January 24, 2016

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Dear Dr. Nasca,

Thank you for the opportunity to participate in the Accreditation Council for Graduate Medical Education (ACGME) plan to review the accreditation requirements for resident duty hours and key dimensions of the learning and working environment. Needless to say, the American Association of Directors of Psychiatric Residency Training (AADPRT) has a very compelling interest in this area as we share with you a dedication to quality in residency education. We are pleased to take this opportunity to share our thoughts with you.

Of the points you requested we address, I would like to begin with the last and say that we are very much willing to participate in a Resident Duty Hours in the Learning and Working Environment Congress, to be held in March 2016 in Chicago, Illinois.

To prepare a response to your questions, we surveyed our members to assure that the opinions we present adequately represent the views of a majority of our members. The survey was completed in January 2016, with 225 responses. Of those responding, 203 are program directors; 70% of these direct general psychiatry programs, and most of the rest direct child and adolescent fellowship programs. Thus we believe this to be a representative sample of our members.

We asked our members questions in several domains. Although we understand the ACGME has asked about both duty hours and other key dimensions of the learning and working environment, we focused on duty hours as being the most controversial issue in residency training.

What follows is a summary of the questions and responses, with an accompanying discussion and comparison with the literature.
Did the ACGME Duty Hours Restrictions Address a Pressing Problem?

Most of our program directors believe that there is a potential for overwork of residents. However most believed this is mainly a problem in other specialties and that overwork, however defined, was not a significant problem during psychiatry training. Since the incorporation of duty hour restrictions, our members felt that violations during psychiatry rotations were rare, and that most occurred when residents were rotating on primary care rotations. Such violations were usually for reasons that are within ACGME exceptions, for example, to complete important aspects of patient care.

A particular concern voiced by members involves the increased restrictions during internship year. Most felt that these additional restrictions were unnecessary; a number commented on the additional burden they create for other residents, particularly those in the second year. Although many acknowledged the importance of sufficient supervision for entering residents, most felt them capable of working at least some call shifts. Many questioned the rationale for the need to treat first year residents as substantially different in terms of work hours.

Have the Duty Hours Improved Patient Safety?

The majority of members felt that the originally stated purpose of duty hours – to decrease medical errors – has not been achieved. The majority felt that duty hour restrictions have negatively affected care through their impact on continuity of care. Many of our members specifically cited handoffs and transitions of care as a major concern affecting patient safety.

This concern is supported by the existing literature on transitions of care and the associated loss of patient information as a major source of preventable adverse events (1, 2). Although the literature also supports the supposition that decreasing caregiver fatigue can lessen errors (3), the concern is that this benefit is offset by the decreased continuity of care resulting from the ACGME duty hour restrictions (3).

Have the Duty Hours Improved Resident Well-Being?

Most of our members believe the duty hour restrictions have improved resident quality of life. However, they do not believe that the restrictions have necessarily improved the problem of fatigue. Several commented that the extra time afforded by the duty hour restrictions allows residents to attend to other aspects of their life, which likely helps with personal well-being, but does not necessarily result in more sleep.

This should not surprise us, as it has been previously noted in other specialties (4), such as in Fitzgibbon’s survey of orthopedic residents (5). Furthermore the work done in other Safety-Sensitive Industries such as the aviation industry, has determined that restrictions on work hours are necessary but not adequate. As a result, the aviation industry also imposes mandatory rest periods (3, 6). We are not suggesting this as a policy, but simply acknowledging the inadequacy of duty hour restrictions as a solution if fatigue is indeed the desired target. To take a larger perspective, it seems simplistic to view well-being simply in terms of hours slept or worked (7).
Have the ACGME 2011 Restrictions Impacted Resident Education?

The majority of our members have changed their curriculum to adhere to duty hour restrictions. The most cited change was moving from on-call systems to night float systems. Many noted that this has had a significant effect on education, as residents on night float miss didactics and other non-clinical educational activities. The majority of our members believe that even if post-call residents should be removed from clinical activities for safety purposes, this should not affect their ability to attend non-clinical educational activities if desired. Some members are creating alternative didactic activities to accommodate night float rotations, but many these were usually inferior to the interactive group experiences that make up most didactic seminars.

Our members noted other educational problems created by night float systems. Some cited the unintended effect of putting inflexible restrictions on the working day; days are “packed full” and more time is spent completing work or paperwork with less time available for discussion and reflection on clinical experiences. Others noted the lost opportunity to follow a patient evaluation from start to finish as residents often have to leave mid-way and handoff the ongoing evaluation to a colleague. Many also noted the shift in clinical responsibilities from residents to attendings, leaving the latter with less time to supervise and teach. Perhaps of most concern to our members was the belief that work time restrictions have contributed to a “shift worker” mentality which has interfered with residents’ sense of ownership for their patients. Many blame the rules for contributing to an unfortunate attitude among some residents that when they are off-duty, they should not be disturbed and that ongoing patient issues were someone else’s problem.

Others noted that the shift work approach has created odd hours in some residencies (particularly in some other specialties), making it difficult for residents to attend to their own well-being and self-care, including mental health care.

This generally negative view of the effect of the ACGME duty hour restrictions on education has been echoed by many other specialties in the literature (4), in which both faculty and residents have raised concerns that the quality of residency education has worsened in the wake of the 2011 ACGME changes. These, of course, represent opinion surveys, and few meaningful outcomes, apart from several small studies using board scores (8), are currently available (9).

Have the Duty Hour Restrictions Affected Our Obligation to Prepare Residents for Clinical Practice?

The majority of members felt that duty hours have negatively affected a resident’s ability to practice independently. Many commented on duty hours’ effect on professionalism, work ethic and the value of occasionally overextending oneself for a patient when appropriate. Similarly, many were concerned that the current system of education was not adequately preparing residents for the “real world” of medicine, including making adjustments for jobs with on-call responsibilities. Many remarked that junior faculty often have difficulty adjusting to the rigors of practice once out of residency.
Perhaps the greatest concern voiced by members was that of patient ownership. Many of our members worried that the aforementioned lack of a sense of ownership was hindering the growth of a sense of the residents’ duty and responsibility to patients.

A number of members voiced the belief that duty hours were one factor contributing to the shift from medicine being considered a “profession” to being a “trade” (although they acknowledged that this is one of many factors).

Similar concerns have been raised in numerous articles and editorials in the medical literature. As with the above discussion, most articles are survey-based. In those articles, educators in many specialties document a concern that the changes in residency education necessitated by duty hour restrictions have worsened the development of professionalism among residents (4).

**Have the Duty Hour Restrictions Directly or Indirectly Impacted the Ability to Administer a Residency Program?**

The majority of our members stated that duty hours have been costly to their departments. Many cited the cost of hiring physician extenders and moonlighters as the major component for that cost.

A number of members spontaneously commented on the administrative burden created by duty hour restrictions. Graduate Medical Education (GME) systems have taken a variety of approaches toward monitoring duty hours, and in many systems they create significant work for training directors and residents. Some GME offices require that residents log their duty hours daily, which seems to offer undue burdens for specialties like psychiatry in which duty hour violations are rare.

These and other indirect costs are of concern to members as making residency programs of less value to hospital systems, and members wondered whether some medical systems might determine that residency training was not worth the effort.

The concern about financial costs is strongly supported by the literature. A number of articles have referred to the “unfunded mandate” that duty hours have created, which adds to an already burdened healthcare system (4, 10, 11). Nuckols and Escarce, in their analysis of the cost implications of the ACGME’s 2011 changes, conclude that the net cost nationwide could be more than a billion dollars (11). They add that some of this cost may be offset by a decrease in preventable adverse events, but the degree to which this is possible is not known. Given our discussion above regarding the offset in patient errors created by handoffs and transitions of care, any hope that decreased patient errors can balance this enormous cost seems unduly optimistic.

**Other Concerns: Medical Student Education?**

Although not a focus of the ACGME, a majority felt that duty hours have also negatively affected medical student education and students’ readiness for internship. This was because duty hour restrictions put more pressure on the available time of both residents and faculty. This leaves less time for medical student teaching, and the pressure to use time efficiently is an impediment to allowing medical students to take on...
supervised responsibility for patients. The result is that medical student rotations are more likely to be passive shadowing experiences that inadequately prepare a student for the next stage of training.

**Summary: What is the Net Effect of Duty Hours on Resident Education?**

The majority of our members felt that the overall effect of duty hours on residency training has been negative. Members who viewed duty hours more positively tended to agree in principle to the idea of work hour restrictions but felt that the current system was too inflexible to allow for the particular challenges of individual specialties or for the varieties of program sizes and regional differences. Many felt that that single approach to all specialties did not adequately respect these inherent differences.

As described above, this generally negative view is consistent across different specialties, and program directors across specialties worry about the “unintended consequences” of the duty hour restrictions on residency education, particularly, the effect it has had on professionalism and patient ownership (4,12).

Also consistent, however, has been the observation that objective data has been limited, particularly on key questions such as whether duty hour restrictions have improved fatigue, decreased medical errors or improved residency education (9).
Summary of AADPRT’s Position on Duty Hour Requirements and the Learning and Working Environment.

1. Psychiatry is a specialty in which training may occur within a reasonable work week that is unlikely to adversely affect resident well-being or cause undue fatigue.

2. Most duty hour violations that occur in psychiatry are during rotations in other specialties (i.e., primary care).

3. The duty hours, as implemented, have not demonstrably improved patient safety or decreased the rate of medical errors. They may well have worsened these through the resulting increase in transitions of care.

4. Duty hour restrictions have not greatly decreased resident fatigue within our specialty. However, they likely have improved overall well-being by allowing more time for non-residency activities.

5. Changes in curriculum and rotations required by duty hours have negatively affected resident education.

6. Duty hour requirements have also likely negatively affected a resident’s ability to practice independently after residency.

7. The duty hour requirements have impeded the development of a professional identity, by encouraging a shift-worker mentality and decreasing the sense of ownership for patients.

8. The changes have been costly to our educational systems and may have decreased our resources for other educational initiatives.

9. Although we are in agreement that attention to resident work hours and patient safety are important, we do not believe the current restrictions have been effective in accomplishing these, and have had unintended negative results which outweigh the benefits.

10. Future changes made to duty hours and other aspects of the learning environment should be made with an eye toward their potential effect on education, particularly on opportunities for supervision, discussion of clinical experiences with superiors and colleagues and personal reflections on their experiences.
Summary of AADPRT’s Recommendations Regarding Duty Hour Requirements and the Learning and Working Environment.

1. We support some duty hour restrictions, but believe the system must allow for more flexibility and opportunities to balance the personal needs of residents, the needs of the health system and the needs of our patients.

2. We believe the additional duty hour restrictions imposed on first year residents should be eliminated.

3. We believe that any duty hour restrictions should focus on limiting clinical activities during which residents are at risk for patient errors. We believe that judicious relaxation of restrictions to allow for additional educational activities should be considered, as long as these are not used by a program as an indirect method of increasing a resident’s clinical load beyond what is reasonable.

4. Any further restriction of duty hours should only occur after more data is available. The iCOMPARE study in internal medicine and the FIRST trial in surgical residencies are ongoing. The initial FIRST results are scheduled to be reported in early February, and the results from the iCOMPARE study finishes later this year. Data from these studies must inform any changes.

5. We believe that every specialty has unique needs and challenges, and the ACGME should consider a system that incorporates flexibility to allow for different duty hour requirements in different specialties.

Please do not hesitate to contact us for clarification of any of these positions or recommendations. We look forward to participating with you at the Resident Duty Hours in the Learning and Working Environment Congress.

Yours sincerely,

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President
American Association of Directors of Psychiatric Residency Training
References


