) reducing the tendency of physicians to adopt a shift-worker mentality. In smaller programs, it will turn interns into nocturnists for a significant portion of the year.

Currently my 8-intern class takes overnight call approximately once a week and "short call" until 7 pm once a week. They do not find this to be onerous. They go home after call and do not return until the next day.
## Maximum Duty Period Length

### Comments not in Support

The current PGY-1s express concerns that the next intern class will not have this experience. They believe, as I do, that dumbing down the first year will delay the real start of their clinical maturation until PGY-2—at the very time they are trying to learn supervisory skills, laparoscopic technique and critical care, to mention only a few.

A better proposal would increase the readiness of new PGY-1s to assume clinical responsibility. That isn't happening consistently now. Many current residents say that, although they paid full tuition, the educational component of the MS-4 academic year occupied only 6 to 8 months and most of that was not very rigorous. The rest was an expensive vacation.

I suggest that all MS-4s have a common pre-internship experience to prepare them for residency training. This would require sub-internships in surgery, medicine, family medicine, critical care and elective specialties, plus skills labs, spanning 9 to 10 months. There should also be a required "coda" course (as at UCSF and some other schools) that brings together all graduating MS-4s to learn in detail about the many things that can harm patients in the middle of the night such as shock, hemorrhage, sepsis, MI, PE, aspiration, acid-base and electrolyte problems, iatrogenia, etc. All medical students should be BLS and ACLS certified as a condition of graduation. Thus, all new MDs would be ready to enter their first day of residency training at a level commensurate with at least mid-internship under the current curriculum. This could be accomplished at very minimal cost.

These views are those of an 11-year veteran surgical program director (me) and not necessarily representative of the views of Kaiser Permanente.

**Name:** J. Craig Collins, MD, MBA, FACS  
**Organization:** Kaiser Permanente  
**Affiliation:** individual

My concern is for the 16 hour shift requirement for interns rotating through the ICU. ICU admissions are never predictable and flexibility is a must to maximize learning on these critical patients. It would be interesting to hear from the ACGME how learning in the ICU could be maximized for interns. Thanks.

**Name:** Rebecca Sell  
**Organization:**  
**Affiliation:** individual

I am a recently graduated resident and feel that my most valuable learning experiences came from caring for patients over a continuous time period and watching the progression of disease/acute illness over that time period. This learning experience will not be available when residents are forced to give patients fragmented care and are only allowed to care for them during a small portion of their acute illness/presentation.

There is an apparent impending crisis in primary care in this country and many primary care physicians are trained at small, community-based programs with a limited number of residents and faculty. I have recently graduated from such a program and feel highly trained and qualified to provide primary care to my patients. These new duty hour guidelines will make it impossible for many of these small programs to function. It seems as if small, community-based programs were not even taken into consideration with these proposed changes. This will further contribute to the shortage of quality primary care physicians available in a system where primary care should be the backbone of care.

**Name:** christy kerr  
**Organization:** Great Plains Family Medicine  
**Affiliation:** individual

I have reviewed the proposed changes to duty hours, and have significant concerns that the 16 hour limit on PGY 1 residents will adversely affect patient care. I have been a hospital Attending for 11 years, and just finished a week of Attending Duty with our hospital team. If the proposed duty hours for PGY 1 are implemented, I believe the rule will increase the risk of medical errors. With the restriction, there will be...
## Maximum Duty Period Length

<table>
<thead>
<tr>
<th>Name: Charles Clements</th>
<th>Organization: MUSOM</th>
<th>Affiliation: individual</th>
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<td><strong>Comments not in Support</strong></td>
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<td>increased potential for &quot;hand off&quot; errors, and increased fatigue due to residents having a disrupted, non-existent, sleep schedule to cover the reduced hours. Make no mistake, residents will have more frequent, broken sleep periods to cover the new rules. Keeping the current rules reduces the frequency of hand off errors, provides for more continuity of care, and provides predictable sleep periods that are consistent with normal circadian cycles. While the proposed rules have the goal of reducing errors due to fatigue, I believe that it will actually result in decreased, broken sleep cycles, and more hand off errors.</td>
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<td><strong>The 16 hr rule is really misguided. Staff physicians are not limited to shifts. We care for the patient until the acute problem is diagnosed and managed. To create a whole new generation of physicians who look at the practice of medicine as &quot;SHIFTWORK&quot; is a path to disaster. It is already obvious even with the 24 hour rule that residents don't care about the patient they only care about themselves and when do they get off work. There is no commitment to the patient. To start this attitude in the 1st year is even more dangerous. There is no conclusive evidence that &quot;rested&quot; residents perform better than committed residents. I would much rather have an experienced tired resident helping to care for my patients than a rested one that doesn't &quot;give a d@&amp;$&quot; about the patient and feels &quot;entitled&quot; to go home.</strong></td>
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<td><strong>Show Me the Evidence</strong></td>
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<td>Where's the evidence that staying only 4 hours after a 24 hr shift is better than 6? Everybody knows that most of the diagnostics (imaging, lab tests, surgical explorations) occur during regular working hours. If a resident hands off a patient and then goes home and doesn't participate in the final work up they miss out on a huge teaching opportunity. To simply &quot;learn what happened&quot; the next day when they're rested will not result in the same retention as &quot;living the results&quot;.</td>
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<td>Patient safety will definitely be compromised as residents as further taught that their responsibility to patient care is &quot;shift work&quot; and that they have no obligation beyond their shift. They feel no obligation to making the patient better only “keeping them alive” until their shift is over. This trend towards shorter duty hours is a huge mistake for the surgical specialties.</td>
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<td><strong>Name: Keith Brandt, MD, Program Director</strong></td>
<td><strong>Organization:</strong> Washington Univ. St. Louis</td>
<td><strong>Affiliation:</strong> individual</td>
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### Maximum Duty Period Length

**Comments not in Support**

Much of medical error occurs in handoff of care from one resident to another. These new hour requirements for interns will increase the number of handoffs, thus increasing the likelihood of error. Please reconsider this. I am currently an Intern and I have no problem with the current 80 hour rule. I hope the next group of interns gets to work under the same arrangements that I do.

Thank you,

Jason Breed, MD

**Name:** Jason Breed  
**Organization:** Integris Family Medicine Residency Program  
**Affiliation:** individual

Regarding the limitation of PGY-1 residents to a 16 hour week, I find this to be an unnecessary restriction and from what I can gather one not based on any data that has been presented in the literature. There is nothing magical that happens between the PGY-1 year and PGY-2 year that somehow makes an intern better able to handle an overnight call, which this rule effectively eliminates. Speaking personally as a PGY-1 surgical resident, this would hinder my education as I would not be able to follow a patient from admission through the first 24 hours of their care, which is a critical time portion both for their care and my education. As a medical student, I took overnight call; as a 4th year student, I took 4 months worth of sub-internships that had overnight call. There is no reason to suppose that this is not adequate preparation for the rigors of an overnight call as an intern.

Another result of this rule is that it will effectively mandate a night float system for interns. While this is not in itself a bad thing, when combined with the rule that no one can take more than 6 consecutive nights of night float, it prevents one from adjusting adequately to a night shift that, say, a month of night float might offer.

**Name:** Geoffrey Fasen  
**Organization:** Mayo School of Graduate Medical Education  
**Affiliation:** individual

The 16 hour maximum duty hour proposal in concerning as it related to the PGY 2's and 3's. Without the work of the PGY-1's past 16 hours, who will address the patient care needs? The second and third year residents are already stretched thin in numerous programs. It does not seem feasible that the second and third years will be able to remain within the duty hour limits with an additonal 8-14hour gap in coverage.

**Name:** Leonie Prao  
**Organization:** Univ of MD Fam Med  
**Affiliation:** individual

I can see that admitting a new patient after 24 hours could be a risky situation. But otherwise, with fewer and fewer hours allowed, how can we learn what we're supposed to? We simply can't experience enough of the medical conditions in the hospital that we need to in the shorter and shorter times we're being allowed. Programs are going to need to add another year (at least) onto training to be certain everyone has the experience they need during residency. I'm not sure how smaller programs will be able to afford this.

**Name:** Charlotte Coyner  
**Organization:** Great Plains Family Medicine  
**Affiliation:** individual

The inherent problem with this proposal is that rising PL2 residents, in some programs, may have never taken a 24 hour call and would then be expected to make that transition in terms of duty-hours as well as new supervisory responsibility simultaneously.

**Name:** Lauren Marlowe  
**Organization:**  
**Affiliation:** individual

consider changing emphasis on napping to countermeasures to mitigate fatigue are recommended....identifying just one of these (napping) seems to convey this is the preferred method..not sure there are good
Comments not in Support

Name: Kathryn Andolsek
Organization: Duke
Affiliation: Individual

I am a 2nd year general surgery resident.

I suspect that limiting PGY 1 residents to 16 hour shifts is intended to make the transition from medical school to residency more gradual. I submit that graduating medical students are already acclimated to working 24 hr shifts. Many clerkship rotations require that medical students adhere to the same call schedule as the residents. I don't believe it is necessary to "ease" PGY 1 residents into the work hours that are required.

If PGY 1 residents are limited to 16 hour shifts, then how will all of the necessary work be completed? I see 2 scenarios, neither of which is desireable: 1. the work will be completed by intermediate and upper level residents, putting increasing strain on their duty hours. 2. (specific to surgery residents) the PGY 1 resident will complete the same amount of work in 16 hours as was completed in 24 hours previously, but this will require that the PGY 1 residents misses out on valuable procedure-related and/or operating room time.

Name: Jason W. Denbo
Organization: University of Tennessee Health Science Center, Memphis
Affiliation: Individual

This is an unacceptable standard for intern duty hours. I view the extended call shift as integral to the concept of the internship. It is an opportunity to maintain both continuity of care for a given patient, and task management, as the intern must oversee the care of multiple patients on his or her service. This is a vital physician skill, and deferring to the upper level years is misguided. There are multiple specialties whose interns go through a transitional or traditional program. These will end up not having that learning opportunity (24+4 hour in-house call shift), as they are less likely to be exposed to that sort of experience in their specialty residency.

Name: Jacob Hansen
Organization: Individual
Affiliation: Individual

The 16 hr limit should not apply in our specialty (OB-GYN) for two reasons; 1. We have attendings in house 24 hours providing direct supervision at all deliveries and procedures. 2. The nature of obstetrics requires ability to function during long hours. Patients are better served when physicians who cannot tolerate such long hours are identified earlier in their training, when a change of career course is more feasible.

Name: R. Michael Brady, MD
Organization: PD, Phoenix Integrated Residency in Ob-Gyn
Affiliation: Individual

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Maximum Duty Period Length

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**Name:** Jacob Hansen  
**Organization:**  
**Affiliation:** individual

In the last decade, ACGME duty hour policies have resulted in significant changes in the culture of medicine, structure of training programs, and training experience of residents completing residency programs. Some of these changes have been positive and have diminished resident fatigue and improved humanistic aspects of residency training programs. However, no demonstrable benefits as a result of these changes have been realized with respect to patient safety or patient care errors. Furthermore, some have argued that these changes have resulted in decreased competency of graduating residents in highly procedurally oriented fields such as the surgical subspecialties. Newly proposed ACGME duty hour policies further restrict the ability of residents to train and gain necessary experience such that they are competent to practice in an unsupervised environment. In addition, they contradict standing duty hour principles and have a potentially negative impact on patient safety (line 630 V1.B.1) by necessitating an increased number of patient “pass offs”. Lastly, these guidelines potentially add to the already cumbersome and increasing volume of documentation required of many training programs which detracts from their mission of resident training in the six core competencies. Many experts project future shortages of primary care as well as subspecialty physicians as our population ages, physician reimbursement decreases, and physician regulation increases. If these projections come to fruition, potential consequences are that future physicians will have to work longer hours as compared to existing physicians or that patients will receive less timely care. Newly proposed ACGME duty hour guidelines do not provide future physicians with the necessary coping skills to deal with these likely future realities.

The majority of academic physicians in direct contact with residents and responsible for their training would agree that the previously instituted ACGME duty hour guidelines have for the most part met one of their core goals by eliminating deleterious resident fatigue. However, they would also agree that incorporation of ACGME duty hour guidelines have failed to demonstrate improvements in patient safety or decreased medical error rates as measured by accepted quantitative metrics. Therefore, institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874, 879-880, and 899-902) are likely to have a nominal effect on patient safety as well as resident fatigue and will likely further erode competency of graduating physicians to work in an unsupervised environment and integrate into a medical community in which they will be required to care for patients over irregular and extended time periods. Because of the above, the University of Wisconsin Orthopedic Residency Training Program strongly opposes adoption of the recently proposed modifications to existing duty hour guidelines as detailed above.

**Name:** Dr. Thomas Zdeblick & Dr. Matthew Squire  
**Organization:** University of Wisconsin Department of Orthopedics and Rehabilitation  
**Affiliation:** organization

I am a 3rd year OB resident at NHRMC in Wilmington NC. After reviewing the maximum duty requirements for PGY 1 (16 hour shifts), I feel this would take away from education. I appreciate the 24 hour shifts that
Maximum Duty Period Length

Comments not in Support

we have done as they are preparing us for how life is going to be after residency. Private OB physicians nationwide are doing 24-30 hour shifts, covering call then clinic the day after. We are getting better prepared for life after residency. Also, for the smaller programs, like ours- 4 residents a year- the 24 hour shifts allow one intern to be off for the weekend. Once we switch to this schedule the intern will no longer be able to have a complete weekend off a month which, in the long run, will be more taxing on them. This may be ideal for programs with 5-6 residents a year, but is straining for the smaller programs. Please take this into better consideration before passing this rule.

Name: Rana Wakim
Organization: NHRMC- OB residency
Affiliation: individual

I think that the current 80 hr/week restrictions are reasonable. However, I think that further restricting and mandating specific hours, especially in the upper levels of training is a dangerous prospect for both patient care and for newly graduated physicians and surgeons. These restrictions basically increase the number of patient handoffs that occur which is clearly a patient safety issue. I also think that it promotes a "shift" mentality in that there is a lack of ownership of patients in that they can be handed off to the next person as their problem. This is very dangerous for patients and is not a concept that should be promoted by medical and surgical educators. Also, it does not adequately prepare newly graduated physicians and surgeons for what "real life" will be like when there are no "shifts" and "caps" on patient loads and with the patient population increasing with healthcare reform, we are setting our next generation of doctors up for failure. The global restriction of 80 hrs is fine to prevent abuse of residents, but programs and residents need more flexibility to be able to train residents without the constraints of the "clock".

Name: Wendy Peterson
Organization: Exempla St. Joseph Hospital General Surgery Program, Denver, CO
Affiliation: individual

To whom it may concern,

Coming from a smaller program, I believe the 16 hour work day for interns will adversely affect all resident levels. As we have 4 per level, the interns will hardly have a weekend off. We have a night float program, leaving only 3 interns available per month to cover weekend call. And if an intern is on vacation, there are only 2 available. Thus, on weekends when an intern is unavailable, second years will have to work more weekends as well as third years...a domino effect. I feel a 24 hour work shift will beneficial, as private OB/GYN physicians often work 30 hour shifts. This will prepare us for that time. I believe interns having 16 hours shifts but with hardly any weekends off will be more detrimental and will lead to higher "burn out" rates. A weekend off makes far more difference to your energy level and quality of life than only 8 hours at a time. Furthermore, if the interns work 16 hours and upper levels work 24 hours, the new intern coming on will be unfamiliar with the service and this could adversely affect the continuity of patient care.

Name: Kimberly
Organization: New Hanover Regional Medical Center
Affiliation: individual

I would like to give you input about the new work hours regulations from the perspective of a medium sized psychiatry program. We are based at an academic medical center, but use 2 additional sites for rotations. Our program has 28 residents, but the number in each class varies depending on how many residents elect to go into a Child Psychiatry Fellowship after their PGY-3 year. Currently, while on psychiatry, the PGY-1 residents average being on call 4 times a month, PGY-2 three times, PGY-3 two times and PGY-4 two times. At our primary site, there is currently always an attending or PGY-4 resident in house, 24 hours a day. I support the proposal to have in-house supervision for PGY-1 residents; the 16 hour shift requirement will have very deleterious effects on our residency program. The net effect will be to increase the total work hours, increase fatigue and impair continuity of treatment. In order to provide adequate coverage, we will need to assign a total of 24 months of night float. PGY 3 residents are not available for night float because they spend the entire year on an outpatient rotation. Unless we require PGY-1 & 2 residents to do 6 weeks of night float in each of their first 2 years, we would have to pull PGY-3 residents out of the OPD to do night
Comments not in Support

float, which would violate the Psychiatry RRC requirement for 12 continuous months of OPD experience, and also adversely affect patient care. In addition, with the night float residents out of the on-call pool, the other residents will take short call more often than is the case for a large program. With the number of months required for night float, it will be very difficult to assure that residents can complete the adult requirements in three years in order to start a Child and Adolescent Psychiatry Fellowship in the PGY-4 year. The other alternative, of putting PGY-4 residents on night float will make recruitment of excellent residents difficult for our program, when compared to larger programs that will not need to have PGY-4 residents take call. Finally, such a system would add an additional patient handoff, increasing the possibility of errors. At this time, while our residents are certainly fatigued at the end of a 24 hour on-call period, in general they feel well rested on psychiatry. In fact, the time they are the most fatigued is when they are on their internal medicine rotation; this rotation operates with a night float system similar to that which would be implemented in order to meet the new requirements. The new requirements pose almost insurmountable difficulties for small to medium sized programs, and are rather perplexing. Why the decrease in work hours for interns if they are well supervised? Rather than diminishing fatigue and stress on interns, it would increase the fatigue and stress of all residents in our program by increasing the total number of hours worked per week and reversing the trend of having less on call as the residency progresses. The only feasible solution would be to increase the size of our residency program. With the current health care financial crisis in New York, support for additional resident lines will not be forthcoming from our institution. If such hours are mandated, it will cause significant difficulty unless there is financial support for additional residency positions, or specialties or smaller programs with reasonable on call schedules and work hours are able to receive an exemption. I hope that you will reconsider a policy change that will have the opposite of the intended effect, and may force the closure of smaller programs that are unable to meet these requirements at a time that medical school enrollment is increasing.

Name: Wendy Thompson, MD
Organization: New York Medical College at Westchester Medical Center
Affiliation: individual

The above citation refers to a study of surgical residents comparing their surgical outcomes between being "rested" i.e. operating during the day, and "tired" operating between 10 pma and 6 am. Guess what, no difference. What data is there to support better outcomes if trainees get to sleep at night? Where is the outcome data to suggest that medical errors are reduced with enforced "naps". With all these restrictions on hours, i have noticed a decline in the work ethic, the professionalism, and patient care, especially with the increased number of hand offs (please see NEJM earlier this year on this issue of inc hand off). As a physician educator, I don’t see the data to support these changes, and see degradation in the way physicians see themselves, and in how our pts see us.

Name: Pamela Karasik, MD
Organization: individual

While the proposed 16-hour time limit for PGY-1 residents is surely well-intended, the effect that this will have on small- to medium-sized community programs will be significant, as they lack the resources of larger hospitals; it may mean that some services may not be provided to the extent they are now. This will come at significant expense to these hospitals. I realize that this alone is not a sufficient reason to revise the proposed requirements.

However, I would have no problem with this at all if there was evidence to support improved outcomes. To my knowledge meaningful data does not exist. On the contrary, my feeling is that 16-hour shifts would increase the number of "handoffs" with the potential to create more problems than it solves.

It is difficult enough to train a competent internist in three years. It is becoming increasingly challenging to do so with stricter duty hour requirements. I am a proponent of good supervision, but fail to see how is this preparing clinicians for "life on the outside" when they graduate and face work loads which are out of proportion to what was allowed during residency.
## Maximum Duty Period Length

### Comments not in Support

The current 24 hour cycle is adequate in my opinion. Further restriction will make it difficult for smaller programs to provide services, at a time when GME funding is an issue and a shortage of primary care physicians is an ever-enlarging problem.

**Name:** J. Matthew Neal  
**Organization:** Ball Memorial Hospital  
**Affiliation:** individual

The 16-hour rule for PGY1s translates into 12 hours plus 4, the equivalent of 24 plus 4 for PGY2s and above. In essence this rule invokes a 12 hour shift on the resident team to facilitate smooth transition of patient care. Having PGY1s leave at odd hours from the hospital to get to their transportation may put their personal safety at risk. No duty hour provisions are made for the PGY1s to begin the transition from PGY1 to PGY2. What “magically” occurs on June 30 to prepare the PGY1 for July 1 and 24 hour duty? Overall upper level residents will be taking more call and the customary lighter rotations and electives will likely be eliminated, resulting in a more fatigued group of residents in the aggregate.

**Name:** Bill Metheny  
**Organization:** Grad School Med - UT Knoxville  
**Affiliation:** organization

I am concerned that limiting PGY-1 trainees to 16 hours will lead to much more of a shift mentality than already exists in residents. It is very likely that interns will work 12 on, 12 off for 6 days a week. Much of the year will be working shifts at night when teaching is not at a premium. On the other hand, I fully agree that physicians should not work 24 hours in a row and I would absolutely embrace a nationwide change to ALL physicians, not just PGY-1’s.

**Name:** David Congdon  
**Organization:** Puget Sound Family Medicine Residency  
**Affiliation:** individual

I feel that intern and resident duty hour limits on duration of continuous posting should be identical. Both should be 16 hours, plus four to engage in hand-offs. Keeping resident-intern teams is very important for intern development. Our experiments with dissociation of intern and resident team schedules has resulted in less "ownership" of intern supervision by residents - I feel sleep deprivation is an equal opportunity impairment and residents are no more immune than interns. I also feel that naps are difficult to mandate and monitor. Programs experimenting with nap-terns have felt them to be unsuccessful. Our residents find this rule distressing and they frankly mock it. As a program director committed to compliance with the new rules, I feel that residents should be scheduled to be awake while on duty and will try to avoid the nap option.

**Name:** Dominick Tammaro  
**Organization:** Brown Medical School  
**Affiliation:** individual

The Proposed 16-Hour PGY-1 Shifts Will Restrict Learning

I completed my internship about one month ago. As identical as my co-interns and I may have seemed at the beginning of the year, nothing became clearer throughout the year of working together than the heterogeneity of learning styles among us. To have limited this heterogeneity would have been to stifle the tools that had enabled us to get as far as we each have in our budding careers. Education can only be circumscribed to a point, after which the methods of individual learning are compromised. Restricting PGY-1 shifts to 16 consecutive hours, as proposed in the 2010 ACGME Requirements, overly limits training environments in a profession where the variety of educational processes should reflect the varied learning styles of those being trained.

Ultimately, the real-world strains imposed upon physicians emotionally and physically will stem from the myriad of demands other than the length of continuous duty that dominates these proposed regulations. The effort to micromanage resident schedules limiting PGY1 shifts to 16 hours—for which there is little
Maximum Duty Period Length

Comments not in Support

evidence of decreased emotional, physical or psychological strain—compromises the broader urgency of residency programs to inculcate professional responsibility while allowing for variety in the process by which physicians-in-training can choose to learn. For some, these goals are better achieved by the physician-roles, team dynamic and the continuity afforded by resident teams structured around overnight intern call. This can involve working greater than 16 hours, but in what can be very supportive, educational, and closely monitored environments. Preserving the ability of residency programs to offer educational structures that not only reflect but also encourage the varied learning styles of each new batch of doctors is an educational imperative that is unjustifiably restricted in proposed ACGME requirements as they are currently written.

Name: Geoff Tison
Organization: Johns Hopkins Hospital
Affiliation: individual

Regarding "In unusual circumstances, residents may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extension of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must: a) appropriately hand over the care of all other patients to the team responsible for their continuing care; b) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director must both review each submission of additional service, and track both individual resident and program wide episodes of additional duty." I feel this is impractical and will promote resident non-compliance - either reluctance to report or reluctance to stay when necessary. Please consider re-formatting this requirement so as to permit us to monitor this practice in our routine duty hours monitoring. I am confident that such monitoring, especially if anonymous, will lead to better compliance by residents and will be ample disincentive against abuse by program directors. If this rule stands, our plan is to set up a web-based form for residents to use with space for their name, date, description, etc. but I worry that no resident will use it and the rule then becomes ineffective due to its burdensome nature. The goal is to track and characterize such events so as to address whether they are justified or reflect a schedule which promotes such overtime. I think this will be hard to do in the current format of the rule.

Name: Dominick Tammaro
Organization: Brown Medical School
Affiliation: individual

I believe that the new guidelines would be a mistake because of several reasons, as far as duty hours are concerned. First, it would be interns would be on call much more often. This would lead to a lower quality of life. Second, this would lead to increased mistakes made in patient care due to increased amount of shift changing. The research has been done to show that most mistakes are made during check-out. Third, there would almost certainly need to be an increase in the overall length of residency duration. There would be less ability for interns to get procedures in during their first year leading to an increased number of senior residency with inadequate numbers to graduate.

Name: Richard Thompson
Organization: NHRMC- OB residency
Affiliation: individual

A weekend off is something that residents value highly. With the new duty hour restrictions, residents in smaller programs may never see a day off. These breaks are important for regrouping, taking a break, and spending time with family.

Name: Molly Kirkhary
Organization: New Hanover Regional Medical Center OB/Gyn Residency Program- R1
Affiliation: individual

This seems contradictory, different rules for different levels. This has the potential to generate different start
<table>
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<td>times for different residents and perhaps even services. For those of us who must work with the schedules of operating rooms, outpatient clinics, etc, this will be a nightmare. It will erode teamwork. You have created excessive documentation. I will spend valuable time &quot;documenting&quot; when I could be facilitating a residents education.</td>
</tr>
</tbody>
</table>
| **Name:** Richard Bell  
**Organization:** USC  
**Affiliation:** individual |
| This is absolutely asinine. In an age where we practice evidence based techniques, we are assuming that decreased hours will improve patient care. There is absolutely no proof that decreased hours works. Nonetheleess we do this anyway. Just keep in mind that patient handoffs are where the errors happen and there is NO WAY to formalize them to make it better. |
| **Name:** Russell Ingram MD  
**Organization:** Resident - Great Plains  
**Affiliation:** individual |
| As Program Director, I would like to first say that I really like the exception to stay longer at the residents discretion if there is a real clinical or educational value that they would otherwise miss. That is exactly right! Nice Job!  
As for the restriction on duty hours, I am opposed to all of the suggested restrictions in this section. I feel the current restrictions are good enough. This is based upon the 15-20% of people who decline in cognitive function after 16 hours. I would suggest that this be entrance criteria to medical school, that if you cannot be awake and alert enough to function after 16 hours then you cannot be a physician, much like a person that cannot lift more than 20 pounds cannot be a firefighter. It is just a requirement for the job.  
I feel this further truncating of clinical experience will be leaving physicians unprepared for practice and as a patient, I do not want my physician to be undertrained or not capable of working in teh middle of the night if i need help during that time. It will also further increase hand-offs and there is no curriculum in the world that can fully mitigate that.  
I am also concerned that these changes are based upon supposition and not actual evidence that sleep deprivation causes more errors. studies have shown that the number of errors is the same before and after the duty hour changes. I understand that the argument is that we haven't gone far enough. I would say that we should never be afraid of doing what is right because some organizations will ask that the duty hour restrictions be legislated. A discussion on capitol hill is not the end of the world. in fact it would allow us to have our day in the sun and perhaps get more exposure and resources devoted to training physicians. We can win this battle as no one wants an untrained doctor or one who cannot perform at all hours of the day.  
The idea of a "strategic nap" is ludicrous and surely those that drafted the req's must have known that and been trying to be funny. I seriously doubt most residents would actually nap then and it would again cause more hand-offs. Also, how can you state that we need to train residents to be able to operate under duress and when somewhat tired and then not allow them to train in a fashion that would allow them to be actually trained to do it. This makes no sense.  
Leave well enough alone. Stick up for our residents and their educations. This is one of your jobs and you are failing at it by submitting to every half-witted idea that comes along. Better yet, do some pilot studies with a few programs and the proposed duty hours and some other models of ensuring fatigue is mitigated and then see which one is best. Why rush into anything. There is no reason to do so. PLEASE do what is right for residents and patients. What you have proposed is not in either's best interest. |
| **Name:** Allen Last MD, MPH  
**Organization:** Univ Wisconsin - Fox Valley Family Medicine Residency  
**Affiliation:** individual |
**Comments not in Support**

Cutting the work hour length may have several negative effects on education and patient care.

1. It will increase the number of hand-offs, which is already demonstrated to harm patient care.
2. Interns will have less exposure to acute decompositions and a wide array of conditions over the course of the year, but they will be expected to manage these situations and lead a team after completing their intern year.
3. The 16 hour rule will be addressed by some institutions with having interns work 16 hours through the night or on varying shift work schedules which can be just as taxing and have been associated with large numbers of errors as well.
4. Residencies in internal medicine will need to be increased to 4 years as exposure will be limited even more than it is currently.

**Name: Gary**  
**Organization:**  
**Affiliation:** individual

I am writing to you as president of the Society of General Internal Medicine (SGIM) to provide comments regarding the ACGME Quality Care and Professionalism Task Force Proposed Changes for 2011.

SGIM is an organization of approximately 3000 general internists nationwide who teach medical students and resident physicians, who conduct research on healthcare delivery and education, and who provide care to patients in outpatient and inpatient settings. Our membership includes many leaders in academic medicine and individuals who also play important roles in other professional societies and their communities.

SGIM strongly endorses the need to address key features of the learning environment beyond duty hours, in particular VI. A) Professionalism, Personal Responsibility and Patient Safety; VI. B) Transitions of Care and VI. F) Teamwork. We applaud the ACGME’s efforts to bring attention to these critical areas of medical education and encourage professional societies to work collaboratively to advance these currently underrepresented topics in residency education.

Regarding all of these three areas of medical education, our organization feels strongly that consideration must be given not only to learning and responsibility in traditional inpatient environments but also to transitions, professionalism and teamwork in outpatient settings. Clinical assignment strategies required by the changes in duty hours (in particular VI.G.4a. “16 hours for interns” VI.G.5a “10 hour break”) must not adversely impact education in one arena to allow for duty hours to be met in another.

Given the comprehensive nature of the proposed changes and the financial implications of duty hour reforms, SGIM most strongly believes that the timeline for mandatory implementation must extend beyond the proposed July 2011. It is our concern that a July 2011 deadline will not allow for mobilization of the financial resources needed to successfully implement these duty hour and comprehensive curricular changes.

Additionally, there is substantial risk that programs will design systems that meet the reduction in shift length (in particular VI.G.4a. “16 hours for interns” VI.G.5a “10 hour break” and VI.G. 6”no more than 6 nights of consecutive night float”) at the expense of educational opportunities for residents. In particular, this deadline will not allow for programs to share strategies, and for national organizations, such as ours, to facilitate this process. Lastly, this deadline will not allow for identification of outcome measures and evaluation strategies in advance of the changes. It is imperative that outcomes related to patient care and education are identified and measured so that they may inform any future changes. Systems to closely monitor financial impact of the changes as well as to monitor for other potential unintended consequences must be put into place. ACGME should commit to re-evaluation of the changes based on this data in a 3-5 year horizon.

Therefore, on the behalf of the members of SGIM, the council and I urge you to strongly consider our comments.

**Name: Kay Ovington**
## Maximum Duty Period Length

### Comments not in Support

**Organization:** Society of General Internal Medicine  
**Affiliation:** organization

I believe limiting interns to a 16 hour shift is detrimental to learning for an intern and for patient care. For one, the most learning comes from admitting a patient overnight and discussing the patient on rounds. This cannot happen within 16 hours. Second, a 16 hour shift mandates at least 2 handoffs daily. On a 30 hour shift, one intern is present for rounds to hear the plan, overnight to care for the patient, and the next set of rounds to discuss the events and how decisions were made. That continuity is priceless.

**Name:** Lori Kestenbaum  
**Organization:**  
**Affiliation:** individual

16 hr max length shift is neither realistic or practical. Being an unopposed family medicine residency, we will end up making the residents work more days per week because of the “shift work mentality” that this will cause. The entire group of 18 residents here is completely opposed to this idea. They always have the option to go home or rest if needed, but if not needed they would rather work a longer shift rather than have to work 6 days a week which this rule would result in. Also, there is no evidence that shortening the shift will improve patient outcomes, but it will increase the frequency of patient hand-offs which we know is a safety issue!.....and if we do the rest of our decision-making based on evidence based medicine, then why don’t we make our policy decisions based on the same standard? Media should not be deciding our policies, we should !!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!! In real life I have to work all day, be on call all night, and then go to the office the next morning. Having to do that in residency made me more prepared to do it in real life. Again, this has worked fine for our residency, and I see no good reason to arbitrarily change a policy that is working well. Less patients will be seen, which is NOT what we are seeking in health care reform these days. I am a Program Director, and I am really, really busy. I do not need more to do...as a matter of fact, I do way too much already. I certainly think exceptions need to be tracked, but I would leave it to the residency to determine who in the organization tracks it, and not force it on the Program Director.

**Name:** Don Beckstead MD  
**Organization:** Altoona Family Physicians Residency  
**Affiliation:** individual

The American College of Surgeons supports the ACGME requirement that recognizes the need for intermediate-level and senior residents to remain beyond their scheduled period of duty to continue to provide care to a patient under unusual circumstances. This should serve patients well and support the education and training of residents to handle complex situations.

The American College of Surgeons also supports the ACGME requirement that permits intermediate-level and senior residents to remain on site for periods of up to four additional hours beyond the 24 hours of continuous duty to ensure effective transitions of care. The recommended use of alertness and fatigue management strategies is appropriate.

The American College of Surgeons would like to express very grave concerns regarding the limit of 16 hours of duty placed on PGY-1 residents. This limit will result in a negative impact on patient safety and continuity of care unless there is a substantial increase in human resources to replace the residents. The 16 hour requirement is likely to result in transfer of work from PGY-1 residents to intermediate-level and senior residents which will increase their burden and could negatively impact patient care. Even with additional resources, the requirement essentially mandates use of night float systems, which may not be appropriate for certain residency programs and are not the best way to educate residents. The restriction will also be disruptive to the structure of residency training in surgery because of the need for frequent transfers of care with the associated risks to patient safety. The 16 hour requirement will reduce the operating room experience of the PGY-1 residents, thereby negatively impacting their preparation for subsequent years of training. Also, the strict limit will most likely have the unintended consequence of eroding residents’ professional commitment to their patients, as young trainees will not learn the value of using their...
### Maximum Duty Period Length

#### Comments not in Support

Professional judgment to stay longer to deliver optimal care to patients. Finally, this restriction will postpone the development and process of acclimation of PGY-1 residents to the demands of the more advanced years of residency training.

**Name:** David B. Hoyt, MD, FACS  
**Organization:** American College of Surgeons  
**Affiliation:** organization

Certainly I am aware of the already reduced hours compared to when I trained, and the changes that are in place currently I am mostly in favor of. It gets to the point however, where the proposed changes become ludicrous to the point that a residency program becomes day camp, with naptime. What happens when they become attendings and have to learn how to deal with a busy inpatient census? I am a core faculty member; 16 hours then a nap? Heck, I want naptimes built into my schedule. Some of the changes proposed are downright need to be re-thought to ensure that they have the time to put into a clinical experience. Otherwise, it will be a culture shock when they become true "attendings." I have to stop now. It is time for my nap.

**Name:** Dr. Rich Snyder  
**Organization:** Easton Hospital  
**Affiliation:** individual

I disagree with the limit of continues 16 hours of work for the PGY-1. The most junior and young member of the team, that has the most of energies and physical strength, and the one that need the most of time to perform the duties (because is less efficient than the other residents) should work less!?!?! This does not make sense to me. I remember that as PGY-1 it took me twice as long to write a note, or to find the pertinent information from the chart of a patient than now that I am a senior resident. I really believe that with this rule, we do deprive these residents from the possibility to use their most youngest years when they are full of energy and want to learn and gain the needed experience. In 16 hours they will be able to see far less patients than in 24. It will take for them longer times to figure out what they need to know about a patient, and so they will see less patients and gain less experience. I think they should work the same work hours as everybody else, to be able to gain the needed experience.

Naps? As much as I think this is not a bad idea, I wish everybody luck with this on having the nurses not call the resident on duty for 15 minutes, or having the patients not present to ER, or not wrecking their car for 15 minutes because this is the time when the resident in-house on night duty is taking a nap. I believe that if this is to be implemented, everybody in the hospital should be involved. With this I mean, that the nursing staff should reduce calls to the resident on call at a minimum during the night. Most of the issues that a resident is called, can be resolved in the morning, or the nurse supervisor for the ward can triage the calls to the residents to those that need immediate attention, and defer those that do not need immediate attention for the next day. The same should work with ER physicians, and everybody involved in the patient care during the night.

**Name:** Mateo Ziu  
**Organization:** UTHSCSA  
**Affiliation:** individual

Limiting PGY 1 to a maximum of 16hrs duty makes practical application of this problematic. For example we use a night float system which I suspect more programs are using. But even the night float needs to have 24 hrs period off per these regulation. Therefore during this time period, when night float is off either the program use a "second" night float to cover the day/days the primary night float is off or use traditional 24 hr coverage to cover this period. Smaller programs do not have the warm bodies to cover this period due to night float rotation limits set by your organization. The other option is to have a traditional 24 hr coverage with senior and intern for 16hrs then send the intern home and cover the remaining 8hrs with the senior only which is not optimal, if during that 8hrs patient volume or acuity increases. It would be more practical to allow the intern to stay for the 24hrs and then decrease the transfer of care time to allow the night coverage team to go home sooner.
Maximum Duty Period Length

Comments not in Support

Name: Atul Singh  
Organization: WVU/Charleston  
Affiliation: individual

These restrictions increase the number of handoffs that a patient has, and greatly diminishes the sense of direct responsibility that a resident has toward a given patient -- the feeling that the patient is “my” patient and I am responsible for what happens to him or her. This will have a gravely negative impact on patient care in future years, and in my view is a serious mistake.

Name: David Kimberlin  
Organization: UAB  
Affiliation: individual

I disagree with the limit of continues 16 hours of work for the PGY-1. The most junior and young member of the team, that has the most of energies and physical strength, and the one that need the most of time to perform the duties (because is less efficient than the other residents) should work less!?!?! This does not make sense to me. I remember that as PGY-1 it took me twice as long to write a note, or to find the pertinent information from the chart of a patient than now that I am a senior resident. I really believe that with this rule, we do deprive these residents from the possibility to use their most youngest years when they are full of energy and want to learn and gain the needed experience. In 16 hours they will be able to see far less patients than in 24. It will take for them longer times to figure out what they need to know about a patient, and so they will see less patients and gain less experience. I think they should work the same work hours as everybody else, to be able to gain the needed experience.

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Name: Mateo Ziu  
Organization: UTHSCSA  
Affiliation: individual

I think that limiting the consecutive duty hours for interns is likely to drastically limit their exposure and experience during their intern year. For most specialties, the intern year is a year dedicated to learning and building a foundation of essential skills and knowledge. This foundation is then expanded upon during more senior years, but this expansion is not possible unless the building blocks have been formed.

Many services function on a 24 hour call system, and if the interns are allowed to participate in only 2/3s of that, they will miss out on many learning opportunities. By limiting the amount of time the interns are able to work when they are being directly supervised and taught by upper level residents or attendings, it will make them less prepared for their upcoming years.

Furthermore, for the many services that function on 24-hour call system, limiting the amount of consecutive intern hours will result in either there being less hours in the day where an intern is available to help (thus increasing the work load and responsibilities for the upper level resident) or more frequent change over of team coverage (and thus less continuity of care).

Either way, I feel that limiting intern consecutive hours will have two predictable outcomes:

1- The interns will be less prepared for their upcoming years, when they are given more autonomy.
2- Patient care will be affected because of higher workloads on upper level residents and/or less continuity
Maximum Duty Period Length

Comments not in Support

Name: Mary Herzog  
Organization: GRMEP  
Affiliation: individual

While recognizing the debate and conflicting data present regarding maximum duty periods, there is concern that limiting interns to 16 hour shifts may lead to a significant negative impact on the development of the resident from an educational standpoint. Much of what is learned occurs as the course of a patient is followed closely over time. Even the loss of 8 hours time may have a deleterious effect. Furthermore, in order to rise to the next level and be responsible for a 24 hour period, lack of experience in working that time may lead to a difficult transition and may result in graduating residents not acclimated to what will be experienced as independent practitioners.

There is also concern about the rapidity of this part of the proposal on top of the supervision requirement. With less than 1 year from the time the formal decision is made to the time of implementation, there is grave concern that institutions will not be in a position to comply in such short order. Consideration should be given to phasing in this component after the supervision provisions take effect July 2011. A period that would make this particular change live 1 year later (2012) would be a prudent approach.

We strongly support the recognition that unusual circumstances do exist for exceeding designated hours and feel the oversight proposed is appropriate. We also support the recognition that residents in their last year need to start the transition to independent practice and are given further supervised leeway as well.

Name: Richard Liebowitz  
Organization: New York Presbyterian  
Affiliation: organization

I feel that the proposed work hour restrictions would limit continuity of care. In order to implement the changes, the intern schedule would be quite disjoint. I would recommend keeping the 24 hour limit with the proposed break time, although this would be difficult to regulate.

Name: Zachary Zwolak, DO  
Organization: St. Luke's Family Medicine  
Affiliation: individual

As a residency program director in Pediatrics for almost 20 years in New York State, where there have been stricter work hours in effect, I am very concerned about the impact of 16 hr shift limitations for interns. Much of the learning in residency comes from following patients closely during the first day of their hospitalization and from the sense of personal ownership and responsibility for your patients. Moving towards shifts dilutes this sense and takes away valuable learning time. In addition, the multiple transitions this new type of schedules imposes will actually make patient care less safe rather than improve it.

Name: Elizabeth A Wedemeyer MD  
Organization: NYP-Morgan Stanley Children's Hospital  
Affiliation: individual

For residency programs, such as Ob/Gyn, E-med, and Anesthesia, which have 24/7 in-hospital ATTENDING LEVEL supervision, the 16 hr / shift rule is unnecessary. We are already CLOSELY supervising our PGY1s (as well as our upper level residents) to minimize error and ensure patient safety and thus should not be subject to this rule. It also disrupts continuity of care and increases the risk for errors due to multiple hand-offs.

Name: Jessica Bienstock  
Organization: Johns Hopkins University Ob/Gyn  
Affiliation: individual

1. Remove the 16 hour restriction for the second six months for an intern.  
- Devastating for faculty and supervision (especially in small programs). We are at HIGH risk for losing faculty if this goes through (since we cannot use residents, we are too small) and in real danger of shutting
Maximum Duty Period Length

**Comments not in Support**

- Intern learning. Should they really be experiencing full call with pages, admissions, calls WHILE SUPERVISING the new intern for the first time too?
- Patient care numbers for admission. We are discussing adding a full year onto family medicine residency. Of course, this would not make us attractive to residents if other programs do not (Primary care is already facing shortages, please be careful to not add to that “motivation” as you are trying to do a good thing.

**Name: Natascha**  
**Organization: Hendersonville Family Medicine Residency**  
**Affiliation: individual**

There should be no differentiation of how long a person has continuous duty based on their PGY status. Limiting PGY 1 residents to 16 hour shifts will create less free time off for PGY 1’s, more shift working and swing shift scheduling to manage educational rotational coverage, and less free time for PGY 2 and PGY 3 residents who will have to cover for the PGY 1 resident during their time off. Instead of averaging 80 hours (some weeks with only 45 to 60 hours) with at least an 18 hour period of time off duty post call and 1 to 2 complete free weekends a month, PGY 1’s will now be pushed to work 80 hours a week with only a 24 hour period of time off. Their rotations will unfortunately include many more night float type rotations. In a specialty like Family medicine, where our residents rotate on other specialty services, I fear that our residents will be utilized to fill such roles. An aspect of the resident duty hour debate is concerning patient safety, and personal health. Yet this limitation on PGY 1 residents will actually create worse situations for both. It increases patient care transitions and it reduces over all time off thus free time for physical activity, family interaction, and personal reflection.

**Name: Mitch Shaver, M.D.**  
**Organization: Marshall University Family Medicine Residency**  
**Affiliation: individual**

This is where my problem with the council's proposed changes really lies. It is completely ridiculous, even ABSURD to cut back interns' work hours by nearly 50% (30h to 16h) & then turn around and expect them to function efficiently and well as an upper level resident. Not to mention all of the inherent scheduling difficulties and service obligations that a 50% reduction of intern work-hours places on programs. We will be foisting even more responsibility on our senior residents, who, after next year, will be senior residents who have only ever worked 16 hours at a time. Again, this is completely absurd. We will no longer be teaching interns to function independently and think on their own, we will be teaching them to merely survive their 16 hour shift (because that's what residency will become, shift work) until they can leave & their upper level residents can take over.

I don't disagree that 30 hours is too much time for continuous duty, and cutting back on resident duty hours is certainly warranted. However, I don't know where this 16 hours rule came from. Even if that's the eventual goal, it is much, MUCH more realistic for the council to recommend cutting back on work hours gradually, over a number of years. I think making this 50% jump in the span of less than 12 months places too much of a scheduling burden on programs, programs that quite frankly must adjust their entire training infrastructure to comply. I am a future chief in my program, and I have spoken with multiple people on multiple levels regarding this recommendation, and it is no exaggeration to say that not one person has thought that only 16 hours for interns is a good idea. Not even the current interns. The council needs to think seriously about this recommendation, and try to formulate options to help programs of all sizes come up with scheduling plans that will comply, if indeed it is the council's intent to formalize this recommendation.

**Name: Meagan ONeill**  
**Organization: Indiana University Pediatric Residency Program**  
**Affiliation: individual**

VI.G.4. Maximum Duty Period Length. The IMA believes that restricting PGY-1 residents to 16 hours maximal duty periods to be overly prescriptive. Again we can appreciate the balance that the ACGME is trying to develop with progressive responsibility of resident training but this restriction in terms of how residents work will only increase problems with transitions of care and turnover of care to multiple providers
Maximum Duty Period Length

Comments not in Support

who do not know that patient. We are concerned that this may actually increase medical error rate and not
relieve it. “There is a burgeoning literature on medical errors as a result of handovers. Over 2,500 articles
were researched in the cited review. As a state appointed committee, we are very concerned that you have
not taken into account the additional risks to patient safety that will result from the increased number
of handovers.” [1] [1] We would request that this provision be struck in the ACGME work hours requirements
and have it return to a 24 hour period of time with 4 hours to complete duties before going home.

VI.G.4. (b). (2). Continuity Clinics. The provision of having residents not attend continuity clinics after 24
hours of continuous in house duty is overly prescriptive. Many times this is the best way to ensure continuity
clinics are occurring. We certainly understand the spirit of this is that an exhausted and tired resident may
not be at their best post-call to see continuity patients. However many call nights are such that residents get
adequate amounts of sleep and certainly are functional post call to see a continuity clinic before going
home. Our concern is that upon graduation these residents will become fully credentialed physicians
working post call in continuity clinics as a matter of necessity. We believe residency programs should help
shape this experience so that it can be effectively demonstrated before the resident graduates.

Name: Ron Hodge
Organization: Idaho Medical Association
Affiliation: organization

Due to the restrictions of PGY-1 duty hours, interns will not be prepared to enter the work duty hours
expected of them in the PGY 2-5 years. Working shift work during the intern year will not allow interns to
fully understand and follow the scope of disease processes. Intern shift work will increase the number of
check-outs increasing the risk of mistakes, affecting patient care. With shift work, interns will be missing
rounds, the period of time when patients are discussed in-depth and teaching is performed. Interns will be
missing a lot of didactic teaching, if shift work is required. We suggest that the intern shift coincide with the
senior shifts with a maximum work duty of 24 hours.

Name: Amanda Pennington
Organization: MUSOM
Affiliation: individual

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Name: Awni Al-Subu
Organization: MUSOM
Affiliation: individual

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missing a lot of didactic teaching, if shift work is required. We suggest that the intern shift coincide with the
senior shifts with a maximum work duty of 24 hours.

Name: Kelli Brown
Organization: MUSOM
Affiliation: individual

Some general remarks, pertaining to duty hours and other aspects of the proposed standards:
Maximum Duty Period Length

Comments not in Support
We are also concerned for smaller programs that will not be competitive in the recruitment process because of the restrictions placed upon them by these new standards.

An overarching concern is the "one-size-fits-all" nature of the proposed standards. While these standards may be necessary and more functional such as medicine or surgery, they do create significant logistical problems in smaller specialties such as psychiatry.

Name: Susan Stagno, MD
Organization: University Hospitals Case Medical Center
Affiliation: individual

Patient care transitions can lead to medical errors. Based on the available evidence, it would seem that limiting PGY-1 shifts to 16 hours may contribute to medical error by increasing transitions of patient care, without compelling evidence that the reduction in hours would improve patient safety.

Name: Kyle Griffin, MD
Organization: Cox Family Medicine Residency
Affiliation: organization

In discussing this with our current PGY2 residents who have just completed their first year of training, they have given me the feedback that they expect to work hard and put in longer hours during their first year, and find this a useful educational experience. This "immersion" experience, they feel, is valuable in gaining confidence, and accruing skills required for the remainder of their residency. Because of the number of educational activities we have occurring during the day, many residents who are post-call are missing out on the continuity of patient care conferences, and educational programs that build from one presentation to the next. This has been a concern expressed by both residents and faculty. In general, the issue of tight restrictions on duty hours appears to convey the message that medicine can be practiced in "shifts". While we certainly recognize that some of our specialties such as emergency medicine, do function in this way, most do not. The issue of erosion of a sense of individual responsibility toward the patient, and overall professionalism, is a significant concern.

Name: Susan Stagno, MD
Organization: University Hospitals Case Medical Center
Affiliation: individual

I am strongly opposed to having different duty hour limits on different classes. Our residency covers a labor and delivery floor, 24-hour shift at a time. This works well. No one is ever on more than Q3 and I appreciate having a nice post-call day each time I'm on call. If our interns could only work 16hrs at a time, we would have to go to a 12-hour shift which would fragment personal time and double the number of patient hand-offs. This would also disrupt continuity as labor often takes longer than 12 hours.

Name: Randall Pace
Organization: ISU Family Medicine
Affiliation: individual

In discussing this with our current PGY2 residents who have just completed their first year of training, they have given me the feedback that they expect to work hard and put in longer hours during their first year, and find this a useful educational experience. This "immersion" experience, they feel, is valuable in gaining confidence, and accruing skills required for the remainder of their residency. Because of the number of educational activities we have occurring during the day, many residents who are post-call are missing out on the continuity of patient care conferences, and educational programs that build from one presentation to the next. This has been a concern expressed by both residents and faculty. In general, the issue of tight restrictions on duty hours appears to convey the message that medicine can be practiced in "shifts". While we certainly recognize that some of our specialties such as emergency medicine, do function in this way, most do not. The issue of erosion of a sense of individual responsibility toward the patient, and overall professionalism, is a significant concern.
The following comments are excerpted from our letter. Please see this letter for further details on how these comments relate to our overall response:

As we have discussed in this letter, achieving the primary goals of residency requires consideration of both the quantity and quality of duty hours. Long hours can compromise patient safety, resident safety, and resident learning. However, cognitive overload, excessive workload, time spent in marginal activities, poor supervision, and other components of the quality of duty hours can also hinder patient safety, resident safety, and resident learning. It seems that these considerations of the quantity and quality of duty hours are magnified the greatest for interns. This leads to the critical question: How do we balance these factors in the ideal design of the intern working and learning environment?

We appreciate the Task Force’s discussion in its Impact Statement regarding this Proposed Standard [14]. This discussion clearly delineates the struggle the Task Force must have had with formulating this standard. Given that an ideal answer is difficult to define, it seems that this Proposed Standard is perhaps one in which reasonable people with the same intent can disagree. Does one limit hours at the cost of achieving optimal cognitive loads and workloads or limit cognitive loads and workloads and maintain longer consecutive working hours? Which optimizes resident education and safety as well as patient care and safety now and in the future?

The AAP SOMSRFT does not support the Proposed Standard to limit consecutive intern duty hours to 16 hours. We believe this Proposed Standard will negatively impact patient safety and resident education, rather than enhance either of these primary goals of residency training.

Clearly, it is not in the best interest of patient safety and resident safety and education to have interns work excessive hours. However, it is also not in the best interest of intern education to limit their hours too much. Limitation of intern hours poses the following risks, many of which are supported in the literature:

- The inability to follow a patient for an extended period of time, greatly limiting resident learning. The importance of following a patient’s illness course as it unfolds is especially important for early learners as well as in the initial hours of a patient’s admission.
- The adoption of a shift work mentality in which intern ownership of and investment in patients is not facilitated, leading to detriments in patient care and safety as well as in resident education [27].
- The compression of more information and work into less hours in conjunction with increased work intensity [27, 28], which is most harmful to less experienced learners whose cognitive load and workloads are already elevated, fragile, and tenuous.
- The creation of odd shift schedules that do not facilitate normal non-duty hours to enjoy daytime life outside of work and prevent burnout, including spending time with spouses, children, and friends.
- The participation in less didactic teaching on rounds, which negatively impacts resident learning as well as patient care and safety. Furthermore, the inability to receive direct feedback on decisions made during call while on rounds inhibits professional development in clinical competence because “the acquisition of superior performance in medicine is closely related to engagement in practice with feedback during medical training.” [29]
- The inadequate preparation of interns to become supervisory residents due to lack of clinical experience.
- The potential for increased transitions of care depending on the manner in which programs structure a schedule with limited intern duty hours [27].
- The participation in less formal educational activities of the program [24, 27].

With these concerns in mind, the AAP SOMSRFT believes that consecutive intern duty hours should be limited to 24 hours and that interns should be allowed to remain on their clinical duties for four additional hours after 24 hours of work to ensure adequate transitions of care as well as to enhance learning and patient care. Recognizing the evidence to structure the intern working and learning environment differently
Maximum Duty Period Length

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Name: Dan Schumacher  
Organization: American Academy of Pediatrics Section on Medical Students, Residents, and Fellowship Trainees  
Affiliation: organization  
Please recommend NOT applying the 16 hr limit to PGY -1s in OB/GYN. With 24 hour in-house attending coverage and direct supervision of all procedures and labor commonly not being a 16 hour process, we would sacrifice important learning continuity by limiting the PGY-1 exposure in this way. Please recommend NOT applying the “no averaging” clause to q 3 night call frequency. Resident should be able to do an occasional “every other” with the averaging disallowing more than an average of every third. In restricting this significantly limits schedules especially in small programs when residents take vacation or education time. |

Name: Leslie E. Robinson  
Organization: York Hospital (WellSpan Health System)  
Affiliation: individual  
The following comments are excerpted from our letter. Please see this letter for further details on how these comments relate to our overall response: |

As we have discussed in this letter, achieving the primary goals of residency requires consideration of both the quantity and quality of duty hours. Long hours can compromise patient safety, resident safety, and resident learning. However, cognitive overload, excessive workload, time spent in marginal activities, poor supervision, and other components of the quality of duty hours can also hinder patient safety, resident safety, and resident learning. It seems that these considerations of the quantity and quality of duty hours are magnified the greatest for interns. This leads to the critical question: How do we balance these factors in the ideal design of the intern working and learning environment? |

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With these concerns in mind, the AAP SOMSRFT believes that consecutive intern duty hours should be limited to 24 hours and that interns should be allowed to remain on their clinical duties for four additional hours after 24 hours of work to ensure adequate transitions of care as well as to enhance learning and patient care. Recognizing the evidence to structure the intern working and learning environment differently than the senior environment, we believe the best way to ensure optimal patient and resident safety as well as resident education from an intern perspective is to improve the quality of intern duty hours. For us, this includes ensuring optimal cognitive loads and workloads through standards such as the limitation of patient loads and admission volumes in defined time periods, minimizing work of marginal educational value, and ensuring optimal supervision.

We recognize the incredible pressures from the government and the public that must be felt around the “need” to limit resident duty hours. However, as the ACGME has so excellently stated on multiple occasions and in multiple areas of their Proposed Standards website [30], we need to ensure that we are training residents of today to care for patients of today and tomorrow. There is no substitute for experience in attaining this competence, and experience can only come through time spent at work. Furthermore, it can best be achieved through time at work completing the correct activities with the correct cognitive loads, workloads, and supervision.

“We don't receive wisdom; we must discover it for ourselves after a journey that no one can take for us or spare us.” – Marcel Proust

Name: Dan Schumacher  
Organization: American Academy of Pediatrics Section on Medical Students, Residents, and Fellowship Trainees  
Affiliation: organization

I am a PGY-5 resident in surgery. I feel that the maximum 16 hours for PGY-1 is just not adequate. They will be capped at this level and then be expected to perform at a level with nearly twice the shift hours when they move to PGY-2. They will struggle with this I am sure and they will not have the confidence I believe to make this transition safely and smoothly. I feel that Interns need to be on call and in the hospital.
### Maximum Duty Period Length

#### Comments not in Support

Supervision is key but to not let them be responsible in house physicians I feel will make them feel like a glorified medical student and not be effective at training the residents.

**Name:** Steve Eaton  
**Organization:** Marshall University  
**Affiliation:** individual

In trying to provide a reasonable schedule for first year residents so they do not have to work every weekend I would request that we allow them to work 24 consecutive hours. They are always supervised by an in house attending 24 hours a day seven days a week.

**Name:** Kathleen Schaeffer, D.O.  
**Organization:** Cooper University Hospital  
**Affiliation:** individual

In the real world, physicians in OB/GYN often have duty hours that exceed 36 straight hours. Limiting residents to half of that will not prepare them for the future when they have even less supervision. 24 hour call as a resident is good so they can learn how to manage patients even when tired and when they have faculty to help supervise and train them. If they leave residency without that experience and knowledge, then patient care will suffer after residency while if they learn this before leaving residency, then patients will still be safe due to the supervising physician's input.

**Name:** Jon Hathaway  
**Organization:** individual

If interns can only work 16 hours but need 10 hours off between each shift that will increase not decrease a night float based system. You will also have a higher amount of transitioning of care and loss of continuity. There will be more requirements for checkouts and I think this will lead to increase mistakes and errors.

**Name:** Jennifer Knight  
**Organization:** WVU  
**Affiliation:** individual

I am the Chair for an institutional Duty Hours Task Force formed by our GME office to address our issues and plan for implementation of the proposed regulations across all of our institutions GME programs. The requirement restricting PGY-1 residents to 16 hours of continuous duty is by far our greatest challenge and concern. Our potential options for implementing this guideline include:

1. Adding more or new Night Float rotations to our curricula.
2. Shifting more upper level residents away from daytime rotations and into night shift responsibilities.
3. Utilizing affiliate providers (NP/PA) for nighttime coverage responsibilities.
4. Requiring faculty to provide night coverage.
5. Pulling residents from non-clinical experiences such as research rotations to provide night coverage.

From an educational perspective the best option is going to vary depending on specific characteristics of each program, but the options that protect or preserve our residents' educational experiences tend to be the ones that involve adding non-resident resources to our clinical services (attendings, NP's, and PA's). These options, though advantageous require a substantial financial investment, as well as recruitment and training efforts. At our institution we have considerable experience in this as we have developed Affiliate provider programs and 24/7 Hospitalist programs to support our Internal Medicine Residency Program. Expanding these types of resources to our other GME programs is possible, but cannot be accomplished in the time frame proposed by the ACGME-implementation by July 2011. Our budget cycle is based on an October-October fiscal year and it would be impossible at this late date to develop a budget, recruit and hire, and train affiliate providers by next July.

**Name:** Richard M. Forster, M.D.
Maximum Duty Period Length

Comments not in Support

Organization: University of Massachusetts Medical School
Affiliation: organization

I have previously commented on the timeline challenges of meeting the 16 hour provision for PGY-1 residents by utilizing affiliate or faculty providers for night coverage. Because these solutions cannot be implemented by July 2011, many of our programs will be forced to provide night coverage by pulling upper level residents from other educational experiences and placing them in less educational night time rotations. This will be correctly perceived as an increase in service burden at the expense of education, which I am sure is not the intent of these regulations. In some cases these night rotations may be in conflict with RRC restrictions on night float experiences.

Name: Richard M. Forster, M.D.
Organization: University of Massachusetts Medical School
Affiliation: organization

We are writing as a group of Internal Medicine program directors from University programs that are concerned with an aspect of the new recommendations from the ACGME Task Force on duty hours. Our programs have a long record of success training leaders in Internal Medicine. We are sincerely committed to continuing our record of training outstanding clinicians, investigators, policy makers, professionals, and role models. For the reasons articulated below, we feel that limiting PGY-1 work hours to a 16-hour shift is not based on a foundation of evidence, is too proscriptive, and should have flexibility if appropriately justified in terms of a program’s educational and professional goals, objectives, pedagogy, and supervision.

We read closely the NEJM Sounding Board article summarizing the deliberative process and proposing the new duty hours standards. The emphasis on supervision is positive and has potential to improve resident education and patient safety. We also appreciate consideration of different specialties in formulating the proposal. However, it is in this context that we appeal to the Task Force to modify the recommendations for the PGY-1 year.

The optimal pedagogical model to train future Internists is not clear. Assuredly, in the last decade core duty hours rules such as an 80-hour work week have gone a long way to address overworked and unsupervised trainees. Since 2003, many Internal Medicine programs have switched from an overnight call system to a 12-16 hour shift system for PGY-1 trainees. We are not aware of any data supporting the superiority of one of those models in terms of patient or trainee outcomes. The study cited by the Task Force as the basis for this new rule was done at one of our institutions (1). In that study, there was no difference in serious non-intercepted adverse events or errors that reached any patient. Supervision, redundancies and safety measures in place at that time were sufficient to intercept errors and no harm was detected by trained observers, health care provider reports or chart review that reached the patients. Since that time, measures have been implemented broadly that make patient harm even less likely to occur on extended or any shifts (e.g., near-universal implementation of electronic medical records, improved supervision guidelines, in-house senior residents and attending physicians, decreased physician census caps). The ACGME proposals to increase the rigor of supervision within existing work rules will assure a safe environment.

The controversial nature of this debate highlights the uncertainty concluding one model is better or safer than another. Our profession prides itself on the rigorous examination of varying forms of diagnosis or treatment, basing conclusions on data and outcomes. Thus, while many varying ideas were taken into account while crafting these recommendations, no data suggests that a mandated switch to a single approach will provide the optimal outcome in terms of education or patient care.

Many Internal Medicine Program Directors (including the signers of this letter) firmly believe that closely supervised 24-hour call with minimal patient handoffs for PGY-1 residents is the most effective model to teach important lessons in clinical judgment, medical decision making, and professional responsibility. Unlike many specialties, where critical periods of risk are associated with a time-limited procedure, the nature of inpatient internal medicine is that longitudinal observation of a patient after an initial clinical decision is the most effective fashion to learn about disease and therapeutics. Through the provision of intense longitudinal care, first year Internal Medicine trainees develop an appreciation of the time course of disease, receive rapid feedback on initial clinical impressions, have prolonged contact with their patients during the important first day of hospital admission, and develop a sense of ownership. This approach also recognizes the inherent inefficiency of PGY-1 residents and allows them to rapidly develop the skills,
knowledge, and attitudes of a more experienced clinician in a setting of appropriate supervision. The lessons learned in this model serve as the foundation for subsequent development of clinical, educational, and professional competency. We worry that the very tight regulation of hours will promote less in-depth review of patient details and complex presentations, create gaps in understanding the natural history and dynamic nature of internal medicine as well as lead to a relatively superficial approach to cases in the most formative year in training. We have residents who are adult learners who benefit from meaningful responsibility with supervision. Good clinical judgment is born from seeing the consequences of one’s decisions.

We know of no data that dispute the contention that 24-hour call provides an unparalleled learning environment without compromising patient safety nor any data that demonstrate worse patient outcomes from overnight call. We are not asserting that this is the only approach to resident education. It is an approach that has allowed our programs to produce some of the nation’s finest physicians over many years with no evidence that it is detrimental to learners or patients. We do feel that if a program is going to utilize an overnight call approach in the PGY-1 year, the experience should be appropriately supervised and should be justified with defined objectives, goals, supervision, and pedagogy.

It is not coincidental that interns vote with their feet, frequently choosing to match at programs where interns experience overnight call. They recognize that this provides the opportunity to follow the natural history of disease, maximize continuity with individual patients, and to take personal responsibility over care in the first, critical hours for the sickest patients. Equally important, interns are aware that with supervision systems in place to assure safe care, as exist at all of our hospitals, the requirement to leave the hospital after 16 hours forces the untenable choice of getting to know their newly-admitted patients and families or violating duty hour rules. In the absence of compelling data that this is better or safer, this is a false choice that undermines the development of professionalism. While trainee preference should not be the basis for rules when there is a clear safety advantage, in this case the data are very nebulous, at best. The recently published national poll of Program Directors also strenuously objects to the 16-hour maximum length of PGY-1 duty hours with 79% of program directors disagreeing with this proposal (2).

We therefore ask the ACGME Task Force on Duty Hours to slightly modify the proposed recommendations to allow PGY-1 residents to perform 24 hours of continuous duty with an additional 4-6 hours for transfer of care and educational activities, at least for a large portion of the year. If a program chooses to adopt this model, the experience must be appropriately justified with educational goals and appropriate supervision to ensure patient safety. With this flexibility, programs and applicants may decide the pedagogical model that best fits their specific educational needs and philosophy.

In addition, we ask the ACGME and the RRC-IM to allow for a multi-centered study of the two intern maximum shift lengths (16 vs. 28 or 30), with patient safety as the pre-specified principle outcome measure, which will answer this question in a rigorous way currently not available. Conducting a well designed study in multiple internal medicine residency programs could overcome some of the major weaknesses of existing data – reliance of surrogate measures, small sample size and generalizability.

Thank you for listening to our heartfelt concerns, and for your consideration of these requests.

Mark Babyatsky (Mt. Sinai Medical Center), Hasan Bazari (Massachusetts General Hospital), Lisa Bellini (Univ. of Pennsylvania), Melvin Blanchard (Washington Univ.), Carol Croft (Univ. Texas Southwestern), John Del Valle (Univ. of Michigan), Jodi Friedman (Univ. of California-LA), Harry Hollander (Univ. of California-SF), Joel Katz (Brigham and Women’s Hospital), Diana McNeill (Duke Univ.), John Sergent (Vanderbilt Univ.), Kenneth Steinberg (Univ. of Washington), Charles Wiener (Johns Hopkins Univ.), James Woodruff (Univ. of Chicago)


Name: Drs. Babyatsky, Bazari, Bellini, Blanchard, Croft, Del Valle, Friedman, Hollander, Katz, McNeill, Sergent, Steinberg, Wiener, Woodruff
Organization: Concerned Internal Medicine Program Directors
Affiliation:
Maximum Duty Period Length

Comments not in Support

This is too much of a limitation with intern hours that will drastically decrease quality of life of the residents. It will force interns to work more shifts, which decrease days/weekends off. This is more detrimental to mind set of interns to work more often than to work mildly longer hours, and have quality time with their families.

Name: Elizabeth
Organization: Baylor Medical Center Dallas, Tx
Affiliation: individual

Our residency believes strongly in maximizing time off work to foster better patient care, better learning, and better quality of life overall. However, minimizing the number of hours a PGY-1 can work to only 16 would require more interns work to cover the same time period that a single intern can cover now. The decrease in hours would ensure that the intern class would never have 2 consecutive days off. We feel that this would lead to greater fatigue and dissatisfaction for the residents overall. Also, I think we need to be mindful of the fact that every time we decrease the number of consecutive hours a resident can work, we increase the number of patient hand-offs which can be very detrimental to patient care.

Additionally, I am concerned that a strict 24 hour shift limit will also lead to problems with patient hand-off. Even 1-2 extra hours for shift change would be very helpful.

Name: Lindsey Longerot
Organization: PGY 3, Baylor University Medical Center, Dallas, TX
Affiliation: individual

The GMEC believes that limiting PGY-1 residents to a 16 hour duty period is not based on any evidence that such a limit will enhance resident well-being or patient safety. The proposed limit will be particularly disruptive to surgical programs and there are also concerns about unintended consequences of limiting duty hours of one group of residents based exclusively on level of training. Where is the evidence that a PGY-1 resident is more subject to fatigue than a more senior resident?

Not allowing residents to attend continuity clinic after being on-call will have a significant negative impact on the educational program. It is not realistic to expect that call schedules can be altered to accommodate this restriction. This restriction will prevent residents from effectively following patient progress resulting in a negative impact on the quality of care and the educational curriculum.

Name: Robert C. Fore, EdD, FACME, CCMEP
Organization: University of TN College of Medicine Chattanooga
Affiliation: organization

The Alliance for Academic Internal Medicine (AAIM) does not believe the scant evidence cited to support the elimination of overnight call for first-year residents justifies the elimination of this training paradigm for all interns in all settings. While the organization supports the development of regulations based on evidence, AAIM would rate the evidence cited to support this requirement (i.e., the study by Landrigan and colleagues) as limited, at best, due to the constraints of the study related to site, scope, duration, and assessment of educational outcomes. The task force’s statement that “Decreasing the shift length for PGY 1 residents is indicated by this study,” certainly is not substantiated by this organization’s assessment of the publication. The scientific method and tenets of evidence-based regulation demand more attention to study validity and reproducibility before allowing limited literature to so broadly affect the future of residency education.

AAIM is aware of additional studies that are currently underway to assess patient-care and educational outcomes from a variety of approaches to duty periods in various educational venues over a period of time (e.g., National Institutes of Health study 5R01HL094593-02 by Volpp and colleagues). The alliance believes these studies will provide substantially better evidence upon which to make a long-term decision about extended shifts for PGY-1 residents. A premature decision at this time to eliminate extended shifts and thus overnight call for interns may eliminate future options to return to such systems for PGY-1 residents if the ongoing studies support overnight call as a best practice for educating medical residents. Recognizing that ACGME faces considerable pressures to cap all resident effort at 16 hours, the alliance strongly recommends ACGME adopt a compromise position to limit PGY-1 residents to 16-hour periods of maximum duty length during the first six (or fewer) months of training but to allow PGY-1 residents to have duty
### Maximum Duty Period Length

**Comments not in Support**

periods equal to those allowable for PGY-2 residents during the second six months of training. This compromise maintains the developmental, progressive, graded responsibility for PGY-1 residents sought in the draft duty hours language. The compromise is also particularly important for the transition between the PGY-1 and PGY-2 levels given the increased responsibilities of second-year residents.

**Name:** Charles P. Clayton  
**Organization:** Alliance for Academic Internal Medicine  
**Affiliation:** organization

The GMEC believes that limiting PGY-1 residents to a 16 hour duty period is not based on any evidence that such a limit will enhance resident well-being or patient safety. The proposed limit will be particularly disruptive to surgical programs and there are also concerns about unintended consequences of limiting duty hours of one group of residents based exclusively on level of training. Where is the evidence that a PGY-1 resident is more subject to fatigue than a more senior resident?

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**Name:** Robert C. Fore, EdD, FACME, CCMEP  
**Organization:** University of TN College of Medicine Chattanooga  
**Affiliation:** organization

As a recent PGY-I, now PGY-II, I am ENTIRELY opposed to the 16hr limit on PGY-I duty hours. Decreasing the hour limits will adversely affect their ability to learn. I personally learned more about management of patients from my nights on call, than from any other individual responsibility.

Perhaps these restrictions are perceived as necessary for traditionally inpatient services or for services that habitually under-report their actual duty hours. But for outpatient services (such as family medicine), these restrictions will only serve to ham-string the interns, and you will produce PGY-II's who are ill-equipped to function as residents and who are incapable of effectively overseeing interns.

**Name:** Caleb M. May, DO  
**Organization:** Tripler AMC  
**Affiliation:** individual

I have had feedback from all our teaching programs at four hospitals that of all the proposed standards, this one will prove to be the most difficult to implement. Much concern.

**Name:** Mary Ann Clemens EdD, FACHE  
**Organization:** Advocate Health Care  
**Affiliation:** organization

More evidenced-based research needs to be done to determine the maximum duty hours a resident may work before establishing restrictive rules.

**Name:** Jeffrey Postlewaite, D.O., President  
**Organization:** American College of Osteopathic Obstetricians & Gynecologists  
**Affiliation:** organization

More evidenced-based research needs to be done to determine the maximum duty hours a resident may work before establishing restrictive rules.

**Name:** Thomas Alderson, D.O., Chairman, Medical Education Committee  
**Organization:** Mount Clemens Regional Medical Center  
**Affiliation:** organization

The 16 hour PGY1 limit gives me heartburn. It will cause much difficulty with scheduling and will create
Maximum Duty Period Length

Comments not in Support

problems with my upper level residents who will by necessity be strapped with responsibilities that were formerly carried out by PGY1 residents (duties that they have already done as PGY1’s). Of course, this will only be for the two years following implementation of the new rules. It seems that the ACGME believes that after one year of 16 hour limits, the residents will have learned skills that enable them to work for 24 hours effectively and safely. I would argue that only by working 24 hours can one learn effective skills to perform adequately under these circumstances, so we will just be delaying the inevitable difficult first year of learning how to work longer hours. Why not require 24 hour call duty during the M4 year of medical school so these skills can be learned prior to becoming a resident, and in circumstances where supervision would be more available and necessary. We just seem to be backing up progressively in our expectations for physicians to function as physicians.

Where is the evidence that limiting work hours will enhance patient safety or improve resident's education? I am concerned that the increased patient transfers-of-care will result in more, not less patient safety problems.

These requirements will also impact community based programs much more than university programs, since fewer residents are generally in community based hospitals. In my 7-7-7 program, I will either have to stop having PGY1 residents make weekend rounds (with the PGY2, PGY3 and faculty member) or I will have to have 3 different PGY1-residents on call at various times on the weekend, which creates problems for having 1 day off in 7.

My last concern is for the resident’s education. With the restrictions that are proposed, residents will either miss one full day away from their learning experiences on rotations, both pre- and post-call, or will miss a week at a time while on a night float week. Either of these situations will significantly impact their learning. For a program that is very dependent on volunteer community faculty for teaching, this will create absences which will be interpreted as lack of interest in learning, lack of caring, and will necessitate less reliance on the PGY1 resident for patient care, impacting their experiential learning and moving them to more of an observer situation rather than being truly involved. I really think this will require that we move to a 4 year program for Family Medicine, which will further decrease interest in primary care and result in more specialist being trained—not what the country or medicine needs.

Strategic napping is something that almost all my residents have done for years while on call, though it didn’t have such a fancy name. Of course you should sleep when you have the opportunity to do so, but does this need to be a requirement? Even though it is “strongly suggested”, the interpretation could evolve over time to be that program directors need to be making ongoing, recurring arrangements for residents to have protected nap time while on call, increasing the number of persons on call, and further impacting education.

I applaud the requirement that residents may not attend continuity clinics in their post-call hours. Thank you. This has been abused by some faculty members to the point that residents are always in clinic when post-call and I have never liked having them do so. Problem solved.

I also appreciate that residents must document their reasons for working beyond their duty hours and submit that to the program director. My residents never report working beyond the duty hours in their monthly reports to me, but several like to report that they do so on the ACGME survey. I realize that they can still do this, but I think the site visitor/RRC will take it with a grain of salt if there are files and records that indicate the infrequency (or absence) of these episodes. I also like that residents may stay longer for specific needs as long as they document their reasons. This will teach them some personal responsibility for their patients and reinforce the importance of continuity of care which had been lost with the first duty hour standards.

Name: Jimmy Acklin, MD
Organization: UAMS, AHEC Fort Smith
Affiliation: individual

The maximum duty period lengths simply do not allow for coverage of patient care demands without expanding residency programs (an unlikely proposition for primary care programs given currently low levels of interest among students for these programs and given the expense of the larger programs) or posing a burden on faculty (which likely make for faculty shortages.)

Further, they will truncate the clinical education experience for residents to such a degree as to severely diminish its value.
Maximum Duty Period Length

Comments not in Support

Finally, the requirement that program directors review each submission of additional service and track episodes of additional duty will add further to the already sizeable administrative burden associated with graduate medical education. It is difficult to envision anything other then negative consequences resulting from this additional bureaucracy.

Name: Dilip Nair  
Organization: Marshall University  
Affiliation: individual

I believe limiting PGY-1 duty hours to 16 hours is a mistake. I feel that being on overnight call was a very valuable learning experience. The work hour rules should not be changed.

Name: Justin Garrett  
Organization:  
Affiliation:  

The ACGME needs to ensure that questions related to duty hours on the Resident Survey are well written so that residents fully understand the meaning of each question being asked. Shouldn't 'patient safety' be emphasized rather than a specific period of time (PGY-1) of resident training?

Name: Priscilla Markwood  
Organization: Association of Pathology Chairs (Program Directors Section - PRODS)  
Affiliation: organization

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Comment:  
This standard for PGY-1 residents received the greatest number of comments and some of the strongest opposition. The APA received comments from 203 members: 80% did NOT endorse this standard. The APPD felt that this standard would be more acceptable if a 4-hour period following the 16 hours was allowed for transitions of care which would enable residents to participate on Morning Rounds after an overnight duty hour shift. Specific comments relate to clinical, educational, and institutional impacts:

This restricted period of time does not allow for continuity of care following the admission of a patient to a hospital.

More frequent transfers of care will occur because of decreased shift duration.

Limited data exist to support the limitation of a shift length to 16 hours for reasons of patient safety and there are conflicting perceptions about the validity of these data.

It is inconsistent to restrict PGY-1 residents to a shift of 16 hours and allow upper level residents longer duration of shifts.

Limiting the duration of a PGY-1 shift creates a need for additional resources on many existing inpatient teams, adding to the cost of providing care.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

Comment:  
There was general endorsement for this standard. Most are skeptical that strategic napping will occur in busy clinical environments.

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions of care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Comment:
Maximum Duty Period Length

Comments not in Support

There was no consensus about the optimal length of time for transitions of care following a 24-hour duty period. Many are concerned that 4 hours is an insufficient period of time for participation on Morning Rounds.

VI.G.4.B).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Comment:
There was widespread endorsement of this allowance for extensions of periods of duty under very specific circumstances.

Name: Theodore C. Sectish, M.D.
Organization: Federation of Pediatric Organizations
Affiliation: organization

This proposed change has the most dramatic and the most negative impact on residents and training programs alike. A shorter shift length (16 hours) for PGY-1s marginalizes their clinical education as well as their direct involvement in and impact upon patient care. A duty period limited to this length truly results in “shift” work for the PGY-1 residents and fundamentally opposes the concept of the resident physician, as it negates any true call for interns. Not only will interns not experience and learn from a 24-hour call period when they can truly follow the course of patient care, but they will be unprepared to function in more senior roles when they are required to take longer call periods and supervise the work of others.

Essentially this represents a step backwards from the experience of a third and fourth year medical student, which is unregulated in call length and is meant to prepare senior medical students for the responsibilities of a ‘resident’ physician. In addition, this change simply defers a greater call burden on more senior residents. Junior level responsibilities will be shifted to more senior residents as interns are taken out of the call schedule, negatively impacting both education and quality of life in opposition to two of the fundamental goals of the proposed changes.

Admittedly, the first 24-hour call nights are painful and intimidating, but these are not experiences that should be shifted to the second year of residency. It has already been well documented that residents are increasingly pursuing further training in fellowships because they feel unprepared for independent practice by residency. This change can only enhance this sentiment. Additionally, if the PGY-1 residents become shift workers they will inevitably be unavailable to attend daily lecture series and conferences. This will deny them the very educational experience we aim to promote. The change of post-call transitional periods (to 4 hours from 6 hours) will not likely have a significant impact on patient care.

Name: Brian Drolet, PGY-2; Lucy Spalluto PGY-5
Organization: Rhode Island Hospital / Brown University – Council of Residents
Affiliation: organization

Recently, we conducted an online National 2011 ACGME Duty Hours Proposal survey among current family medicine residents in U.S. Over 650 completed the survey. 26.8 % strongly agreed or agreed that interns should be limited to 16 work hours per day, while 58.1% disagreed with such proposal. 33.0% strongly agreed and 18.9 % agreed that limiting interns to 16 work hours per day will have a negative impact on their education and training, while only 27.8% strongly disagreed or disagreed. They perceived negative impart on continuity care (77.1%); commitment to patient care (54.3%), commitment to personal training (56.4%), expectation of future work hours (62.7%), and personal and career satisfaction (22.9%) However, with limiting interns to 16 work hours per day, the perceivable benefits included: sleep more (57.1%), more alert and less error (71.4%), learn better because less fatigue (70.4%), better mental health (72.2%), greater personal and career satisfaction (58.8%)

Name: Vincent Lo
Maximum Duty Period Length

Comments not in Support

Organization: San Joaquin Family Residency
Affiliation: organization

This proposed change has the most dramatic and the most negative impact on residents and training programs alike. A shorter shift length (16 hours) for PGY-1s marginalizes their clinical education as well as their direct involvement in and impact upon patient care. A duty period limited to this length truly results in “shift” work for the PGY-1 residents and fundamentally opposes the concept of the resident physician, as it negates any true call for interns. Not only will interns not experience and learn from a 24-hour call period when they can truly follow the course of patient care, but they will be unprepared to function in more senior roles when they are required to take longer call periods and supervise the work of others.

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Name: Brian Drolet, PGY-2; Lucy Spalluto PGY-5
Organization: Rhode Island Hospital / Brown University – Council of Residents
Affiliation: organization

As a PGY1, I strongly object to the proposed changes in the maximum duty period length. Due to the current limitations on maximum hours of work per week and the duty period length, it is not uncommon for a PGY1 resident at our institution to be responsible (under supervision) for as many as 35 patients on a weekend call shift, the majority of whom he or she is unfamiliar with. Many of the errors in patient management that occur over the weekend are due to a lack of familiarity with each patient’s medical history and hospital course. A detailed sign-out from the on-duty resident is necessary at the end of each duty period in order to minimize this type of error. The proposed changes in duty period length will lead to an increase in the number of sign-outs over the weekend, with compromise of continuity of care and patient safety.

As it stands, my patients have already expressed their dissatisfaction with having their care change hands between multiple physicians over the weekends. This problem will only be exacerbated by the proposed changes. I agree that resident fatigue does contribute to medical error, but there are several additional contributing factors that should not be ignored. Patient care errors are also caused by multiple handoffs during patient care, increased percentage of duty time required for administrative work, and decreased time for resident education, all of which will be negatively affected by shortening the maximum allowed duty period length while keeping the weekly duty hours and minimum days off per month constant.

Name: Joy Sarkar
Organization: Tripler Army Medical Center
Affiliation: individual

Internship should mirror the experience a physician must face in reality, having spent time in the military and is isolated communities for the public health service, there have been times when there was no alternative but to take care of patients for >24 hours. The training received as a physician should mirror what will happen in the physicians that may serve the rural communities. Would strongly recommend a limit of < 26-30 hours, 24 hours not realistic for setting the experience the surgeon or physician will face in the rural settings.
### Maximum Duty Period Length

#### Comments not in Support

Additional comment, these hours are setting expectations for what the physicians expect when working in private practice, you will be placing states and rural settings up for significant problems to recruit physicians to these areas in the future. Creating far more problems that what they already currently have.

**Name:** Douglas Husmann  
**Organization:** Mayo College of Medicine  
**Affiliation:** individual

As a PGY-2 in pediatrics, I can attest that the most taxing part of taking 30-hr overnight call is the end of the call, the last 4 hours. During this time, technically, residents are supposed to be transitioning the care of patients. However, in reality, residents are rounding on patients, making medical decisions, fielding management questions from nursing, and inputting orders. These last 4 hours are fraught with increased potential for medical errors. Thus, I don't think overnight calls should be limited to 24 hours. They can be 26 hours as long as the last 2 hours are limited to rounding on the post-call person's patients and nothing else: no order input, no fielding questions from nursing; simply, presenting one's plan which can then be implemented by another team member.

**Name:** Marleny Franco  
**Organization:**  
**Affiliation:** individual

It is difficult to justify the arbitrary decision that PGY-1 residents can never deliver care safely and learn effectively after 16 hours of consecutive duty, yet other residents can for up to 24 hours. Maximum duty shift lengths should be determined by program directors and program faculty through an ongoing evaluative process that specifically assesses this.

**Name:** David Holub  
**Organization:** University of Chicago (NorthShore) Family Medicine Residency  
**Affiliation:** individual

It would appear to be inconsistent that PGY-1 house staff are assumed to be sufficiently fatigued after 16 hrs, while upper level residents would not be.

This is particularly true in the surgical and anesthesia specialties, but incorporates all specialties where difficult cases would likely require upper level house staff involvement in the case.

In addition, the 'strategic napping' sentence, while laudable in spirit, is ineffectual. One would presume that house staff will sleep during a quiet night shift. In the event of a very busy day and night shift requiring continuous resident activity, this text falls short of the goal of providing for protected sleep time blocks for house staff. It might as well be omitted since practically the program will work the resident according to the needs of the patient care. Parity of a 16 hour workday for upper level residents and/or the intervention of a defined duration for a protected block of strategic napping would appear to be more appropriate in this context.

**Name:** Kenneth Eichenbaum  
**Organization:** Maimonides Medical Center  
**Affiliation:** individual

While the 16 hour limitation for PGY-1s is likely to be the most problematic change to operationalize, it is the most scientifically based of the proposed changes. It would be helpful if the ACGME as a whole or individual RRCs, could assist programs by providing sample work hour templates that might be used to restructure training experiences.

**Name:** Guy Hewlett, MD  
**Organization:** Crozer-Chester Medical Center  
**Affiliation:** organization

I do not favor the 16 hour restriction for PGY 1. If the "evidence" is real it should be applied to all levels of
Maximum Duty Period Length

Comments not in Support

clinical work - PGY 1 and above in training and I do not recommend such. I believe trainees in acute care settings in particular will loose out on critical interactions with patients that typically evolve over the course of an admission. they will lose that late at night sit down with the patient and have a quiet meaningful conversation about their care plan. They will be pushed more and more to cram only the "tasks" of their job into the 16 hours and loose much of the processing time, much of the informal teaching time, and much of the physician-patient relationship building time.

I also think it is not responsible to change work hours this dramatically independent of requiring a review by the individual specialty RRC's to be certain that under these new rules the specialty governing bodies are confident that they can train competent physicians who are ready to "practice medicine in an unsupervised setting" which is our current standard. Duty hours and the work environment rules should not be changed independent of the training requirements for each specialty. I propose that an 18 month impact period be implemented to allow each specialty to review the impact of these changes on their field with the specific goals of determining if there need to be changes made in training - e.g., for medicine, the minimum amount of ICU training, the distribution of outpatient and inpatient training, the minimum number of patient contacts in various settings, and most importantly, the duration of training.

Name: Stephen Huot.  
Organization: Yale Dept of Medicine  
Affiliation: organization

When I consider making change, the question I ask is "Why." What is the evidence, research or facts, that indicate that a change has benefit, and in this case specific benefit for patient outcomes first and resident education second. The answer for these Duty Period recommendations is not evident to me. It appears that there are computer simulation studies, which do not truly simulate patient care and one (1), yes one lone study on PGY-1s. I would very rarely change patient care based on only 1 study. So, the evidence to support these changes is not present. Yet there is great potential harm to the continuity of care of patients and education of residents. Essentially this rule greatly decreases the number of hours of patient contact and care available for resident education, especially for specialties with required continuity clinics, family medicine, internal medicine and pediatrics. These are the primary care physicians that our country so greatly needs -- and they must be competent. As a result residents will be less prepared to progress to the next level of their program, and will require additional residency time to complete the requirements and experiences necessary for them to practice independently. Where will the time come from to ensure residents are competent to practice independently? There is no indication that the federal government or any other entity is willing to pay the cost to increase the years in residency training to ensure competency as a result of this proposed decrease in training time. While this alone should not determine duty hours, without patient outcome data or resident outcome data, and the large negative potential outcome from decreased education of residents, implementing these proposed changes in duty period length is not appropriate.

Name: Inis Jane Bardella, M.D.  
Organization: Medical Education Consultant, 14.5 years full time faculty in medical education  
Affiliation: individual

In regards to section VI.G.4.a of the ACGME Impact Statement, this is a good addition – but it should be extended to all PGY levels, as was recommended by the IOM (Sleep, Supervision and Safety, p. 14)

VI.G.4.b - 24 hours plus the additional 4 hours added for transition of care (VI.G.4.B),(1), = 28 consecutive hour shifts. This amounts to a reduction of only 2 hours and is not what the IOM report had in mind when it said, “The Committee believes there is enough evidence from studies of residents and additional scientific literature on human performance and the need for sleep to recommend changes to resident training and duty hours aimed at promoting safer working conditions for residents and patients by reducing resident fatigue.” (Sleep, Supervision and Safety. P. 11)

The IOM supported a 30-hour shift only if a “5-hour uninterrupted continuous sleep period is provided between 10:00 pm and 8 am” and “residents admit no new patients after 16 hours during an extended duty
## Maximum Duty Period Length

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</table>
| **Name:** Farbod Raiszadeh  
**Organization:** Committee of Interns and Residents/ SEIU Healthcare  
**Affiliation:** organization |
| This is not beneficial to the residents and is potentially harmful for patient care. It goes against the stated goal of minimizing the number of transitions of care. The residents will miss a lot of patient contact, patient care. Scheduling will be a nightmare. |
| **Name:** Elizabeth Pritchard  
**Organization:** Univ of TN, Dept of Surgery  
**Affiliation:** individual |
| In regards to section VI.G.4.a of the ACGME Impact Statement, this is a good addition – but it should be extended to all PGY levels, as was recommended by the IOM (Sleep, Supervision and Safety, p. 14) |
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If programs did not schedule up to the maximum shift length, this problem could largely be avoided, e.g. planning a schedule with 14 hour shifts, would allow plenty of time for transition of care and provide the flexibility to stay up until 16 hours to care for an unstable patient.

Name: Farbod Raiszadeh
Organization: Committee of Interns and Residents/ SEIU Healthcare
Affiliation: organization

The limiting of PGY-1 duty periods to a maximum of 16 hours has potential for both positive and negative effects on education and patient care. While better rested residents are potentially better able to learn and commit fewer errors, the decreased continuity of care and increased number of handoffs necessary to support this change could negate (or exceed) these benefits. Shortening the duty period for PGY-1 residents inhibits the chances for seeing both progression of disease as well as the outcome of their treatment decisions. For many training programs, this change would require extensive changes in rotation schedules and patient coverage. In many instances, programs would consider expansion in program size and/or additional of physician extenders. Changes in PGY-1 coverage also can have an effect on sub-specialty fellow work load on associated services. The proposed date of July 2011 for the proposed program requirements to take effect will be difficult for many programs to achieve in a way that assures both compliance as well as care system redesign to ensure patient safety.

Name: John Co
Organization: Partners HealthCare
Affiliation: organization

I do not think that these proposed work hour changes would be practical for a surgical residency. As a surgical resident, I also do not feel that this would have a significant impact on resident quality of patient care or quality of life. What I anticipate the result will be is a lengthening of residency duration to compensate for the decreased experience due to work hour restrictions.

Name: Jeff Knox
Organization: Tripler
Affiliation: individual

Personally I am a big fan of night float when compared to working 24 hour shifts. However, I see no reason why only PGY-1 residents need to stop work after 16 hours and senior residents can keep working. Experience does not allow one to work long hours without sleep, as one cannot train oneself out of the need for sleep. Everyone’s performance suffers at the 24 hour mark. Thus it is ridiculous to single out one group of residents, thereby requiring other residents to work more of the 24 hour shifts. This merely shifts the burden of longer calls to senior residents, requiring them to put in more long shifts. In the end, this results in senior residents being more sleep-deprived.

Name: Alexandra Bright
Organization: University of Washington
Affiliation: individual

To the ACGME and Task Force on Quality Care and Professionalism,

The general surgery residents of the University of Minnesota appreciate the opportunity to give our feedback on the proposed changes and, specifically, would like to express our opinions regarding the proposed changes in duty hours. The opinions below were compiled from submissions by individual residents, from interns to chiefs, and were, for the most part, concordant. By and large, we strongly support the 80 hour work week. We believe that we are healthier and happier doctors for the 80 hour work week, which translates to more thoughtful and compassionate care.
Maximum Duty Period Length

Comments not in Support

Our main objections to the proposed changes, and the overall scope, are as follows:

1. The blanket regulations that govern every program are too rigid. A surgical residency program is different from an emergency medicine residency program, which are both different from an internal medicine program. The spectrum of disease and complications associated with the surgical specialty is such that we cannot and should not be bound to the same arbitrary work regulations as other subspecialties.

We have attached a list of references to support our stance above.

2. Further reductions in work hours (specifically, the 16-hour cap on intern work hours and 24-hour cap on junior work hours) will erode professionalism, education, and patient care. Already with the current eighty hour work week requirement, we residents have experienced being shut out of the operating room when operations have gone over expected time, or not allowed to participate in managing complications of surgeries we were involved in, for fear of duty hour violations. None of this helps us to become better professionals, surgeons or doctors.

Furthermore, pass rates on the board exams have dropped, and there are also concerns that surgery residents are graduating without adequate preparation. With more restrictions on our training time, it stands to follow that we will either need to lengthen an already lengthy residency program or be forced to graduate inadequately trained surgeons.

What we are calling for are as follows:

1. More autonomy and self-governance. We do value the leadership and camaraderie of the ACGME. However, it would be reasonable for the ACS to set our standards within the framework of the ACGME.

2. To be treated as professionals. None of us went into medicine to log duty hours on a daily basis. The 80 hour work week in general is a good guideline, and quite easily met. However, there are times when it is reasonable that we should be able to work more than the proposed 16 or 24 hours if need be, or occasionally have less than eight hours off from the hospital, without the threat of punishment and the need for more documentation to defend our work ethic. In other words: Just Let Us Do Our Jobs.

We understand that duty hour limitations were implemented in the first place to improve patient safety as well as to limit abuse of residents. In general, we support the existing guidelines, but feel that there is no evidence to suggest that further limitations in work hours will either improve patient safety or resident well-being. In fact, we feel that further work hour limitations will prove ultimately to be detrimental.

References


Name: Kathryn Chen
Organization: University of Minnesota
Affiliation: organization
Maximum Duty Period Length

Comments not in Support

For many of our larger programs, the 16 hour maximum duty rule for interns will generate significant scheduling and coverage problems. Residents are more likely to be functioning without interns, i.e., as “resiterns,” with diminished opportunities for teaching and supervision. Furthermore, the ability of interns to gain an understanding of a patient’s evolving disease process and to develop the analytical reasoning needed to create a cost-efficient diagnostic and treatment program will be seriously compromised; the majority of the “critical thinking” required for a newly admitted patient occurs during the first 24 hours of the admission.

The cost associated with the proposed changes and their impact on already distressed academic medical centers must also be taken very seriously, particularly in the absence of data to support the recommendations, as noted above. For smaller programs, in particular, the economics of the changes may be untenable and they will need to close. While we appreciate that the RAND group is investigating the financial impact of the proposed changes, we are concerned that the analysis will minimize these costs or that they will not be viewed as a reason to modify or postpone the proposed regulatory changes.

Another trend we are observing as a consequence of more restrictive duty hours (coupled with increasingly difficult financial conditions for academic institutions) is the reduction in elective and off-site rotations; trainees are brought back to their core rotations to fill the “gaps” resulting from the more restrictive duty hours requirements, which reduces the educational opportunities afforded to the residents. This trend has particularly negative implications for procedure-based specialties in which off-site rotations may offer exposure to patient populations and disease states necessary to acquire the requisite number of cases for graduation and board certification. With fewer hours of training available, program directors will have to sacrifice elective time for core training opportunities. Fewer trainees will gain exposure to other specialties or subspecialties and they will have less opportunity to interact with their colleagues outside their specialty. Cross disciplinary communication, teaching and learning, and team-building can all suffer because of this.

We appreciate that the Task Force acknowledges the potential benefits accruing to a trainee by staying at the bedside beyond the allotted hours under certain conditions. While it is logical from a statistical perspective to limit hours according to set parameters, it would be a mistake to assume that all hours of the day provide the same opportunity for learning. It can be difficult to predict when the most important teaching and learning moments will occur. It is valuable to have a mechanism in place to allow trainees to take advantage of these opportunities when they arise. While we appreciate the value of this “exception,” we are concerned that the need to justify and document these instances will impose another regulatory burden on program directors who are already overwhelmed with documentation requirements. Most program directors and medical educators feel that their administrative duties have grown markedly in recent years and that such activities already interfere with their ability to teach and mentor trainees. As their administrative workload continues to increase, we fear that we are creating a system that will create significant disincentives for faculty members who would otherwise be willing to assume or remain in an educational leadership position.

While we understand that there is currently considerable political pressure to provide strict oversight on duty hours and supervision, we recommend that the ACGME advocate strongly for easing the overall administrative burden on training programs and institutions, and for streamlining the regulatory processes whenever possible. This would include using standardized templates and protocols that meet the proposed documentation requirements, providing more directed faculty/administrative leadership development, and facilitating the sharing of best practices among educational leaders nationally and at the local level. While all institutions and programs value, to some degree, their autonomy in building and managing their educational programs, most would also agree that if they are going to be held accountable to certain minimum standards, those standards need to be extremely clear and that they should be accompanied by practical instruments and procedures with which one can document compliance.

We convened a focus group of trainees at our institution to elicit their opinions of the new proposed standards and to discuss the impact the new guidelines would have on their personal training experience and their training program in general. This focus group included residents from a variety of specialties and
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<td>each PGY level was represented. Below is a summary of the specific comments elicited from the group regarding education.</td>
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The resident group expressed several concerns regarding the impact of the proposed guidelines on their education. First, they all uniformly agreed that they felt the learning they did overnight on call, as well as in the intensive care unit for interns (24 hour shifts), was essential to their development as a physician. They appreciated the opportunity to follow a critical patient through the night during an ICU rotation, and several mentioned the unique opportunities available for learning during overnight call. They also expressed concern that if their experience as an intern was diminished as a result of the new requirements, they would not be adequately prepared for the increased responsibilities and decision making required in their subsequent years of training.

The group also expressed concern that to comply with the new duty hours standards, rotations will have to be modified and this will negatively impact their overall experience. To meet the duty hour requirements, more residents will be needed to cover a given rotation. The residents are concerned that they will have to sacrifice elective time to fill gaps in core rotations to meet scheduling requirements. Research time and important electives will be in jeopardy. With interns unable to take call overnight, this burden will often fall to the upper level residents, taking away from their time for other educational opportunities as they consider options for fellowships and various practice opportunities.

In surgical specialties, there is a particular concern that further limits imposed on clinical hours will reduce their operative experience, especially for the rarer cases, to the point that they will not be prepared to practice independently at the end of their training. The group also noted that they truly value the opportunity to spend time on rotations in other specialties and fear that this option will be lost if their program must comply with the new duty hour standards.

**Name:** Angela Byers/ Sean Kelly MD (DIO)  
**Organization:** Beth Israel Deaconess Medical Center Program Directors and Residents  
**Affiliation:** organization

In obstetrics, patient care would be significantly disrupted by more frequent care transfers during labor if the proposed 16 hour PGY-1 shift length is adopted. Resident education in obstetrics would also be adversely affected as the learner would not be able to care for a patient from hospital admission to delivery in many cases. Clinical education in obstetrics requires longitudinal care of women in labor and the 16 hour requirement would reduce resident experience in our specialty. A 16 hour shift also creates scheduling issues as the shift will have to be followed by a 10 hour rest period, creating a cumbersome mismatch with a 24 hour scheduling cycle. This will result in fragmented schedules for other PGY levels. Team dynamics will be adversely impacted by asynchronous shifts for PGY-1 versus upper level residents.

**Name:** Daniel Breitkopf  
**Organization:** Mayo Clinic Dept. of Ob/Gyn  
**Affiliation:**

CREOG would like to stress the fact that provision of quality Obstetric and Gynecologic care is a 24 hour-a-day activity. There are few other physicians who have knowingly committed to the volume of “around the clock” patient care provided by our specialty. Residents who choose a career in Obstetrics have made a commitment to that patient care model and should be included in its culture from the beginning of intern year. If R1s in Ob/Gyn are restricted from providing 24 hours of continuous care, their education will suffer due to their inability early in their careers to provide continuity of care for patients with extended labors or to participate in the volume of spontaneous and surgical deliveries that occur at any hour of the day. We acknowledge that R1s may be the most vulnerable of learners to errors, and need the most supervision to ensure their provision of safe patient care. Our commitment to this is evidenced by the presence of an attending physician at all training sites 24 hours a day to provide close supervision of our R1s and other level residents. We believe that this on-site attending supervision mitigates the difference between R1 and more advanced residents and request that they be considered equal to other residents in our program regarding their hours of maximum duty.
Maximum Duty Period Length

Comments not in Support

Name: Diane Hartmann, MD  
Organization: ACOG/CREOG  
Affiliation: organization

I think a 4 hour transition of care period should be strongly considered for PGY-1 residents, given how strict the time limitations are at 16 hours. This four hour transition period could still allow for a modified q4d overnight call schedule, with PGY-1 call starting in the late afternoon and ending after rounds with the primary team the next morning. This could obviate a night-float system for those programs who do not wish to use that.

Name: Daniel Horton  
Organization: CHOP  
Affiliation: individual

The 16-hour limit will be especially hard on smaller programs although all programs will struggle with the requirement. It limits continuity of surgical care and teaching and will most likely result in lengthening of training to achieve a competent surgical trainee! How was 16 hours chosen versus 12, 14 or 18???
No averaging for q3 night call will be especially difficult for smaller programs or around holidays and vacations.

Name: Joel A Goebel, MD  
Organization: Otolaryngology Program Director's Organization (OPDO)  
Affiliation: organization

Proposed Requirement: Duty periods of first year (PGY 1) residents must not exceed 16 hours in duration...Strategic napping, especially after 16 hours of continuous duty and during the hours between 10PM and 8AM, is strongly suggested.

Response: While we are supportive of the examination of the supervisory and duty hour requirements, the DIO and GMEC members are increasingly concerned that the proposed more restrictive duty hour requirements, particularly the PGY-1 limitations, may compromise the quality of patient care. To assure compliance, these new requirements will result in more hand-offs and move us from an apprenticeship model toward a shift work approach. Communication is critical during hand-offs, and we anticipate that miscommunications because of the hand-offs will increase proportionately. These limitations appear to contradict another proposed requirement that states that “Programs must design clinical assignments to minimize the number of transitions in patient care (VI.B.1).” Continuity of care also will become fragmented further because of the need to have more hand-offs. We and other academic institutions are actively engaged in creating, implementing and monitoring new and reliable communication processes. However, we are concerned that state-of-the-art communication processes will lag behind the imposed fragmentation of care.

We also are very concerned about the 16-hour rule limitations for the PGY-1 residents. We are troubled that this too will further fragment the relationships between residents and patients, as well as residents and faculty and will affect the quality of patient care and education, respectively. It will become increasingly difficult to judge the competence of any given trainee when a faculty member has observed them in so few encounters. Meaningful assessment of competence is contingent upon longitudinal relationships between residents and faculty. Additionally, without meaningful relationships between residents and their patients, residents may no longer have the opportunities they once did in providing the overall care, treatment and assuring quality outcomes for their patients. Patient care relationships may become more impersonal as a result.

The DIO and GMEC are also concerned about the "strategic napping" recommendation, and do not believe this is a feasible option for many programs with one resident on call in the hospital at night. Since patient demands are unpredictable, it is not realistic to have a nap built into the resident schedule, particularly with our smaller programs. Therefore, programs will need to have a night float system in place to cover hospital call; thus as stated previously there will be increased hand-offs and more opportunities for errors in communications during these hand-offs. The smaller the overall program, the logistically more difficult it will
Maximum Duty Period Length

Comments not in Support

Name: Jonathan E. Gottlieb MD  
Organization: University of Maryland Medical System/Center  
Affiliation: organization

Additional Response: We are appreciative that we were given 45 days to review and respond to these proposed requirements; however, this has not provided us with an adequate timeframe to be able to strategically plan how the institution and its sponsored programs can effectively implement these new requirements. We would like to suggest delaying implementation of these requirements until July 1, 2012, as the implications are significant from an educational, patient safety and financial perspective to the sponsoring institution, its programs and trainees. The sponsoring institution broadly surveyed all of its residency programs and the preliminary data that has been provided indicates that there will be a greater need for additional resources to assure compliance with the proposed requirements. Further and more in-depth assessments and evaluations will be needed to be able to drill down and more accurately identify for the sponsoring institution our anticipated incremental resource needs. Broadly stated, the residency programs anticipate the need for additional resident and non-resident resources (e.g., physician assistants, nurse practitioners, teaching faculty and non-teaching faculty such as hospitalists), estimated at about $2-3 million dollars. In the current economic environment, additional resources, regardless of type, may result in elimination or the delay in other program and institutional strategic initiatives. Since these represent an unfunded mandate, they must be thoughtfully and more carefully assessed over the coming months to assure a budget neutral approach can be achieved.

While we are supportive of the examination of the supervisory and duty hour requirements, the DIO and GMEC members are increasingly concerned that the proposed more restrictive duty hour requirements, particularly the PGY-1 limitations, may compromise the quality of patient care. To assure compliance, these new requirements will result in more hand-offs and move us from an apprenticeship model toward a shift work approach. Communication is critical during hand-offs, and we anticipate that miscommunications because of the hand-offs will increase proportionately. These limitations appear to contradict another proposed requirement that states that “Programs must design clinical assignments to minimize the number of transitions in patient care (VI.B.1).” Continuity of care also will become fragmented further because of the need to have more hand-offs. We and other academic institutions are actively engaged in creating, implementing and monitoring new and reliable communication processes. However, we are concerned that state-of-the-art communication processes will lag behind the imposed fragmentation of care.

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The proposed limitations for residents also seem inconsistent to those experiences the residents are expected to encounter upon completion of their training and entry into practice. Therefore, these restrictions may prove to be a hindrance to adequately preparing the residents for independent practice in a real world scenario. Programs and certifying bodies may soon find that the current program training length is insufficient to adequately prepare residents for independent practice with these more restrictive hours, and extension of the overall training length of some programs may be essential to assure residents achieve competency to practice independently. This may discourage many from entering the field of medicine, particularly if programs extend their training length because of dilution of experiences due to frequent hand-offs to their colleagues.
### Maximum Duty Period Length

#### Comments not in Support

We are extremely concerned about providing an optimal learning environment for our trainees, a reliable environment of safe, high quality care for our patients, and the responsible management of resources bestowed upon us by the citizens of the United States. As we and our colleagues struggle with trying to find a balance among these imperatives, we urge you to provide sufficient time for all of us to develop the innovative approaches that will best achieve that balance.

**Name:** Jonathan E. Gottlieb  
**Organization:** University of Maryland Medical System/Center  
**Affiliation:** organization

The specialty of emergency medicine (EM) and the Residency Review Committee for Emergency Medicine (RRC-EM) have historically been very proactive in developing standards that protect both the patient and the resident during the educational process. Many of the changes and recommendations suggested by the Duty Hours Task Force did not affect EM as significantly as other specialties. Current training standards in EM have already emphasized patient safety by requiring continuous on-site supervision of residents. Resident fatigue has been addressed with restrictions of shift lengths and limitation of consecutive days worked. There are a few minor details to bring to the attention of the ACGME with the proposed duty hour restrictions that may cause unintended consequences if left in the current draft form.

Line 877 – “Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.” Many programs have morning report, educational conferences or other learning activities that would be missed with this change. Some overnight call duties are much less taxing than others and on these occasions, the residents should not be forced to leave educational events to go home merely due to time spent in the hospital. We suggest a change that would allow this period to be extended to six hours only for didactic educational activities that do not include patient care. The program director is still responsible for assuring the resident is relieved of any responsibilities when fatigue is a concern in these cases.

Submitted on behalf of the following emergency medicine organizations:
1. American Academy of Emergency Medicine (AAEM)  
2. Association of Academic Chairs of Emergency Medicine (AACEM)  
3. American College of Emergency Physicians (ACEP)  
4. American College of Osteopathic Emergency Physicians (ACOEP)  
5. Council of Emergency Medicine Residency Directors (CORD)  
6. Emergency Medicine Residents Association (EMRA)  
7. Residency Review Committee of Emergency Medicine (RRC-EM)  
8. Society for Academic Emergency Medicine (SAEM)

**Name:** Mary Jo Wagner, MD  
**Organization:** EM Consensus Group  
**Affiliation:** organization

Proposed Requirement: Duty periods of first year (PGY 1) residents must not exceed 16 hours in duration...Strategic napping, especially after 16 hours of continuous duty and during the hours between 10PM and 8AM, is strongly suggested.

Response: While we are supportive of the examination of the supervisory and duty hour requirements, the DIO and GMEC members are increasingly concerned that the proposed more restrictive duty hour requirements, particularly the PGY-1 limitations, may compromise the quality of patient care. To assure compliance, these new requirements will result in more hand-offs and move us from an apprenticeship model toward a shift work approach. Communication is critical during hand-offs, and we anticipate that miscommunications because of the hand-offs will increase proportionately. These limitations appear to contradict another proposed requirement that states that “Programs must design clinical assignments to minimize the number of transitions in patient care (VI.B.1).” Continuity of care also will become fragmented further because of the need to have more hand-offs. We and other academic institutions are actively engaged in creating, implementing and monitoring new and reliable communication processes. However, we are concerned that state-of-the-art communication processes will lag behind the imposed fragmentation of care.
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Name: Jonathan E. Gottlieb MD
Organization: University of Maryland Medical System/Center
Affiliation: organization

Lines 863-866 The reduction in maximum duty periods will have a significant impact on resident learning, as described under clinical responsibilities. The reduced time in clinical settings will reduce the exposure to necessary skills that must be mastered before advancing to upper levels of training.

The required 16-hour day for interns does not allow ample time to teach appropriate transitions of patient care, and does not provide interns with a realistic experience in residency. While it is understood that interns require more supervision and additional time for reading, the expectations that interns will automatically transition well to PGY2’s and be better able to handle longer work shifts in addition to other stressors of training appears unrealistic.

At WU/B-JH/SLCH GME Consortium, several services will need to create or modify their night float systems. It is expected that these will negatively impact continuity of care and increase hand-offs, and increase concerns for medical errors and patient safety.

Lines 865-955 The requirements should also clarify whether the maximum time spent in all years includes research responsibilities. If so, it will likely have a significant negative impact on fellowships that provide both research and clinical training.

In order for programs to comply with the minimum and maximum work hour standards as outlined in the proposed requirements, it is important to emphasize the effects rigid schedules could inadvertently have on house staff. The changes could penalize the very trainees we are trying to protect by not allowing enough flexibility for schedule adjustments to accommodate individual needs for sick time, vacation time, or personal time away from training, thus leading to increased frustration and poor morale among trainees.

Name: Rebecca McAlister
Organization: WU/BJH/SLCH Consortium
Affiliation: organization

With all due respect to the IOM and the literature cited on sleep deprivation this restriction is a huge mistake. The 16 hour rule will create more transitions and increase serious patient errors...NOT decrease these errors as proposed. It also will create a poorly trained upper level resident with inability to triage, and inability to care for a very ill patient. The flexibility in the upper years of staying over duty hours is a good try but the new PG1’s will not know they need to stay because they will not be able to recognize a critically ill patient!!!
Maximum Duty Period Length

Comments not in Support

Name: Paulette Wehner
Organization: Marshall University School of Medicine
Affiliation: individual

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Name: Rebecca McAlister
Organization: WU/BJH/SLCH Consortium
Affiliation: organization

The reduction in maximum duty periods and in particular the limit for PGY1 residents will have a significant negative impact on resident learning. Both the length of duty requirement and maximum work hour/week requirements threaten the research component of fellowships and residencies. Several services would eliminate elective rotations in subspecialty areas.

Name: James Crane MD, CEO Faculty Practice Plan
Organization: Washington University School of Medicine - Faculty Practice Plan
Affiliation: organization

VI.G.4. Maximum Duty Period Length
The FMRI believes that restricting PGY-1 residents to 16 hours maximal duty periods to be overly prescriptive. Again we can appreciate the balance that the ACGME is trying to develop with progressive responsibility of resident training but this restriction in terms of how residents work will only increase problems with transitions of care and turnover of care to multiple providers who do not know that patient. We are concerned that this may actually increase medical error rate and not relieve it. “There is a burgeoning literature on medical errors as a result of handovers. Over 2,500 articles were researched in the cited review. As a family medicine residency program, we are very concerned that you have not taken into account the additional risks to patient safety that will result from the increased number of handovers.” We would request that this provision be struck in the ACGME work hours requirements and have it return to a 24 hour period of time with 4 hours to complete duties before going home.

VI.G.4. (b). (2). Continuity Clinics
The provision of having residents not attend continuity clinics after 24 hours of continuous in house duty is overly prescriptive. Many times this is the best way to ensure continuity clinics are occurring. We certainly understand the spirit of this is that an exhausted and tired resident may not be at their best post-call to see
Maximum Duty Period Length

Comments not in Support

continuity patients. However many call nights are such that residents get adequate amounts of sleep and certainly are functional post call to see a continuity clinic before going home. Our concern is that upon graduation these residents will become fully credentialed physicians working post call in continuity clinics as a matter of necessity. We believe residency programs should help shape this experience so that it can be effectively demonstrated before the resident graduates.

Name: Ted Epperly, MD
Organization: Family Medicine Residency of Idaho
Affiliation: organization

This new constraint on scheduling coupled with the previous duty hours restrictions begs the question "when are we going to talk about extension of training?" For some programs this will result in almost 30% reduction in the number of clinical contact hours, depending upon how frequently call is taken. In a 3 year medicine residency, that amounts to an entire year of training. This is not just a lack of sleep issue, but one of lack of exposure. Furthermore, the clinical learning curve is very steep in the beginning. If we reduce clinical exposure early on, trainees may never hit an efficient point in their clinical care.

Name: Susan Culican, MD
Organization: Washington University
Affiliation:

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Name: Ted Epperly, MD
Organization: Family Medicine Residency of Idaho
Affiliation: organization

Greater New York Hospital Association (GNYHA), which includes among its membership academic medical
Maximum Duty Period Length

Comments not in Support

centers and other teaching hospitals in metropolitan New York, Connecticut, and New Jersey, would like to offer the following observations on the proposed standard which states that “First year (PGY 1) residents must not work more than 16 hours of consecutive duty”, based on the discussions we have had with GNYHA member hospitals.

1. The reduced limit will force teaching hospitals to incur additional expenses

GNYHA believes that limiting the maximum number of consecutive duty hours of PGY-1 residents to 16 hours will require teaching hospitals to add additional staff in order to compensate for the decreased coverage provided by residents within patient care areas. Depending on the existing staffing level and staffing model used at the hospital, this new requirement will undoubtedly entail hiring additional physician assistants, nurse practitioners, hospitalists, or even additional residents to cover the important and needed service aspect of the residents. Hiring this type of staff is costly and will certainly contribute to the financial strain already placed on these hospitals.

2. The reduced limit creates multiple transitions in progressive responsibility instead of one transition

GNYHA respectfully questions one aspect of the rationale behind this proposed change. We have been led to believe that there is a belief at the ACGME that newly graduated medical students may somehow not be prepared to cover overnight shifts that last longer than 16 hours. In speaking to senior medical educators in our hospitals, we understand that it is not uncommon for fourth-year U.S. medical students to be assigned to these types of overnight shifts during their sub-internship. If that is the case, we question the appropriateness of a person being on duty for 24 consecutive hours one year, then being limited to no more than 16 hours, then moving back up to 24 consecutive hours the following year. While we are not saying that the responsibilities associated with being a sub-intern and a PGY-1 are anywhere near the same, we would respectfully suggest that the ACGME consider whether this kind of a scheduling path is appropriate for an individual being educated to become an autonomous physician. GNYHA also questions why the ACGME seems to believe that this multi-stage transition from medical school to PGY-1 level to PGY-2 level is more appropriate than the current one-time transition that occurs between all medical school activities and residency training activities.

3. The reduced limit will most likely lead to the development of more 12 hour shifts

In order for hospitals to use residents as part of the team that is covering patient care services, it is likely that they will employ 12 hour shifts for PGY-1s, merely for the ease of scheduling and to assure compliance with this requirement. The disadvantage of 12 hour shifts, however, is that residents will then miss didactic conferences which take place during the day if and when they are scheduled to cover a 12 hour shift at night. If the hospital utilizes 12 hour shifts and residents are scheduled for night shifts for multiple days in a row, this will severely diminish their didactic educational experience.

4. The reduced limit will undoubtedly increase the number of patient handoffs

GNYHA believes that further limiting the continuous duty hours for PGY-1s will increase the number of patient handoffs, and this may contribute to more duplication of care or a lack of coordination of care. In the current model, PGY-1 residents are permitted to work an overnight shift and are therefore allowed the opportunity to follow a patient (in particular a critically ill patient) throughout the course of the night. If the maximum continuous duty limit were to be shortened to 16 hours (or if the programs were to decide to limit the shifts to 12 hours), the continuity of following the same patient will be disrupted and the residents will lose a valuable educational experience. While GNYHA recognizes the educational benefit and importance of learning proper transition techniques, we question whether a mandated lower duty hours limit for such an important member of the patient care team might not create more fragmentation in a health care system that is desperately trying to close care gaps in the system. Hospitals are engaged in multiple strategies to ensure continuity of care for patients, reduce preventable readmissions, and ensure that patients are provided with the most appropriate level of care at the right time. For teaching hospitals, which already have to contend with a transitional resident work force as part of their mission, this mandated reduction in hours further challenges their ability to ensure the best continuity of care for their patients.

5. The reduced limit will require multiple resident monitoring strategies
Maximum Duty Period Length

Comments not in Support

GNYHA member teaching hospitals have extensive experience monitoring resident duty hours compliance, as a result of the longstanding independent surveillance activities of the New York State Department of Health (DOH) and its contractor. When DOH enhanced its surveillance activities, many hospitals considered implementing special requirements for surgical residents as the DOH regulations permitted. One reason why many hospitals ultimately decided against this approach was the difficulty in monitoring two separate sets of requirements on a hospital-wide basis. GNYHA notes that special tracking of compliance with the 16 hour limit for one particular PGY level will likely be burdensome and difficult for hospitals from an operational standpoint.

GNYHA would also like to offer the following observations on the proposed standard which states that “Strategic napping especially after 16 hours of continuous duty and during the hours between 10 pm and 8 am is strongly suggested”, based on the discussions we have had with GNYHA member hospitals.

New York teaching hospitals have tried various methods to mandate rest time in order to be able to utilize the “surgical exemption” included within the New York State Department of Health regulations. Hospitals have had limited to no success in implementing this exemption as it is all but impossible to mandate sleep or rest time in a busy teaching hospital. In the experience of our hospitals, “strategic napping” is extremely difficult to implement due to the fact that the hospital must have another caregiver available to provide coverage for the resident during the time which he is taking a nap. This is particularly critical during the night shift, when there is generally less staff present in the hospital and the critical patients must be watched more closely.

GNYHA believes that this requirement should be modified to make clear that it is the responsibility of the sponsoring institutions and residency programs to make strategic napping options available as needed in cases where the resident or his supervisor believes that fatigue may be contributing to reduced performance and alertness. We believe that with this modified language, hospitals will continue to engage in efforts to encourage and allow residents to rest during shifts whenever possible and be aware of the signs and symptoms of fatigue in both themselves and their fellow trainees, as is already prescribed in the requirements.

We appreciate the thoughtful deliberations engaged in by the Duty Hours Task Force and the various ACGME standing committees, and we are grateful for the opportunity to make comments on behalf of our member hospitals on this topic.

Name: Tim Johnson
Organization: Greater New York Hospital Association
Affiliation: organization

We the undersigned representatives of the thoracic surgery community do not support the recently proposed changes in first-year residency duty hours. The proposed changes are unnecessary and will further compromise thoracic surgical education and patient safety.

The implementation of duty hour regulations by the ACGME in 2003 effectively limited resident work hours. However, as acknowledged by the ACGME Task Force on Quality Care and Professionalism, reduction in resident work hours is not associated with a reduction in medical errors.1 The Task Force also reported that there is no connection between resident work hours and morbidity and mortality in any given hospital.2-4 Furthermore, the ACGME has acknowledged that resident sleep time has not changed since the work hour limitations went into effect,5 nor has resident fatigue been reduced.6,7 And the additional “time off” has not been used by residents for reading or study.1

Rather than work hours, the resident issues that have, in fact, been implicated in malpractice claims are handovers, resident supervision, and communication.8 While we strongly support efforts to improve each of these three problem areas, the proposed changes in first-year resident work hours will actually work counter to such efforts. The prevailing literature has failed to demonstrate that limitation of resident work hours improves the quality of patient care and safety.1
The proposed changes call for a maximum duty length of 16 hours for first-year residents. To comply with a 6-day, 80-hour work week, the resident will not be permitted to work the proposed 16-hour days; this adds up to 96 hours over 6 days. Instead, the resident will be permitted to work only up to 13-hour days (78 hours over 6 days). Of necessity, at least two shifts (a day and a night shift, and probably an overlapping third shift) of thoracic surgical residents will be required to cover any 24-hour period. The thoracic surgical resident workforce necessary to provide such shift work simply does not exist. Further, the number of applicants for thoracic surgical residency positions is small; in 2010, there were only 67 applicants from US medical schools in the applicant pool. It is therefore impossible to generate such a workforce.

The structure of thoracic surgical education is rapidly changing from independent to integrated programs. This change has been carefully considered and vetted by the American Board of Thoracic Surgery, and programs across the country have been implemented. The number of applications for such programs submitted to the RRC-Thoracic Surgery is growing. The resident complement for each of these six-year programs is typically only one resident per year. The proposed changes in work hours for first-year residents will have a devastating effect on such integrated programs, making it impossible for them to function. Program directors of the integrated thoracic surgical residencies feel that compliance with the proposed work hour changes will lead to program closures.

The proposed change in work hours will be detrimental to resident education. Over the course of the academic year, therefore, the first-year resident may reasonably be expected to spend approximately one-half of the year on a “night shift”. During such night shifts, no didactic conferences are held, contact with faculty and senior residents is minimal, and clinical teaching is nonexistent. It is impossible to argue that shift work is in the best interest of resident education.

Furthermore, shift work in the health care setting is inherently filled with more transitions in patient care, lapses in communication, and compromised resident supervision - specific issues cited by the ACGME Task Force on Quality Care and Professionalism as justification for its proposal.9 Every academic medical center in the country strives to improve these problem issues, recognizing them to be the leading causes of compromised patient care and safety. But the proposed limitations on first-year resident work hours will only exacerbate the problems. It is therefore predictable that the new proposal will compromise, rather than improve, patient care and safety.

At the same time, these proposed work hour limitations will stunt the growth of professionalism and limit the acquisition of medical knowledge among first-year residents. A major tenet of professionalism is continuity of care. This tenet, already greatly compromised under the current work hour rules, will be nigh impossible to achieve under the proposed changes. Furthermore, the proposed reduction in resident work hours will preclude responsiveness to patient and family needs above resident self-interest.

Perhaps most importantly, implementation of the 2003 ACGME work hour regulations has led to a significant decrease in clinical and operative experience for thoracic surgical residents,10 which has resulted in greatly compromised medical knowledge. The failure rate among thoracic surgery residency program graduates on the American Board of Thoracic Surgery certifying examination has nearly doubled since the implementation of the work hour limitations; the failure rate on the oral exam has reached 30 percent for each of the last four years. The proposed work hour changes will further reduce the clinical experience of thoracic surgical residents. As such, the competency of our residents will be further compromised.

In summary, the ACGME proposed changes in work hours will compromise patient care and resident education. The specialty of thoracic surgery is dedicated to providing the best possible educational experience for its residents and the best possible care for its patients. We therefore do not support the proposed work hour reductions. We strongly urge the ACGME to withdraw this proposal.

Sincerely,
Maximum Duty Period Length

Comments not in Support

Douglas J. Mathisen, MD, President, The Society of Thoracic Surgeons
Irving L. Kron, MD, President, American Association for Thoracic Surgery
Valerie W. Rusch, MD, Chair, American Board of Thoracic Surgery
George L. Hicks, Jr., MD, President, Thoracic Surgery Directors Association
Michael J. Mack, MD, President, Thoracic Surgery Foundation for Research and Education
Keith S. Naunheim, MD, President, Southern Thoracic Surgical Association
Robbin G. Cohen, MD, President, Western Thoracic Surgical Association
Carlos Mery, MD, President, Thoracic Surgery Residents Association

References

9. Information release-June 23, 2010. ACGME Task Force proposes graduated duty hour and supervision standards to ensure excellent resident education and quality. Distributed electronically to residency programs and professional societies.

Name: Douglas J. Mathisen, MD
Organization: The Society of Thoracic Surgeons
Affiliation: organization

Good addition – but it should be extended to all PGY levels, as was recommended by the IOM (Sleep, Supervision and Safety, p. 14) 24 hours plus the additional 4 hours added for transition of care (VI.G.4.B). (1), = 28 consecutive hour shifts. This amounts to a reduction of only 2 hours and is not what the IOM report had in mind when it said, “the Committee believes there is enough evidence from studies of residents and additional scientific literature on human performance and the need for sleep to recommend changes to resident training and duty hours aimed at promoting safer working conditions for residents and patients by reducing resident fatigue.” (Sleep, Supervision and Safety. P. 11) The IOM supported a 30-hour shift only if a “5-hour uninterrupted continuous sleep period is provided between 10:00 pm and 8 am” and “residents admit no new patients after 16 hours during an extended duty period.” (Sleep, Supervision and Safety, p. 14-15.) We do not support the mandatory nap because it is neither feasible to implement, nor possible to adequately monitor for compliance. Given the intensive case load (see comments VI.E. Clinical Responsibilities) and the pace of work in today’s teaching hospitals, it is not feasible to expect that residents will be able to “strategically nap” enough to reduce the negative effects of 28 hour shifts, every third night, with no guaranteed day off each week. Using the excuse that no study has been done specifically on more senior PGY levels is not sufficient. In our field, we often extrapolate scientific data to better understand and make decisions about health and treatment regimens. Research of many professions from pilots, to truckers, to PGY 1 residents demonstrates the dangers of fatigue. We must recognize that resident
**Maximum Duty Period Length**

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<td>physicians are human and we can use data collected in all professions to support the decision to regulate duty hours. (reference to IOM report pg 65) The ACGME acknowledges substandard learning on post-call days, yet retains these days for senior years of an educational residency. Just as the 2003 ACGME on-call shift limits of 24 hours plus an additional 6 hours for transition effectively morphed into a universal 30 hour shift, so too will the new limits of 24 plus an additional 4 hours morph into 28 consecutive hours. We are strongly in support of the notion that outpatient and longitudinal care situations must be included in considerations of patient safety. While the idea that a resident can stay past his/her shift in a particular circumstance for an unstable patient is a good one – it is certain to be abused by programs, particularly when rotations are understaffed. The documentation required will also most likely be ignored. If programs did not schedule up to the maximum shift length, this problem could largely be avoided, e.g. planning a schedule with 14 hour shifts, would allow plenty of time for transition of care and provide the flexibility to stay up until 16 hours to care for an unstable patient. We would have more faith in the success of this measure if there were stronger review and enforcement mechanisms to stop abuses.</td>
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<tr>
<th>Name: Sonia Lazreg</th>
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<tr>
<td>Organization: American Medical Student Association</td>
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<tr>
<td>Affiliation: organization</td>
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The psychiatry RRC has the following concerns regarding the proposed limitation of 16 hours for PGY1 residents:
1. This rule will force most programs to use a night float system. This will have a large negative impact on the education program for small programs.
2. This rule will limit the ability of PGY1’s to gain experience as a first line member of the medical team.
3. Reducing work hours leads to more handoffs, which decreases patient safety.
4. This and other rules that limit duty hours leads to increased “shift mentality” among residents, which decreases physicians’ feeling of responsibility to the overall care of their patients and therefore has a negative impact on professionalism.

In addition, the psychiatry RRC believes that strategic napping - while a laudable goal - is not practical, since it is hard to force or require someone to nap while remaining the responsible on-duty physician. However, The Committee supports standards that require an environment where napping is promoted and space is easily available for resident napping when they are not providing care. 

The psychiatry RRC notes that while fatigue prevention is central, it is evident in the proposed duty hour requirements that insufficient attention has been paid to assuring that residents learn how to respond and act appropriately when experiencing fatigue as they must do in order to be competent physicians. 

The Committee notes that in some psychiatric clinical training rotations, not allowing PGY1 residents to work more than 16 hours will limit patient access to psychiatric services and the resident’s training with patients in assessment and treatment, as well as participation in other training activities (supervision, conferences and didactics). The Committee proposes language that would allow all residents, including PGY1 residents, to exceed the 16 hour limit up to an additional six (6) hours at the discretion of the program director; this must be based on evaluation of resident knowledge, skills and abilities, including professionalism.

The RRC supports the flexibility allowing longer hours in the service of patient care and when unusual learning opportunities occur. While this should be rare, they are an important part of learning to be a responsible physician.

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<th>Name: Psychiatry RRC</th>
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<td>Organization: ACGME</td>
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<td>Affiliation: organization</td>
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On behalf of the OB/GYN RRC, the following comments are made in response to Lines 865-866. To avoid an excessive amount of call, for senior residents, 24-hour shifts may be split between two PGY-1 residents. This could be viewed as a conflict with Line 630 in which rotations must be designed to minimize hand-off's. Also, complying with this requirement may be a challenge for programs that have less than five (5) residents
## Maximum Duty Period Length

<table>
<thead>
<tr>
<th>Comments not in Support</th>
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<td>per year. It may mean that the work load would have to be augmented by physician extenders or intensivists.</td>
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**Name:** Dr. Missy Fleming  
**Organization:** ACGME  
**Affiliation:** organization

On behalf of the National Association of Children's Hospitals (N.A.C.H.), I appreciate the opportunity to comment on the proposed revisions to the ACGME duty hour standards. N.A.C.H. appreciates the hard work of the ACGME Duty Task Force in creating these revised standards. N.A.C.H. represents more than 140 children's hospitals across the country. Children's hospitals train 30 percent of all pediatricians and half of all pediatric specialists. Therefore, these new standards will have a major impact on children’s hospitals’ training programs.

We would like to support the comments provided by the Federation of Pediatric Organizations and we highlight these below:

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Comment:  
We believe that this standard would be more acceptable if a 4-hour period following the 16 hours was allowed for transitions of care which would enable residents to participate on Morning Rounds after an overnight duty hour shift. Specific comments relate to clinical, educational, and institutional impacts:

* This restricted period of time does not allow for continuity of care following the admission of a patient to a hospital.  
* More frequent transfers of care will occur because of decreased shift duration.  
* Limited data exist to support the limitation of a shift length to 16 hours for reasons of patient safety and there are conflicting perceptions about the validity of these data.  
* It is inconsistent to restrict PGY-1 residents to a shift of 16 hours and allow upper level residents longer duration of shifts.  
* Limiting the duration of a PGY-1 shift creates a need for additional resources on many existing inpatient teams, adding to the cost of providing care.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

Comment:  
There are concerns that strategic napping will be unlikely to occur in busy clinical environments.

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions of care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Comment:  
Four hours may be an insufficient period of time for participation on Morning Rounds.

VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Comment:
Maximum Duty Period Length

Comments not in Support

We are supportive of this allowance for extensions of periods of duty under very specific circumstances.

Several additional items deserve special comment:

1. There is significant concern that the ACGME needs to take responsibility for the measurement of outcomes related to the impact of these revised duty hour standards on patient safety, resident competence, education, institutional resources, and on academic faculty. It is only through the development and sponsorship of a carefully crafted research enterprise, that the ACGME can build an evidence base to inform any future revisions in its duty hour standards and other program requirements.

2. The ACGME has kept to a timeline for putting these standards into effect as of July 2011. Many in the pediatric GME community believe that this timeline is unrealistic, given the need of many programs to develop and hire additional staff to support the 16 hour shift duration for PGY-1 residents. This short timeline and the need for evidence and research would suggest that an alternative implementation plan with phased in standards and the opportunity for research would better address this issue.

3. As noted in the NEJM Commentary on June 24th, the GME community was consumed with implementing new duty hour standards in 2003 and, therefore, larger changes in the learning environment never occurred. These proposed duty hour standards will continue to consume the efforts of program directors to meet new accreditation requirements. There is growing concern that regulatory compliance forcing the redesign of models of care will overshadow or stifle educational innovation and improvement.

4. Redesigning models of care to comply with these duty hour standards will require substantial additional resources. It is estimated that as many as 20-25 percent additional providers are needed to create compliant care delivery teams. These additional costs occur at a time when the cost of our nation’s health care system is under intense scrutiny and we struggle with the initial enactment of health care reform. The financial impact on hospitals and departments must be factored into the adoption and timing of these new duty hour standards.

Name: Lawrence McAndrews
Organization: National Association of Children’s Hospitals
Affiliation: organization

PGY-1 16 hrs - Physical, emotional, and psychological resilience improves with conditioning, under appropriately supervised circumstances. The PGY-1 year is the time when trainees have the most supervision available, and supervisors are most aware of the trainees lack of experience. Further, PGY-1’s should have the least accumulated fatigue that occurs over years of residency training. Consequently, the PGY-1 year is exactly the time to have them learn how to provide patient care, and learn how to learn. Additionally, while the rule is 16 hrs, with the 10 hr between shift expectation, this means 14hrs. And, to avoid getting close to violations, turnover will start earlier. So, these rules effectively put PGY-1’s on 12-13 hr shifts, which will disrupt their ability to follow patients through the trajectory of care, be it a pregnant patient laboring, or working up and treating an MI, or following an MVA patient from the ER to the OR to the ICU.

Name: William Leininger, MD
Organization: Naval Medical Center San Diego, ObGyn Residency Program Director
Affiliation: individual

Family Medicine is concerned about the disconnect between the statement that residents can't see continuity patients when they are post call and the requirement to see a set minimum number of patients.

Name: Bryan Martin, DIO
Organization: The Ohio State University
Affiliation: individual

I am very concerned and following up on our clinical executive board discussion that has raised concern over the increased number of “pass off” experience that will occur with this requirement that will impact resident education, patient care and potentially patient safety.
Maximum Duty Period Length

Comments not in Support

I do not know where to put this comment as it applies to the application timeline for the recommendations. I am placing the comment here, but hope that it will be considered as part of the global review, not just supervision.

I am very concerned with the potential disruption to our education programs with a rapid implementation of these new guidelines in July 2011. To have a proper implementation, I would strongly suggest a voluntary compliance for the first year beginning 2011 with monitoring and full implementation to begin in 2012 or beyond.

Name: Grant W. Cannon
Organization: Salt Lake City VA
Affiliation: individual

There is no logical reason to treat PGY1 residents differently than others, it is disruptive to the night teams and means that these residents cannot work Friday day, take call at night and go home and sleep Saturday, they would have to leave at 10pm. Where would a resident come from who has not worked during the day? It means extending the night float intern to six nights in a row, which is more onerous and disruptive to their personal lives.

It also means Saturday call is broken into two shifts which my residents are unhappy about because they will have to work more weekends, they would rather get it over with and maximize completely free weekends. In obstetrics and gynecology, we are used to 24 hour shifts, it is how most attending physicians work and minimize handoffs during labor. It is what residents will encounter when they graduate.

Name: Carmen Sultana
Organization: Thomas Jefferson University
Affiliation: individual

We hesitate to support duty hour changes that would eliminate the early exposure to continuity of care. Under the proposed changes the maximum allowable duty period of a PGY-1 resident would be 16 hours, we feel that even at the PGY-1 level the educational opportunity of experiencing continuous, overnight in-house call is beneficial and valuable to the development of a physician. We hesitate to endorse this restriction of PGY-1 work hours and would prefer to see PGY-1 residents protected through mechanisms that instead safeguard duty-free time.

American Academy of Emergency Medicine – Resident and Student Association

The new limitations of duty hours will decrease the overall educational time and clinical experiences for family medicine residents over their current 36 months of training.

The limitations will also specifically impair many programs' ability to meet the required continuity patient care visit thresholds in the ambulatory setting, thus compromising a key educational component of family physician training.

We believe that the new restrictions will especially compromise our residents' ability to provide continuity care for their obstetrical patients.

The limitations in duty hours are likely to promote a "shift work" approach to practice that is not consistent with our efforts to move toward more patient centered care. This standard decreases the ability of PGY-1 residents to see the early evolution of acute clinical disorders and compromises their opportunities to see the results of their decision-making and clinical interventions during inpatient care.

• This standard adversely affects the ability of PGY-1 residents to get the required continuity ambulatory family medicine training by limiting the number of patient care sessions in the Family Medicine Center during the critical first year of training.
• This standard limits the continuity of care and the availability of residents to their patients both in the hospital and in the ambulatory setting. This will result in a negative impact on patient care through increased hand-offs and transitions of care.
• In the July 2010 survey of family medicine residencies, 92% of program directors reported that this standard would negatively impact their programs.
Comments not in Support

American Academy of Family Physicians
We are particularly alarmed by the requirement that would limit the consecutive duty hours of first-year residents to 16 hours, rather than the 24 hours of second- and third-year residents. We oppose this regulation, because we believe that such a limitation would have a number of adverse consequences, including insufficient clinical exposure and experience to prepare residents for greater patient care responsibility, inadequate time for residents to observe the course of a disease's or illness' development, more frequent hand-offs of patients, and the fostering of a shift mentality among new residents. We have also noted an absence of evidence to justify the 16-hour requirement, which thus seems an arbitrary timeframe. Since many attending physicians often work more than 16 consecutive hours, the Academy regards such a restriction as out of step with the reality of medical practice.

American Academy of Pediatrics (AAP)
In looking at the new duty hour requirements, the one most difficult to envision furthering education and preserving patient care is that at VI.GA.a (line 865-866), the 16-hour restriction for PGY1s. During their inpatient rotations this will mean that shifts will be required, increasing hand-offs and not allowing them ever to view the whole first day of admission. I don't understand either why it was thought that interns required a shorter duration of their longest shift as opposed to the senior residents. I think it is more critical for them to see this period of time, i.e. the 24 hours, during their first year when they spend more time on the general wards than in the second year when they are on critical care rotations.

AAP Committee on Hospital Care and AAP Section on Hospital Medicine
Wording on duty periods for PGY 2 and above (IV.G.4.b.) is vague and immeasurable. "must encourage ... alertness management" and "Strategic napping ... is strongly recommended" Supporting Rationale: Most of the requirements are phrased with traditional "must" and "should". These terms have specific meaning to RRCs and to residency program directors. It is known how imperative a requirement is based on the use of those two terms. As worded, strategic napping will not be required because it is not coupled with must or should. For large residency programs, having more than one senior resident on call during the evening is common and will facilitate alternating strategic napping of the supervising residents. For small to medium size programs where a single senior on call at night is common, this recommendation will likely be ignored, since it is not feasible to provide supervisory coverage during the "nap gap."

AAP Committee on Pediatric Education
While we are aware of the realities that exist within fellowship training, the AASM recommends the following rule be adopted for all resident physicians regardless of program year: work hours be limited to 80 hours per week; a duty period not exceeding 16 hours in duration; and a limit of no more than 6 days a week of educational and clinical responsibilities. This recommendation is based on available literature - including Resident Duty Hours: Enhancing Sleep, Supervision, and Safety and abundant evidence published in peer-reviewed journals - that reports ill associations between work hours and medical errors. A recent study published in the August issue~ of SLEEP details the, negative implications associated with shifts exceeding 17hours: In a systematic review of the literature, investigators found that reduction or elimination of resident shifts exceeding 16 hours led to improvements in quality of life; improvements in patient safety and quality of care; without negatively impacting medical education.

American Academy of Sleep Medicine
By far, the issue that received the most discussion was the sixteen-hour restriction for PGY I residents. Our members found this requirement particularly arbitrary, and could find no reason for PGY I's being singled out in this way. Moreover, they noted many costs which they found onerous and deleterious. Implementing a 16-hour limit for psychiatry PGY I's will mean that they are limited to serving overnight as night float and, as such, will spend more of their time on this kind of rotation than they otherwise would. For example, many small psychiatry programs (4 residents per year) noted that a night float system would require that their residents do 3-4 months of night float, or that they eliminate crucial training sites. Both of these solutions would have a negative impact on residents' educational experience. Night float is seen as a less rich
**Maximum Duty Period Length**

### Comments not in Support

- **American Association of Directors of Psychiatric Residency Training**
  1. "Duty periods of PGY-1 residents must not exceed 16 hours in duration (/.865-866)" While this proposal does not directly apply to cardiovascular disease training programs, we have difficulty accepting the rationale that a blanket limitation of this magnitude is a necessary and beneficial change. It will have a negative educational impact, and likely will lead to some marginalization of the PGY1 trainee in the care of the hospitalized patient. It will also affect the principle of graded responsibility. It does not recognize that rotations and call assignments differ in the intensity of the required work, or that there is a difference in trainees during the first and second halves of the PGY1 year. Finally, it does not support the tenet that trainees and faculty have some role in monitoring and limiting fatigue. "Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m. is strongly suggested. (/872-874)" In the view of most of our training directors, the phrase "strongly suggested" in an ACGME document means: "do it consistently and document it." We agree that there should be mechanisms for rest (and back-up) for call that result in sustained and intense work. We believe, however, that this will be influenced by the type of call and variability of the required work on a given call night. Furthermore, we feel the rule as written will require a complex documentation system. Especially at the fellow level, we recommend flexibility, while consistently adhering to the prior work rules.

### American College of Cardiology Foundation (ACCF)

Lastly, we have concerns in regard to requirement VI.G.4.a., "Duty periods of PGY-1 residents must not exceed 16 hours in duration." Although we are aware of the published data in regard to PGY-1 residents, length of shift and rates of medical error (Landrigan, 2004; Lockely, 2004), it is important to recognize that their research focused on medical residents in an ICU setting. Any consideration of a mandatory limit of 16 hours must also take into consideration the appropriateness of extrapolating their data to orthopaedic residents, medical error which might occur with the increased frequency of patient handoffs, and the educational value for even the PGY-1 resident inherent to a 24 hour shift and the associated continuity of care. Taking all of these factors into consideration, we believe that, on occasion, a 24 hour shift for a PGY-1 orthopaedic resident is both in the best interest of the patient and the maturation of the young physician.

### The American Orthopaedic Association

The APPD strongly disagrees with the requirements limiting the intern shift to 16 hours. The intern 16 hour limit (VI.G.4.a) should be modified to a 16+4 hour Rule to allow transition of care and time for education.

### Association of Pediatric Program Directors

It appears that these requirements will reduce the clinical experience of general surgery residents during their early years of training, especially at the PGY1 level. The overall effect on graduating general surgery trainees is unclear at present. It will be necessary to assess the outcome of these measures across all specialties. In addition, early exposure to specialty disciplines such as pediatric surgery may be diminished. It is clear that mentorship and early exposure for trainees do play critical roles in individual career choices.

### Association of Pediatric Surgery Training Program Directors

The APDS opposes the 16-hour limit for PGY-1 residents for the following reasons:

1. We believe this change will have a profoundly adverse impact on the educational experience of PGY-1 residents as a result of either
Comments not in Support

a. Eliminating night call entirely for these residents, delaying their education in emergent and urgent patient care
b. Forcing the start of a shift in mid afternoon, increasing the number of transfers of care and decreasing the integration of the PGY-I resident into the team
c. Increasing night float, an experience with a less optimal balance of education and service that all programs have worked to minimize
d. Increasing the risk of more variable sleep/wake cycles, with more chronic fatigue, because of more variation in the work start and end times.
e. Making it harder to construct longer blocks of time off

2. We also believe this change will have an equally adverse impact on the educational experience of surgery residents at other levels of training by
a. Increasing night call, which removes the resident from the educational experience of the following day.
b. Increasing night float, again an experience with a lower proportion of educational activities.

3. This change will also have a significant adverse impact on the quality and safety of patient care resulting from less continuity of care and additional transfers of care.

4. Finally this change will disrupt team spirit and dynamics as a result of a. differential performance expectations
b. forcing a mid-afternoon shift start that does not fit within the structure and function of the team

The APDS opposes the reduction of 24+6 to 24+4. We are aware of no data that support the need for this change. In contrast this reduction will adversely affect the education of the residents by further reducing the opportunity to participate meaningfully in educational conferences following overnight call and further limiting continuity of care. The APDS also notes some internal inconsistencies in the proposed requirements and requests specific clarification of the following:

I. the 16-bour limit for PGY-I residents will absolutely increase the number of transitions of care, yet the program directors are required to minimize transitions of care. How will these opposite requirements be reconciled?

Association of Program Directors in Surgery (APDS)

Institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874,879-880, and 899-902) are likely to have a nominal effect on patient safety as well as resident fatigue and will likely further erode competency of graduating physicians to work in an unsupervised environment and integrate into a medical community in which they will be required to care for patients over irregular and extended time periods.

Beaumont Hospital Royal Oak Department of Orthopaedic Surgery

Most members disagreed with limiting the duty hours of PGY-1s to 16 hours. While this requirement will likely decrease resident fatigue, the members of CoPS remain concerned that limiting duty hours will adversely affect resident knowledge, skills and experiences in preparing them for the clinical and academic rigors of fellowship. Should this provision be adopted, we urge that relevant, objective data regarding resident performance (e.g., in-training and certifying examination scores) and career choices be tracked closely during the next decade. Residency programs should be encouraged to implement educational programs (e.g., simulation, observed structured clinical examinations) that will replace the experiential education in patient care that will be lost because of reduced duty hours. Most members agreed with limiting the duty hours of PGY-2 and above to 24 hours plus 4 hours for effective transitions of care. CoPS remains concerned, however, that the revised duty hour and supervision proposal does not sufficiently differentiate between fellows and residents. As proposed, a third year fellow in a pediatric subspecialty must abide by the same regulations as a PGY-2. CoPS and its allied organizations, including the Organization of Neonatology Training Program Directors and Directors of Pediatric Critical Care Training Programs, strongly recommend that fellows be allowed sufficient autonomy and flexibility to obtain knowledge through scholarly and clinical activities that prepare them for successful subspecialty careers. Most members agreed strongly with the flexibility provided to trainees by the provision that residents, on their own initiative, may remain beyond scheduled hours to provide care to a single patient. This thoughtful provision validates the commitment and responsibility that trainees have for their patients and recognizes the important role that professionalism plays in the education of residents and fellows.
Maximum Duty Period Length

Comments not in Support

Council of Pediatric Subspecialties (CoPS)
In the conclusion of our discussions we identified an additional issue to which we would like to draw your attention. While we generally feel that the new standards for PGY-1 residents are sound, we are concerned that limiting the duty periods will negatively impact the educational experiences of certain first year residents, especially in orthopedic and transitional year residencies. In these programs, interns are exposed to very short but crucial periods of training in which their 'on-call' experience is key to their growth as physicians; these learning opportunities may be lost under the proposed framework.

Council of Review Committee Residents
The WBAMC GMEC requests that the following requirements be deleted from the proposal or be substantially modified because they will fragment the medical education of residents, decrease educational activities, and decrease the flexibility in the resident call schedule. a. The 16-hour limit on PGY-1 continuous duty hours; c. The reduction of 24+6 to 24+4.

William Beaumont Army Medical Center (WBAMC)
VA notes the absence of a strong rationale for the 16-hour maximum duty period for PGY-1 s alone and recommends that ACGME adopt a consistent standard for all residents in core training programs. We encourage ACGME to set limits on shift length that are evidence-based and which do not negatively impact continuity of patient care, clinical skill development and professional identity formation.

Department of Veterans Affairs (VA)
Having the PGY1 on a different schedule then the other residents will increase the number of transitions, will lead to a break down in team dynamics, and will have a deleterious effect on their overall education. This should be reconsidered. PGY1 residents need to be part of the team and not treated as a separate entity.

Drexel University College of Medicine
We oppose the following proposed requirements:
I) "VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration."
2) "VI.G.b.(I) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain onsite in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours."
3) "VI.G.4.b.(2) Residents must not attend continuity clinics after 24 hours of continuous in-house duty."

Chief medical officers for the three Los Angeles County hospitals
The only way that I can see to follow the proposed regulations as well as providing adequate clinics, inpatient care and didactic experience would be to begin shifts at odd hours, unlikely to fit with their family schedules or even a natural circadian rhythm. This is particularly true of the 16 hour regulation for interns. Even extending the policy to 24 hours would make continuing to have start times in the morning and most end of shifts in the evening significantly more feasible.

Idaho State University Family Medicine Residency
Use of "may," "must," and "strongly suggested" in the same standard is confusing. Also, an entry for "alertness management strategies" and "strategic napping" should be developed for either an FAQ or for the ACGME Glossary. "Strategic napping" should be removed from the CPRs since it is "strongly suggested" but not required and, therefore, unable to be cited by a Review Committee. See General Recommendation #4: Level and/or Expectation for Compliance. The IRC recognizes the good intention in this standard. However, in addition to the fact that monitoring will be extremely difficult, it is not clear what standard will be applied to review of an accumulation of extensions for a single resident or for multiple residents on one rotation or in one program. It is not clear how a DIO or GMEC could effectively monitor these exceptions, especially in large SIs. See both General Recommendation #3-Philosophical/Definitional Statements and General Recommendation #4: Level and/or Expectation for Compliance.
### Maximum Duty Period Length

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<td><strong>Institutional Review Committee (IRC)</strong></td>
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<td>For the reasons articulated below, we feel that limiting PGY-1 work hours to a 16-hour shift is not based on a foundation of evidence, is too prescriptive, and should have flexibility if appropriately justified in terms of a program's educational and professional goals, objectives, pedagogy, and supervision.</td>
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<td><strong>a group of Internal Medicine program directors from University programs</strong></td>
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<td>We have heard from program directors in our state that though well-intended, the proposed changes (including at the PGY1 level) may actually result in a loss of valuable training experiences for the resident, which will likely manifest itself in compromised patient safety in the future.</td>
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<td><strong>Kansas Medical Society (KMS)</strong></td>
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<td>Institution of further duty hours restrictions in the PGY1 and PGY2 training mayor may not improve patient safety and resident fatigue. The beneficial effects of such a reduction have not been proven. This proposed reduction will impose more cumbersome documentation and administrative support at a time that finances in academic institutions are critically low. This has the potential to erode physician competency and reduce technical skills. We at the Loyola University Orthopaedic Residency Training Program oppose the adoption of the proposed modifications to resident duty hours.</td>
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<tr>
<td><strong>Loyola University Chicago Stritch School of Medicine Department of Orthopaedic Surgery &amp; Rehabilitation</strong></td>
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<td><em>Duty periods of PGY-I residents must not exceed 16 hours ill duration</em> (lines 865-866). To be brief and blunt this rule necessitates the implementation of a night float system, which effectively increases the number of hand-offs and transitions necessary to care for patients. It also does not allow for a preceptor model of training to be successful. At our institution surgical PGY-1 trainees are paired with more senior trainees for the entirety of the PGY-1 year. (instead of continuously being able to work as a team (one PGY-I and one senior trainee, together at all times), PGY-1s will be forced to leave the hospital and a new PGY-1 will cover &quot;the night shift.&quot; When the call period is over and the PGY-V resident goes home, the previous PGY-1 resident will be returning. This will unnecessarily create a pool of rotating PGY-I residents. It will detrimentally decrease the consistency of their training and the care of patients. Another unintended consequence of this rule will be a decrease in the amount of education residents on &quot;night float&quot; will receive. Learning and teaching is greatest during the day when night float residents will be at home resting in anticipation for call duties.</td>
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<td><strong>Mayo Fellows Association (MFA)</strong></td>
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<td>If the PGY 1 resident, for example, is limited to 16 hours of clinical duty time, which becomes 14 hours to allow for 10 hours free of duty prior to the next work period, academic time will further reduce an intern's exposure to clinical medicine/surgery. Can hours in excess of the 16 hour limit for interns be used as academic time? We strongly believe that there must be an unambiguous definition of duty hours with respect to clinical and academic time. The academic achievement of surgical residents should not suffer under such new policies. Academic/research excellence is the mechanism by which scientific innovation improves patient care and will establish a foundation for continued professional growth.</td>
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<tr>
<td><strong>Medical College of Wisconsin</strong></td>
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<td>Some of the rules, such as the 16 hour duty rule for interns or monitoring residents 10 hours off-time, seem capricious, non-evidence based, and would be difficult to impossible to implement. The inability of a resident to have a continuity clinic after 24 hours 'on' will logistically make resident schedules and continuity with patients even worse than today. These particular rules would force curtailment of resident duties and the need to set up different systems of supervision and oversight for each year of training. In the end, not only will patients suffer from curtailment of services and increased &quot;handoffs&quot;, it will become increasingly more difficult for our institution and others to afford to have training programs at all.</td>
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<tr>
<td><strong>Memorial Hospital of RI (MHRI)</strong></td>
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<tr>
<td>Against 16 hour limit for PGY1s, only four hours for transition time for PGY2s and above</td>
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### Maximum Duty Period Length

#### Comments not in Support

**Mount Auburn Hospital Internal Medicine Training Program**

The institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874,879-880, and 899-902) are likely to have a no effect on patient safety, will not significantly impact resident fatigue and may further erode the ability of graduating physicians to work in a medical community in which they will be required to care for patients over extended and frequently irregular time periods. Because of the above, the NYU Hospital for Joint Diseases Orthopedic Residency Training Program strongly opposes adoption of the recently proposed modifications to existing duty hour guidelines as detailed above. Rather, we fully support further study of the already existing guidelines to document the impact on patient safety and deceasing medical errors. When that information is available it should be used as a basis for any further changes in the duty hour policies.

**NYU Hospital for Joint Diseases**

The 16-hour rule for first year residents specifically has created the most discussion and discontent. Generally, our leaders raised many concerns related to "disruption of the team;" "lack of an educational opportunity," and "displacing service burden on others." All of the primary care training programs and general surgery respondents projected that they would have to accommodate the proposed changes either through increased resident numbers, faculty time and numbers, cross cover time by other residents, or requests for mid-level practitioners.

**Oregon Health & Science University (OHSU) School of Medicine**

- The RRC for AN recognizes that a serious unintended consequence of the Task Force's recommendations on the maximum duty period length is that it will necessitate more patient hand-offs and transitions of care. As a result of the increased transitions of care, programs will have to develop better methods to ensure complete and accurate transmission of information and foster better coordination and interaction with patients and staff, particularly in the increasingly complex inpatient environment. In addition, this change will make it difficult for programs to ensure continuity of care by a resident, undermine the resident-patient relationship and, if not actively addressed could compromise the educational experience as well as clinical care.
- The RRC for AN notes that the limitations placed on duty hours, will likely preclude both AN and Surgery residents from following surgical cases from beginning to end. Residents may not be able to participate in some of the critical aspects of complex cases. For those procedures for which the program has limited exposure, this lack of continuity will compromise the educational experience. The programs may have to identify alternative educational approaches to ensure the adequacy of the clinical experience and development of critical clinical assessment and procedural skills. These limitations will be particularly relevant to procedures such as open vascular surgical procedures, cardiac surgical procedures requiring cardiopulmonary bypass and other procedures that are decreasing in frequency, but are complex and educationally critical.

**Residency Review Committee for Anesthesiology (RRC for AN)**

- This standard decreases the ability of PGY-1 residents to see the early evolution of acute clinical disorders and compromises their opportunities to see the results of their decision-making and clinical interventions during inpatient care.
- This standard adversely affects the ability of PGY-1 residents to get the required continuity ambulatory family medicine training by limiting the number of patient care sessions in the Family Medicine Center during the critical first year of training.
- This standard limits the continuity of care and the availability of residents to their patients both in the hospital and in the ambulatory setting. This will result in a negative impact on patient care through increased hand-offs and transitions of care.
- In the July 2010 survey of family medicine residencies, 92% of program directors reported that this standard would negatively impact their programs.

**Family Medicine Review Committee**
## Maximum Duty Period Length

### Comments not in Support

The proposed requirements do not explicitly specify that PGY1 residents will not have four hours of transition time. Because the draft requirements reference “PGY1’s” in Section VI.G.4.a, and “PGY2’s and above” in Section VI.G.4.b, one can conclude that PGY1’s hours are in fact capped at 16 hours and there is no transition time. However, in an effort to ensure clarity around this issue, the RRC-IM recommends including explicit language in the requirements that there is no additional time for transition of care activities for PGY1’s. The RRC-IM recommends that the language that appears in PR VI.G.4.b.3 should also be applied to PGY1 residents. PGY1 residents are also likely to find themselves in unusual circumstances which will require them to remain (on their own initiative) beyond their scheduled period of duty in order to continue to provide care to a single patient. The requirement should remain as 24 hours of duty with up to six hours for transition/didactic related activities, instead of changing it to 24 hours with only four hours permitted for transition activities. It is unclear how reducing the number of hours from six to four will positively impact resident education and patient safety. The impact statement does not address this issue. There is also significant concern that this change will have a detrimental effect on conference attendance/participation. Lastly, although it is only a two hours reduction in time, the change will cause significant scheduling challenges for program directors. The minimum time off between scheduled duty periods (eight hours) presumably begins after the resident completes his/her duties. However, this is not explicitly clear. An FAQ should be developed to make this explicitly clear.

### Residency Review Committee for Internal Medicine

Programs that rely on PGY 1 residents for in house call will obviously be penalized under the new system - they will need to not only comply with the 16 hour rule, but will also need to provide immediately available in house supervision. I think the NRC should define what is acceptable in-house immediately available supervision. There are very few neurology hospitalists - so I don't think faculty will fill this role. The NRC should define if this can be performed by senior neurology residents

### Review Committee for Neurology

The Committee notes that in some neurological surgery training environments, not allowing PGY1 residents to work more than 16 hours will limit patient access to neurological surgery services. The Committee proposes language that would allow PGY1 residents to exceed the 16 hour limit up to an additional eight (B) hours to a maximum of 24 hours at the discretion of the program director; this must be based on evaluation of resident knowledge, skills and abilities, including professionalism. The Committee notes that a rationale for reducing the additional hours from 6 to 4 following the maximum 24 hours of continuous duty was not provided. Limiting additional time for transitions in the care of neurological surgery patients to four hours could negatively impact patient safety, with little to no improvement in resident alertness. The Committee proposes language that would allow intermediate-level and senior residents, to exceed the 24 hour limit up to an additional 6 hours at the discretion of the program director; this must be based on evaluation of resident knowledge, skills and abilities, including professionalism.

### Neurosurgery RRC Response

Limiting the educational experience of PGY1 residents in a surgical specialty could challenge the fundamental basis of residency education in Orthopaedic surgery. Each level of education is a key component in a complex matrix of learning. The PGY1 experience is designed to facilitate the acquisition of fundamental skills of surgical education, particularly in regard to care of the injured patient, something that frequently occurs after usual work hours. Limiting the educational experience to 16 hours during the PGY1 level could cause an imbalance in the fundamental knowledge that these residents should acquire as a prerequisite for the next years of education and training. From a purely structural and organizational perspective, the proposed limit for PGY1 residents will result in juggling of schedules for each year of the residency. This practical matter aside, the Orthopaedic Surgery community believes that there is a tremendous educational benefit to residents and ultimately to patients from the experience gained in caring for patients throughout a 24-hour period.

### Review Committee for Orthopaedic Surgery

However, the Plastic Surgery RRC does not agree with the proposed requirement that limits the maximum
**Maximum Duty Period Length**

### Comments not in Support

The duty period to 16 hours for PGY-1 residents (VI.G.4.a), lines 865-866). The Plastic Surgery RRC believes this requirement would have a significant adverse impact on the education of PGY-1 residents. This mandate would decrease the exposure of those residents to patient care and limit their exposure to performance of cases in the operating room, which is an essential component of surgical programs. Additionally, this requirement would increase the frequency of transitions of care, decrease the sense of “ownership” and investment in the care of individual patients, and impair their acceptance of the professional responsibilities emphasized in the revised common program requirements. The adoption of this requirement would also likely lead to the increased utilization of the unfavorable “night float” system, with its significant ‘service’ obligation and limited educational value. We are concerned that this requirement would also increase transfer of work to higher level residents, disengage the PGY-1 from the patient care team, and potentially lead to resentment by other team members. It also would likely prevent PGY-1 residents from participating in resident education conferences due to scheduling conflicts. This restriction also adversely impacts the preparation of the PGY-1 for subsequent years of residency training. The Plastic Surgery RRC is also concerned that this requirement would be particularly difficult to implement in smaller programs, which may result in program closure. We suggest that the increased emphasis on resident supervision would make this duty period restriction unnecessary and would alleviate concerns about patient care and patient safety. The Plastic Surgery RRC wholeheartedly endorses section VI.G.4.b).(3) that provides that "in unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient." This encourages, rather than prevents the important professionalism, accountability, and continuity of care that is as important to teach in residency training as the didactic or technical components of medical education. This also responds and corrects the ethical quandary residents have had in choosing between leaving patients in order to comply with "the rules", or violating the duty hours standards by remaining with a sick patient when they believe it is their professional responsibility. However, the Committee strongly opposes the stringent documentation requirement that undermines the positive intent of this section. Although it is reasonable to expect the resident to "appropriately hand over the care of all other patients..." (VI.G.4.b).(3).(a).(i)), it is unnecessarily restrictive to require individual patient by patient documentation each time this occurs (VI.G.4.b).(3).(a).(ii)). In fact, at a time when the residents should be focused primarily on a sick patient, he or she is asked to think about and provide written documentation of the rationale behind the extended duty period. The Committee agrees that the program director should "track both individual resident and program-wide episodes of additional duty". However, we feel that individual resident documentation and the requirement that "the program director must review each submission of additional service..." (VI.G.4.b).(3).(b)) is excessive, impractical, and undermines the intent of teaching accountability, professionalism, and patient safety as a core underlying principle. We would strongly recommend using language similar to the subsequent section (VI.G.5.c) and VI.G.5.d)) to provide the appropriate level of oversight for exceptions in this duty hours requirement. We would suggest the following language: "This must occur only within the context of the 80-hour and one-day-off-in-seven standards and must be monitored by the program director." This would then be in line with the similar exception noted in section VI.G.5.c).

### Plastic Surgery Residency Review Committee

The Surgery RRC does not agree with the proposed requirement that limits the maximum duty period to 16 hours for PGY-1 residents (VI.G.4.a), lines 865-866). We believe this requirement would have a significant adverse impact on the education of PGY-1 residents. This mandate would decrease the exposure of PGY-1 residents to patient care and limit their exposure to performance of cases in the operating room, which is an essential component of surgical training programs. Additionally, this requirement would increase the frequency of transitions of care, decrease the sense of “ownership” and investment in the care of individual patients, and impair their acceptance of the professional responsibilities emphasized in the revised common program requirements. We are concerned that this requirement would also increase transfer of work to higher level residents, disengage the PGY-1 from the patient care team, and potentially lead to resentment by other team members. It also may prevent PGY-1 residents from participating in resident education conferences due to scheduling conflicts. This restriction would not adequately prepare the PGY-1 for subsequent years of residency training. The Surgery RRC is also concerned that this requirement would be particularly difficult to implement in smaller programs, which may result in program closure. We suggest that the increased emphasis on resident supervision makes this particular duty period restriction unnecessary.
and should alleviate concerns about patient care and patient safety. We suggest added language to the proposed requirement regarding a transition time of four hours after a 24 hour duty period. The recommended phrase is: "Residents may be allowed to remain on-site in order to accomplish these tasks or for educational activities such as conferences; (lines 877-879)."

**Surgery Residency Review Committee**

The Thoracic Committee wholeheartedly endorses section VI.G.4.b).(3) that provides that "in unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient." This encourages, rather than prevents the important professionalism, accountability, and continuity of care that is as important to teach in residency training as the didactic or technical components of medical education. This also responds and corrects the ethical quandary residents have had in choosing between leaving patients in order to comply with "the rules", or violating the duty hours standards by remaining with a sick patient when they believe it is their professional responsibility. However, the Committee as strongly opposes the stringent documentation requirement that undermines the positive intent of this section. Although it is reasonable to expect the resident to "appropriately hand over the care of all other patients..." (VI.G.4.b).(3).(a).(i)), it is unnecessarily restrictive to require individual patient by patient documentation each time this occurs (VI.G.4.b).(3).(a),(ii)). In fact, at a time when the residents should be focused primarily on a sick patient, he or she is asked to think about and provide written documentation of the rationale behind the extended duty period. The Committee agrees that the program director should "track both individual resident and program-wide episodes of additional duty". However, we feel that individual resident documentation and the requirement that "the program director must review each submission of additional service..." (VI.G.4.b).(3).(b)) is excessive, impractical, and undermines the intent of teaching accountability, professionalism, and patient safety as a core underlying principle. We would strongly recommend using language similar to the subsequent section (VI.G.5.c) and VI.G.5.d)) to provide the appropriate level of oversight for exceptions in this duty hours requirement. We would suggest the following language: "This must occur only within the context of the 80-hour and one-day-off-in-seven standards and must be monitored by the program director." This would then be in line with the similar exception noted in section VI.G.5.c).

The Thoracic RRC also strongly endorses section VI.G.5.c) that provides for residents in their final years of education to have greater flexibility in the scheduled duty hours to continue to care for patients under their responsibility, yet within the overall 80-hour and one-day-off-in seven standards. We agree that this is important to better prepare residents to enter the unsupervised practice of medicine and to provide the accountability and professionalism required in the irregular and extended periods of attending physician practice.

**Thoracic Residency Review Committee**

The Committee raises concerns that the 16 hour duty period limitation for PGY-1 residents may be disadvantageous, because these residents will encounter diminished opportunities for educational experiences in continuity of care for critically ill patients and a reduction in experiences that foster understanding and interpreting of (natural history of) disease processes in a linear fashion. Additionally, any increase in transitions of care that necessarily occur as a result of shortened duty periods may not be balanced by the development of adequate sign out processes that ensure patient safety and quality patient care. The sign out process will require additional layers of oversight (senior residents and attendings) that may pose significant challenges to Programs. The increase in number of transitions of care that will result from the duty period limitation may have unintended consequences, such as a potential reduction in patient satisfaction. The Committee is also concerned that significant resources will be required. The Committee requests that clarification of this revision provide comment on the integration of conferences and didactics (planned educational experiences) during the period immediately following the 24 hour duty period. The Committee notes that there appears to be internal inconsistency with this requirement for decreased duty periods. Intuitively, it seems that decreased duty periods will increase transitions in care and potentially decrease patient safety (despite mandated "effectiveness" of those transitions). There should be further exploration and definition of what constitutes "effective transitions."
Maximum Duty Period Length

Comments not in Support

Transitional Year Review Committee
The Urology RRC applauds the ACGME’s approach in allowing increased flexibility in duty hours for residents in the final years of training. For urology, we would define this group as consisting of the Uro-3 and Uro-4 residents (which correspond to residents at the PGY 4, 5 or 6 levels of training). We have concerns about the additional resources that will be required to comply with the proposed new supervision requirements for PGY-I residents, although we do support the concept of requiring much closer oversight for these new trainees. As the general surgery experience does precede the accredited urology training years, this requirements will have little direct impact on urology residency programs. We also have concerns about the maximum 16-hr duty limits for PGY-I residents, with regard to the resources that will be required to comply with this requirement, and the lack of clear evidence basis for this change. Again, however, this new standard will have little direct impact on urology residency training.

Urology RRC
For example, SAEM applauds the ACGME in recognizing that the novice learner, i.e. PGY1 residents, are more prone to error - it is assumed that the proposed shorter work duty hour periods recognize this fact. The implementation of this change may lead to less errors in patient care and improved educational experiences. However, the proposed 16 hour rule has three potential consequences. First, from a patient safety point of view, it will lead to an increase in the number of hand offs, creating an increased risk for patients in direct conflict with the mandate to decrease transitions in care. Second, residents learn by caring for individual patients; decreasing the number of patient contact hours may in effect decrease learning. Third the requirement for 10 hours off after a 16 hour shift, results in increased scheduling complexity as shifts are based on a 24 hour day. The statement on minimizing transitions of care provides no guidance on how to accomplish this while shortening work periods and "strongly encouraging" strategic napping. The goals of working shorter periods and minimizing transitions of care for the most part, are mutually exclusive. We agree that more experienced physicians should be allowed to work longer hours for two reasons. The advanced resident is less prone to errors in patient care as a consequence of increased mastery in the clinical setting. Furthermore, the ratio of required new learning to service component is reduced in the more experienced resident, thus they are able to channel their "learning moments" more effectively during longer periods of work. SAEM encourages the idea of patient "ownership"; the concept that patient care is critically important to the physician-patient relationship and that duty hours do not apply to post-residency patient care. We appreciate the ACGME acknowledgement that in certain situations the professional course of action would be to stay beyond the assigned 24 hour duty period to provide appropriate care for the patient. We are concerned that documentation issues for such instances would put an undue burden on program directors and designated institution officials, as well as the residents who have sacrificed additional time for patient care already, thereby further adversely affecting duty hours.

Society for Academic Emergency Medicine
The proposed changes call for a maximum duty length of 16 hours for first-year residents. To comply with a 6-day, 80-hour work week, the resident will not be permitted to work the proposed 16-hour days; this adds up to 96 hours over 6 days. Instead, the resident will be permitted to work only up to 13-hour days (78 hours over 6 days). Of necessity, at least two shifts (a day and a night shift, and probably an overlapping third shift) of thoracic surgical residents will be required to cover any 24-hour period. The thoracic surgical resident workforce necessary to provide such shift work simply does not exist. Further, the number of applicants for thoracic surgical residency positions is small; in 2010, there were only 67 applicants from US medical schools in the applicant pool. It is therefore impossible to generate such a workforce.

eight cardiothoracic surgery organizations
• Further reduction in resident work hours will negatively affect the overall learning environment by reducing didactic and bedside opportunities and will ultimately create residents with gaps in depth of knowledge and patient care experiences.
• In particular, reduction in intern work hours to 16hr shifts would limit the kind of overnight call and patient
Maximum Duty Period Length

Comments not in Support

management experience necessary for establishing good clinical reasoning and efficient supervisory skills.
• The estimated 1/3 reduction in work hours would also make the transition to private practice, often requiring overnight and weekend call, more difficult.
• Recommended "strategic napping" is un-measurable and would lead to dangerous mid-shift gaps in coverage or additional unnecessary transitions in patient care, patient "check outs," which have been shown to negatively affect continuity in patient care and patient safety.
• In order to accommodate these recommendations, programs will likely need to implement night float systems which reduce on call resident numbers and also require additional patient check outs.

100 current pediatric residents from Palmetto Health / USC School of Medicine, Medical University of South Carolina, and Greenville Hospital System / USC School of Medicine

For a variety of reasons, handovers are becoming more necessary (inpatient to outpatient, outpatient to inpatient, shift to shift, etc.), lending even more importance to the necessity for methods that teach this process well. However, it should be recognized that current processes are inadequate and simply creating a new system of mandates is not a safe way to change workflow. Shorter work shifts would negatively impact continuity of care and may contribute to a shift-work mentality. Pilot programs that focus on methods for studying the hand-over process and identifying best practices for care transitions are needed before the proposed standard is implemented. Consideration should be given to incorporating shift change transitions early in the medical teaching process. Although time in training is not in itself a guarantee of an enriching educational experience, additional time in training enhances opportunities for more clinical experience. Less time in residency means fewer patient encounters, less exposure to the broad array of diseases, and obviously less time "in the trenches" to diagnose and carry out medical treatment needs. Lengthening residency training periods would create a greater financial burden for hospitals, clinics, and residents. Further, this would constrain the ability to produce more physicians in a timely manner in response to growing demand.

Texas Medical Association's Council on Medical Education

The TSRA does not agree with the new work hour restrictions proposed for PGY-I residents (VLGA.a). Since one of the tenets of most safety studies has been decreasing transitions of care, it is unclear to us why the creation of more transitions within this important group of residents would lead to increased patient safety. Furthermore, it could be anticipated that the proposed changes would transition more service work to higher-level residents and simultaneously alienate the PGY-I resident from the team. This may also erode educational opportunities for PGY-I residents. We would request that the maximum duty period for PGY-1 residents be kept in line with that of other level residents. We are in agreement with the added flexibility in duty work hours allowed (VI.GA.b).(3)). This flexibility simulates more closely the responsibilities that we as physicians will have towards patients after training and at the same time allow for completion of educational opportunities that would otherwise be truncated because of the end of a "shift." This is particularly important in surgical programs where it would be detrimental for both patient care and resident education to promote residents from scrubbing out of surgical procedures because of work hour limitations. We understand why it would be reasonable for program directors to "track both individual resident and program-wide episodes of additional duty," but are concerned with the level of documentation required. Specifically, we are apprehensive about the over restrictive nature of requiring individual patient-by-patient documentation each time an event occurs (VLGA.b).(3),(ii)). We are in favor of section VLG.5.c that allows for residents in their final years to have more flexibility in hour requirements within the 80 hour work week for patients under their responsibility. The varying hours that this change allows more adequately mirrors the often extended periods of care required as a physician in practice.

Thoracic Surgery Residents Association (TSRA)

Institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874,879-880, and 899-902) are likely to have a nominal effect on patient safety as well as resident fatigue and will likely further erode competency of graduating physicians to work in an unsupervised environment and integrate into a medical community in which they will be required to care for patients over irregular and extended time periods. Because of the above, the Tufts Affiliated Hospitals Orthopedic Residency Training Program
### Maximum Duty Period Length

#### Comments not in Support

strongly opposes adoption of the recently proposed modifications to existing duty hour guidelines as detailed above.

**Tufts Medical Center – Department of Orthopaedics**

- 16 hour shifts supported by data in critical care units for first year residents
- Reconsider recommendation in non-critical care units
- Concerns:
  - Requires additional care transitions
  - Reduced continuity of care learning opportunities
  - Acquisition of technical skills
  - Increased burden on PGY-2 residents
  - Unintended consequence of increasing workplace stress for upper level residents
- Increased hour for transitions appreciated
- One of the most important additions to the standards; acknowledges important and unique role of physicians in care of individual patients

**University at Buffalo residents and faculty**

Institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874, 879-880, and 899-902) are likely to have a nominal effect on patient safety as well as resident fatigue and will likely further erode competency of graduating physicians to work in an unsupervised environment and integrate into a medical community in which they will be required to care for patients over irregular and extended time periods. Because of the above, the University of Wisconsin Orthopedic Residency Training Program strongly opposes adoption of the recently proposed modifications to existing duty hour guidelines as detailed above.

**University at Buffalo The State University of New York – Department of Orthopaedics**

The proposed 16-hour limit for first year residents is especially perilous for the development of a modern medical physician. There is strong evidence from closed malpractice suits that lack of supervision, handover practices, and communication are the major factors in medical errors within medical residencies. We agree that the emphasis on improving supervision of first year medical residents may help decrease errors and improve both training and patient outcome. However, the 16-hour limit will have detriments far beyond its intended benefits. The 16-hour limit will lead to a "shift" mentality that is not only a detriment to the training of the resident, but the health of the patient. As the 10M's recommendations reveal that the 2003 guidelines increased the frequency of "handoffs" and "sign-outs." This transition of care is the most perilous period of one's medical care and the institution of proposed limits on work hours will only increase this trend. It also breeds a "loss of ownership" mentality that not only compromises patient care, but endangers the professionalism and high standards our profession requires.

**University of Minnesota Medical School St. John’s Family Medicine Residency**

Further reductions in work hours (specifically, the 16-hour cap on intern work hours and 24-hour cap on junior work hours) will erode professionalism, education, and patient care. Already with the current eighty hour work week requirement, we residents have experienced being shut out of the operating room when operations have gone over expected time, or not allowed to participate in managing complications of surgeries we were involved in, for fear of duty hour violations. None of this helps us to become better professionals, surgeons or doctors. Furthermore, pass rates on the board exams have dropped, and there are also concerns that surgery residents are graduating without adequate preparation. With more restrictions on our training time, it stands to follow that we will either need to lengthen an already lengthy residency program or be forced to graduate inadequately trained surgeons. None of us went into medicine to log duty hours on a daily basis. The 80 hour work week in general is a good guideline, and easily met. However, there are times when it is reasonable that we should be able to work more than the proposed 16 or 24 hours if need be, or occasionally have less than eight hours off from the hospital, without the threat of punishment and the need for more documentation to defend our work ethic. In other words: Just Let Us Do Our Jobs.
Comments not in Support

General Surgery Residents of the University of Minnesota

Institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874, 879-880, and 899-902) are likely to have a nominal effect on patient safety as well as resident fatigue and will likely further erode competency of graduating physicians to work in an unsupervised environment and integrate into a medical community in which they will be required to care for patients over irregular and extended time periods. Because of the above, the University of Missouri – Kansas City Residency Training Program strongly opposes adoption of the recently proposed modifications to existing duty hour guidelines as detailed above.

University of Missouri – Kansas City - School of Medicine - Department of Orthopaedic Surgery

Institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874, 879-880, and 899-902) are likely to have a nominal effect on patient safety as well as resident fatigue and will likely further erode competency of graduating physicians to work in an unsupervised environment and integrate into a medical community in which they will be required to care for patients over irregular and extended time periods. Because of the above, the University of Southern California Residency Training Program strongly opposes adoption of the recently proposed modifications to existing duty hour guidelines as detailed above.

University of Southern California Department of Orthopaedic Surgery

The GMEC believes that limiting PGY-1 residents to a 16 hour duty period is not based on any evidence that such a limit will enhance resident well-being or patient safety. The proposed limit will be particularly disruptive to surgical programs and there are also concerns about unintended consequences of limiting duty hours of one group of residents based exclusively on level of training. Where is the evidence that a PGY-1 resident is more subject to fatigue than a more senior resident? Not allowing residents to attend continuity clinic after being on-call will have a significant negative impact on the educational program. It is not realistic to expect that call schedules can be altered to accommodate this restriction. This restriction will prevent residents from effectively following patient progress resulting in a negative impact on the quality of care and the educational curriculum.

Graduate Medical Education Committee of the University of Tennessee College of Medicine Chattanooga

The shift work created by a 16 hour rule for interns will be detrimental to their learning environment for the following reasons:

- More handovers decrease patient safety
  - With every hand-off, understanding of the patient and the relevant medical issues decreases. The team picking up the patient has less in depth knowledge of the patient's history and ongoing medical problems. It is paradoxical that the committee would call for decreased handovers to prevent this danger while proposing a system that clearly requires more frequent transitions.
  - Nurses (and patients) will have trouble identifying who is responsible for a patient at any given time. This could result in delays in contacting the appropriate provider.
- More handovers decrease the quality of training
  - Following a patient's disease course longitudinally is possibly the most valuable learning experience for Internal Medicine house officers on call. When they must hand their patients over to another provider, they are deprived of essential education. Limiting the ability of interns to spend enough time with a new patient to see the impact of their diagnostic and therapeutic decision making will compromise the acquisition of skills necessary to be a supervising resident, leaving the PGY 2 less experienced and able to safely take on a team leadership role. Long-term, we will produce less qualified internists.
  - Handovers interfere with the quality of the patient/provider relationship. Loss of continuity deprives house officers of the bond they feel with a patient they have followed from admission and the opportunities for emotional and professional maturation that comes with full responsibility for all elements of a patient's care.
  - Handovers send the undesirable message that a "shift work" mentality is acceptable.

Residents choose to train in Internal Medicine to be part of a field that emphasizes commitment to patient longitudinally and specifically because they do not want to be shift-workers.
## Maximum Duty Period Length

### Comments not in Support

**Internal Medicine Training Programs at the University of Texas Southwestern Medical Center at Dallas**

The UW supports the ACGME requirement that allows intermediate-level and senior residents to remain beyond their scheduled period of duty to continue to provide care to a patient under unusual circumstances. This promotes the values of professionalism, dedication, accountability, and continuity of care important in the practice of medicine. It should serve patients well and support the education and training of residents to handle complex situations. The UW also supports the ACGME requirement that permits intermediate-level and senior residents to remain on site for periods of up to four additional hours beyond the 24 hours of continuous duty to ensure effective transitions in care. The recommended use of alertness and fatigue management strategies is appropriate.

The UW would like to express significant concern regarding the limit of 16 hours of duty placed on PGY-1 residents. Of UW survey respondents, 39% thought that this limit would adversely affect patient care and safety. Of note, 40% of residents and fellows considered this limit very or somewhat negative, while 45% thought that it would be very or somewhat positive, from the perspective of patient care. 56% of trainees, and 46% of other respondents, thought that this standard would have a very or somewhat negative effect on resident education. While some respondents supported this change, the majority of comments by survey respondents focused on the negative impacts of this particular proposed new standard on both resident education and patient care, as well as the substantial lack of evidence for the benefit of this proposed limitation of hours. Concerns clustered in several major areas. First, there was considerable concern that limiting PGY-1 residents to 16 hours would actually decrease patient safety and quality of care, as a result of more frequent handoffs and decreased continuity of care. Secondly, respondents expressed concerns about a decreased sense of "ownership", professionalism, and investment in the care of individual patients that would result from more limited shifts. This requirement would also be likely to result in transfer of work from PGY-1 residents to intermediate-level and senior residents which would increase their burden and could negatively impact patient care and resident education. In addition, this restriction would not permit adequate preparation of PGY-1 residents for the subsequent years of residency training. Resident feedback also noted a concern that this would interfere with the inclusion of the PGY-1 resident within the broader patient care team and a possible negative reaction from intermediate and senior level residents, with the potential for unintended peer disparagement. This decision may have a substantial impact on faculty work-load and availability of faculty for other educational endeavors.

**University of Washington**

The sixteen hour maximum duty shift for first year residents does not take into account the intensity of the clinical experience. As an example, an obstetrics rotation in a low volume rural hospital is quite different from a rotation at a high volume urban setting. In small hospital settings, residents may find themselves getting considerable rest during the course of a day and night on call. Shortening duty shifts would result in reduced opportunity for residents to be involved in an entire labor and birth, which would jeopardize the ability of programs to assure that RRC requirements for number of deliveries will be met. Greater flexibility is necessary with a focus on resident fatigue rather than on arbitrarily restricting hours present.

**Graduate Medical Education Committee of the University of Wisconsin Department of Family Medicine**

Institution of further duty hour restriction in the PG1 and PG2 training years (lines 865-66, 872-874,879-880, and 899-902) are likely to have a nominal effect on patient safety as well as resident fatigue and will likely further erode competency of graduating physicians to work in an unsupervised environment and integrate into a medical community in which they will be required to care for patients over irregular and extended time periods. Because of the above, the University of Wisconsin Orthopedic Residency Training Program strongly opposes adoption of the recently proposed modifications to existing duty hour guidelines as detailed above.

**University of Wisconsin Department of Orthopedics & Rehabilitation**

Drop:
### Maximum Duty Period Length

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<td>1. the sixteen hour limit for first year residents and keep at twenty-four.</td>
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<tr>
<td>2. the four hour limit for additional work after 24 hours on and leave it at six hours.</td>
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<tr>
<td>3. the program director review of a additional service for one patient because a resident has appropriately cared for one patient.</td>
</tr>
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### Valley Baptist Family Practice Residency

The proposed guidelines limit intern training to 16 continuous hours and resident training to 28 continuous hours. This recommendation almost sounds as if it is the reverse of what one would want if the limits are being imposed for patient safety. For example, it would seem from a patient-safety perspective that if a well rested POY-1 is making a decision and being supervised by a fatigued resident, errors are more likely than if a fatigued PGY-1 is being supervised by a well-rested resident. An intern is naturally more likely to make mistakes due to inexperience. If the safety check on that intern is a more senior resident it stands to reason that a well-rested resident is less prone to error than a fatigued resident. Also, if teams consist of an intern and resident, when interns change over and hand-off patients more often than residents, there will be more intern to intern handoffs, and more transfer of patient care overall. It seems potentially unsafe to create more transfers of care between the least experienced trainees.

### Yale Primary Care Residency Program Housestaff and Medicine-Pediatrics

Dear madam/sir,

I am the chairman and Ob/Gyn residency program director at Winthrop University Hospital, Mineola, NY. In response to the new proposed requirements about duty hours, I feel strongly that one of the proposed rules (i.e. the duty periods of PGY-1 residents should not exceed 16 hours) is counterproductive and it will decrease patient safety for the following reasons:

1) This rule will increase the number of sign-outs throughout the day (especially during weekend calls). More transfer of information may lead to more lost “in-transfer” information, thus compromising patient safety;
2) It will increase the time that the residents spend away from patients secondary to increasing number of sign-outs;
3) It will compromise continuity of care for PGY-1 residents who need to be accustomed to it as soon as possible;
4) It will create disparity in work hours among the PGY classes which could be perceived as "preferential" treatment for PGY-1's;
4) It will increase the number of shifts to cover weekends and this will adversely and disproportionately affect smaller programs with fewer residents per year; and
5) Shifts of maximum duration of 16 hours do not mimic real life (do not mimic attending work hours).

**Name:** Anthony Vintzileos, MD  
**Organization:** Winthrop University Hospital, Mineola, NY  
**Affiliation:** individual

### Comments Requesting Clarification

The proposed duty-hour standards state "strategic napping over sixteen hours of continuous duty between the hours of 10:00 p.m. and 8:00 a.m. is strongly suggested." As the ACGME states in its impact statement: "the few studies that have looked at a required nap have shown that it is neither practical nor a safe alternative." Mandating a strategic nap would further compromise continuity of care by requiring yet an additional handover of care. Verification of a strategic nap would be problematic, to say the least. Furthermore, how would one ensure that a resident had napped during the allotted time and is "properly rested?" Lastly, the financial impact of such a requirement, as a result of more workers for more shifts, would be significant.

### American Academy of Neurology

It is not clear if the statement regarding the additional four hours allotted for the transition of care applies to all residents or only to residents at the PGY-2 level and above. Supporting Rationale: As we understand the intent, this should apply to all residents (lines 876-880). The continuity clinic restriction only applies to PGY-
Maximum Duty Period Length

Comments not in Support

<table>
<thead>
<tr>
<th>Comments Requesting Clarification</th>
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<tr>
<td>2 residents and above since PGY-1 residents are restricted to a maximum of 16 hours (lines 882-882). Perhaps this could be clarified. The ability of residents to stay, on their own initiative, beyond scheduled duty periods is a significant improvement in promoting development of professionalism and in improving transfer of care for patients [VI.G.A.b.(3)]. Supporting Rationale: While it is reasonable to allow residents to remain in unusual, emergency situations, the limitation to 4 hours may interfere with professional responsibilities. After all, situations like this should not be accompanied by &quot;clock watching&quot;. Also, 4 hours seems an arbitrary issue and unusually precise.</td>
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</table>

AAP Committee on Pediatric Workforce

Does this paragraph mean that PGY-I s and other residents can have up to 4 additional hours to transition patients in addition to the 16 (PGY-I) and 24 (PGY-2 and above) in-hospital hours? Thus, residents can be taking "new patients up to the 16/24 hour deadlines? Supporting Rationale: This paragraph, if correctly interpreted by me, could lead to confusion/added stress/etc. This could be even more problematic in light of VI.G.5.a) as mentioned below. If PGY-2 or -3 only does 20 hours on the floor/PICU, is it correct to assume that they can go to continuity clinic? There is particular concern about the "sanctity" of continuity clinic for the PGY-3. Section VI.G.5.c) suggests that as a training program of pediatrics, we need to get physicians prepared to be taking care of patients in the office/hospital/nursery ICU for a full 24 hours, then working in the office the next day, at least to attend outpatients. Supporting Rationale: The training program's commitment must be to both the hospital patients and to improving the pediatric residents' care of pediatric patients in the clinic. Continuity of care is already compromised on ward services due to continuity clinic twice weekly and post call interns having to check out by noon the day after they have been on call. Now we face the prospect of rounding on 10 or more new admissions from the previous night with no intern who knows anything about the patient due to this 16-hour limit. It is unclear why a second-year resident is able to function capably for 24 hours, while a first-year resident is only good for 16 hours. We already are unable to teach and cover patients adequately on the current system. To further compromise it would seriously compromise the training of the current residents. |

AAP Section on Infectious Disease

This will prevent PGY-1 residents from taking what is now participating in what is now considered "in-house call", and will force implementation of shifts. The float team will be subjected to a new set of stresses due to regular inversions of the work day. Night float has its own inherent problems. Switching from an AM to PM day to a PM to AM day results in disruption of circadian rhythm and is associated with impaired performance until one is acclimatized. Does ACGME have any plans to help accommodate issues surrounding issues associated with the "float shift" concept? The concept of strategic napping during the hours of 10PM-8AM rest period may be difficult in the absence of a night float. This will create additional manpower demands and introduces the previously noted problems that may be inherent in the float shift concept. The nature of appropriate educational experiences remains somewhat vague. Would this include or exclude conferences? |

Otolaryngology RRC

1) [VI.G.4.a] The limitation on PGY-1duty periods will impact residents assigned to Blood Bank Service, Frozen Section Coverage, previewing surgical cases, participation in autopsies, writing autopsy reports. 2) [VI.G.4.b.(3)] There may be instances when residents performing a frozen section may exceed duty hours in order to complete the procedure. Would this situation be considered an exception as defined in the revisions? 3) [VI.G.8] At-home Call: It is unclear if PGY-1 residents will take at home call. The section on at-home call does not separate out PGY-1 and other PGYs. 4) Would a resident be permitted to remain in the hospital (under his/her own volition) to engage in some form of review or activity that would be categorized as 'didactic'?

Residency Review Committee for Pathology

Comments Requesting Clarification
<table>
<thead>
<tr>
<th>Name: Kristin Valderas</th>
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<tr>
<td>Organization: UTSW Austin Psychiatry</td>
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<td>Affiliation: individual</td>
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<td>These regulations omitted the duty hours for fellows who are required to do in house calls as in PICU, CCU and adult ICU. I think the level of care and in ICU setting needs to needs to be clarified more.</td>
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<tr>
<th>Name: Hamza Elkhidir</th>
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<tr>
<td>Organization: RUMC- Pediatrics</td>
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<tr>
<td>Affiliation: individual</td>
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<td>I find that this rule of only 16 hrs for first year residents is counter to continuity of care and creates more handoffs, therefore risk of error. Does this limitation allow then the 4 hours additionally for didactics, patient follow up, and care transitions after the 16 hours of continuous duty?</td>
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<tr>
<th>Name: Caughman Taylor</th>
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<tr>
<td>Organization: USC Dept. Of Pediatrics,</td>
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<td>Affiliation: individual</td>
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<td>Patient safety of course has to be prime concern but I have to wonder 1.) How interns and residents can possibly get the same experience during a 3 year, 4-year etc residency, as their hours are increasingly limited during, 2.) If oversee is, too close how they can learn independence. Are we kicking the can down the road if education is incomplete and physicians are having to &quot;learn&quot; more in unsupervised practice. Do residency durations need to be extended?</td>
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<tr>
<th>Name: Kenneth Weston</th>
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<tr>
<td>Organization: Columbia Family Medical Group</td>
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<tr>
<td>Affiliation: individual</td>
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<td>It is not clear whether the +4 hours for post call rounds applies to the 16 hour duty period for 1st years. If so, I can make this work. If not, my program is not going to continue.</td>
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<th>Name: Paul Lazar, MD</th>
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<td>Organization: McLaren FMR</td>
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<td>Affiliation: individual</td>
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<tr>
<td>Please clarify- does this mean PGY-1 residents have &quot;16+4&quot; duty hour maximum? (16 hours of direct patient care and 4 hours for sign-out/transition of care)?</td>
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<th>Name: Sherwin Gallardo, MD</th>
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<tr>
<td>Organization: Kaiser Permanente San Diego</td>
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<td>Affiliation: individual</td>
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<td>re duty periods for PGY1 not exceeding 16 hours duration, it's not clear from the proposed standard what the duty hour requirements would be for certain subspecialties -- for example, an anesthesia resident: pgy1 year they're usually in a transition prelim spot, but pgy2 they start anesthesia -- in my head I consider them pgy-2, but &quot;pgy-1&quot; for anesthesia.</td>
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<th>Name: EF</th>
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<td>Organization: none</td>
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<td>Affiliation: individual</td>
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<td>For PGY1 Residents, is a 4 hour period beyond the 16 hours allowable, to ensure proper hand-offs and continuity? This seemingly small detail is magnified in its importance when looking at scheduling. There are numerous concerns on the AFMRD listerv regarding continuity, numerous hand-offs, and simply not having Residents get the experience they need. This is especially so for smaller programs.</td>
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## Maximum Duty Period Length

### Comments Requesting Clarification

| Name: Scott A. Levin, MD  
Organization: West Suburban Medical Center FMRP  
Affiliation: individual |
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<td>This is a point of clarification as to whether PGY 1 residents are limited to 16 hours maximum or 16 + 4 for transfer of care and education.</td>
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| Name: Hasan Bazari  
Organization: Massachusetts General Hospital  
Affiliation: individual |
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<td>It appears from the language in the proposed requirements that the 4-hour period of transition after 24 hours on for PGY2 and above can be used for sign-out and transfer of patients only. Please clarify the language to indicate whether it is permissible to use this time for educational purposes as well, eg, conferences.</td>
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| Name: Julia McMillan  
Organization: Johns Hopkins School of Medicine  
Affiliation: organization |
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<tr>
<td>I'm not clear on this. Is this saying that a first year intern can work no longer than 16 hours?</td>
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| Name: Gopal  
Organization: OHSU  
Affiliation: individual |
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<td>Line 870; PR: VI.G.4.b: This line appears to be redundant with the alertness management section.</td>
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| Name: Caroline Fischer  
Organization: RRC for Pediatrics  
Affiliation: organization |
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<td>Can you please clearly define &quot;duty period&quot;--does it only include scheduled working hours? Hours directly working with patients? Hours directly working with new patients? Hours doing any patient related activities (e.g., patient care, charting, phone calls). As an institution, it can be difficult to know if programs are complying with the requirements when duty period can be defined differently by different programs and seemingly defined differently by different RCs. I would really appreciate a succinct, unambiguous definition included in the requirements. Thanks.</td>
</tr>
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</table>

| Name: Kathleen Quinn-Leering  
Organization: Medical College of Wisconsin Affiliated Hospitals  
Affiliation: individual |
|---|
| If it is reasonable that residents be allowed - effectively required! - to work shifts longer than 12 hours, why aren't physicians also required to do the same? No patient should be endangered by being placed into the
Maximum Duty Period Length

Comments Requesting Clarification

care of sleep-deprived staff!

**Name:** James Langhammer  
**Organization:** private  
**Affiliation:** individual

Questions from GMEC, submitted on behalf of DIO:  
Does the additional four (4) hours for transition of care also apply to PGY1 residents, which would allow for a total of 20 hours for maximum duty hour length?

**Name:** Lisa Phillips  
**Organization:** MAHEC  
**Affiliation:** organization

If appropriate supervision is provided for PGY1s can they stay past their 16 hour limit for educational programs that are key to their training?

Submitted through the Residency Advisory Council

**Name:** Bryan Martin, DIO  
**Organization:** The Ohio State University  
**Affiliation:** organization

Neutral Comments

Reading through the new proposed ACGME requirements, there have been many positive changes. I do have significant concern about the potential decrement in work hour shifts for both PGY-1s as well as residents.

First off, from a resident perspective, if the work week is still 80 hours, I personally would prefer being on call and doing a longer shift rather than potentially having five 16-hour shifts in the week. In addition, I think the overnight call is a vital part of the training for an intern--being able to see the patient from presentation through their course, especially considering many of the patients will worsen overnight. With shorter shifts, the interns will potentially lose their experience in such cases, which will not only be a decrement to their learning but could also potentially make it much more difficult for them to function in a supervisory role.

Second, as has been shown in the study regarding an increase in post-surgical complications secondary to increased transition of care in the era of less work hours, I am not sure how cutting the intern and resident work hours will help with this issue. In fact I think it will only make the issue worse. As a fellow I am already seeing this now with the new residents--they do seem to know their patients much less well. I am not sure if this is a function of the type of people going in to medicine or also potentially the work hours restrictions.

Third, we already struggle to provide the interns and residents with appropriate teaching and have worked extremely hard to find a teaching schedule that fits into their schedule. This will become much more difficult with the potential decrement in work hours.

Finally, although some may feel that the way things used to be done and were only a rite of passage, I worry that we are moving towards swinging the pendulum too much in the opposite direction. Are people going to enter medicine that are less devoted knowing the work hours are going to be easier to manage? Are people going to be able to maintain their professionalism? Are new doctors going to be able to get adequate teaching? Are new doctors going to be prepared to handle difficult situations and sleep deprivation as fellows and attendings when they may not have got the full experience during residency?

Looking back at my residency, it was difficult but manageable and definitely prepared me for fellowship. I worry this would not have been the case with further limitations in work hours.

**Name:** Anu Agrawal  
**Organization:** Pediatric Hem/Onc Fellow, Children's Hospital and Research Center at Oakland
### Maximum Duty Period Length

**Neutral Comments**

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<tr>
<th>Affiliation: individual</th>
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<tr>
<td>Exceptions should be made for optional participation in Quality or Performance Improvement Projects, Educational Conferences and Hospital Committee Meetings etc</td>
</tr>
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**Name:** Jill Butler, MD FACP  
**Organization:** Trinitas Regional Medical Center  
**Affiliation: individual**

Regarding duty hours - PGY-1 (first year) residents also have to do maximum of 24 hours of continuous duty in the hospital instead of 16 hrs.

**Name:** Nishit Patel  
**Organization:**  
**Affiliation: individual**

A resident was stranded at the hospital for a couple of hours during the blizzards. She waited for her ride in the team room, it being the most congenial site. As the attending, I was there with some hours of work to complete.

I reminded her, and checked to verify, that she must do nothing in the team room that had any chance of benefitting any of her patients. And that I would frown on any attempt at education if it were related to an in-patient.

**Name:** Tom Finucane  
**Organization:** JHU School of Med  
**Affiliation: individual**

"Residents may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extension of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family" - provision for the program to initiate and mandate this when necessary;

**Name:** Tyagaraj  
**Organization:** Maimonides Medical Center  
**Affiliation: individual**

I remember reading a letter sent out to program directors (sometime after 1st of this year) from the president of the ACGME and it discussed new hour rules that would likely take place 1/2011. I thought the ACGME was going to recommend possible longer hours, not shorter ones, based on multiple sleep deprivation studies cited in that letter. I feel the current duty hour rules are not too strenuous. A decrease in the amount of time interns may be on duty will negatively affect the amount they learn. I believe that it takes volume and repetition of patients as well as diversity of disease to hone skills necessary to manage the vast variety of presentations that come through the ED door. The learning curve is steepest in the intern year and unless the number of "mistakes" is unacceptable for interns nationally, I think it would be a shame to limit the learning potential. I'm sure these recommendations are based on evidence and expert opinion on sleep deprivation's effect on performance. I'm not an expert in this, but I appreciate the opportunity to voice an opinion.

**Name:** David Boone  
**Organization:** Carilion Clinic, Internal Medicine, Roanoke, VA  
**Affiliation: individual**

The CRC recommends that a sub-heading "PGY-I" should precede line 865 and that a sub-heading "Specific Only to PGY-2 and Beyond" should be added after line 865. The CRC recommends that the first reference to "continuous duty in this standard should be revised to read "continuous on-site duty" and to delete "in the hospital" at the end of that sentence. The CRC suggests that the standards or Frequently-Asked Questions (FAQs) should clarify what educational activities are acceptable for residents to engage in.
Maximum Duty Period Length

Neutral Comments
during the added four-hour period. The CRC recommends that this standard should be revised to read: "Residents must not attend clinics after 24 hours of continuous in-house duty or participate in routine procedures." The CRC notes that it will be helpful in an FAQ to indicate what constitutes "routine procedures." The CRC recommends that this section should specifically reference the PGY-2 and Beyond" resident. (see line 865 above) The CRC recommends that the phrase “transitions in patient care” should replace use of "hand over." (see lines 630-63/ above)

Council of Review Committees (CRC)

Task Force Committee Response

Maximum Duty Period Length

Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident must:

appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Rationale and response to comments:
The vast majority of comments received by the ACGME were in reference to this group of standards, and in particular the 16 hours of consecutive duty for PGY-1 residents. While the majority of comments concerning the 16 hours of consecutive duty for PGY-1 residents were negative, a minority of respondents, including many of the major medical organizations, were supportive of this change. The majority of the comments concerning the PGY-2 and above standards, and the flexibility for these house officers to remain with an acutely ill patient beyond the usual time limits were well-received and supported by most who commented. The exception to this statement is the subset of those who supported the 16 hour limits for PGY-1 residents, but felt that the 16 hour limit should be applied to all residents.
Maximum Duty Period Length

Task Force Committee Response

The Task Force re-considered the 16 hours for PGY-1 residents, and the standards for PGY-2’s and above (including flexibility) and strongly reaffirmed these standards for the following reasons:

1. There are data from four, single-site, small studies in medical and general surgical PGY-1 residents that residents on a 16 hour versus a traditional schedule make fewer errors.

2. There are ACGME data that demonstrate that PGY-1 residents work the most hours of any cohort of residents.

3. There is physiologic data that demonstrates a dip in performance of psychomotor vigilance tasks between 16 and 24 hours that is statistically significant. This data is of questionable clinical significance, especially in the context of medical decision making and the current medical model. This decline is likely to be substantially worse for some residents than for others, given the variability in severity of affect among study participants.

4. The Task Force believes that sleep physiologic observations are only one factor in the design of educational standards, rather than the organizing principles which should drive our residency educational paradigm.

5. There was a consensus on the Task Force that the clinical care environment has become much more complex, and requires that novice residents be more clearly and directly supervised to promote both patient safety and resident learning, and that supervision is likely the more important factor in preventing errors.

6. The training paradigm adopted by the Task Force is predicated on better preparation and supervision of the learning of the PGY-1, and progressive liberalization of the duty hour standards as the resident demonstrates the competency to be delegated greater degrees of conditional independence in the care of patients.

7. These standards occur in the context of an expansion of the dimensions of expectations for residents and faculty concerning alertness management, fatigue mitigation, professionalism, enhanced specificity of supervision, and an explicit declaration that residents must be prepared to enter the unsupervised practice of medicine at the end of residency.

The Task Force clarifies that the additional four hours is sufficient for transitions in care to be provided. As one resident noted in the comments, their program did not schedule the additional six hours after a 24 hour call for handovers, they scheduled 30 hour shifts. The Task Force is making clear that the four hours after 24 hours of consecutive duty is to be used for transitions in care. Furthermore, the Task Force reiterated that the additional four hours for transitions in care did not apply to PGY-1 residents. Similarly, the ability to remain beyond time to care for a single patient does not apply to PGY-1 residents. Were that to be permitted, a resident would potentially work 20-22 hours, and immediately begin their next 16 hour period of duty.

The Task Force notes that PGY-1 residents may be scheduled for up to 80 hours per week, averaged over four weeks. Their contact time with patients should not be diminished. Similarly, their time “away” from their patients is less than on their post call day in the current situation of 24+6 call. If designed properly, continuity, especially from the patients’ perspective, can be enhanced.

These standards do not preclude the PGY-1 from working at night, and gaining experience that will prepare them for the nighttime hospital environment and the problems encountered. They will be more
Maximum Duty Period Length

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<td>alert during their first experiences with nighttime care of patients.</td>
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The Task Force noted with gratitude the letter from the American College of Surgeons, beginning the process of establishing specific competencies that residents would be expected to master prior to being granted the “right” to work for 24 consecutive hours. They propose a competency based promotion model prior to the completion of the PGY-1 year. The Task Force applauds this as a model to work towards, but in the absence of clearly established expectations, a standardized method to measure achievement, and faculty development programs to assure effective evaluation, this model awaits study and operationalization. The Task Force does, however, believe that this model should be considered in the next revision of the resident duty hours standards as a part of the move towards outcomes based resident education. The Task Force also suggests that this might well serve as a pilot proposal for study.

Finally, the Task Force considered this section of the duty hour standards as part of the broader context of creating an educational model that takes advanced beginners and molds them into experts at graduation.