Comments from the American Board of Family Medicine
Revision of Duty Hours Requirements in the ACGME Common Program Requirements

The ABFM is pleased to respond to your request for input on accreditation requirements for resident duty hours for consideration by the Phase I Task Force.

A review of the literature reveals that the 2003 and 2011 duty hour policies have been insufficiently studied for effect on the central reasons for their implementation, namely patient safety and resident well-being, and most research has focused on inpatient care. We recognize that the 2003 policy was a response to both herald cases of patient harms associated with fatigued and poorly supervised residents, and with variable duty hour policies across RRCs that were also inconsistently applied. The 2011 modification, triggered by the related, 2009 Institute of Medicine report, made further modifications, specifically to clarify total hours of work and instruction and to clarify supervision requirements. We found several studies relevant to the impact of these policies, most of which are survey-based and of poor to fair quality, and summarize some of the best and most relevant to family medicine. A few studies looked objectively at impact of these policies on training outcomes other than fatigue, safety or well-being. The few studies that evaluated primary outcomes using pre/post analyses suffer from many other coincidental health system changes, making it difficult to understand causal relationships, but did show no changes in patient mortality.\(^1,2\) A few benchmark studies of the 2003 duty hours policy impact on surgical outcomes and adverse drug events in hospitals did not show improvement.\(^3,4\) We have heard anecdotally that a controlled trial underway in surgery residency programs was recently challenged in court. Impact in primary care programs for the 2003 and 2011 policies have had relatively little research or evaluation.

A study of related policies in Canadian medical education used semi-structured interviews with faculty to reach the conclusion that there was a need for flexibility based on specialty-specific factors.\(^5\) The Canadian faculty perceived clinical care gaps related to duty hour restrictions, and that these gaps also affected quality of education, preparedness for practice, care continuity, and provider well-being (figure). The lead author of the Canadian, qualitative study, was a resident associated with the National Steering Committee on Resident Duty Hours, and both the paper and the Steering Committee concluded that specialty-specific training needs should considered. A recent randomized, crossover study in a single US institution substantiates the Canadian concerns, finding that the change to the 2011 duty hour policies resulted in more sleep for internal medicine residents, particularly interns, but decreased educational opportunities, increased patient handoffs, and increased perceived decline in care quality (by nurses and residents).\(^6\) A related study of residency graduates from South Carolina Area Health Education Consortium-affiliated family medicine residency programs from 2005 to 2009 found that while the vast majority felt that the 2003 ACGME policies did not adversely affect their preparedness for practice (97%), 20% of them felt that they did not have adequate supervision.\(^7\) Interestingly, 81% said that they worked fewer hours in practice than in residency.
A study at the University of Missouri found that the 2011 work hour policies erased gains made in prior institutional efforts to increase resident continuity clinic experience as part of the Preparing the Personal Physician for Practice (P4) Initiative, a national program heralded by Dr. David Leach while he still served at the ACGME.8-10. The duty hours impact was due, in large part, to the creation of night-float resident teams which limited post-call clinic time and time spent in inpatient and outpatient settings. Quantitatively, total resident visits declined by more than 4,000, annually. Missouri’s informal feedback from other P4 Initiative partners was that they experienced a similar reversal of P4 outcomes, namely reduced inpatient and outpatient experience, but increased consideration of lengthening training, and increased collaboration with other providers. The University of Washington Family Medicine Network (UWFMN) residencies have collaborated for more than a decade in collecting and comparing data regarding the productivity and operations of their training programs to identify the program-level effects of a variety of environmental changes, including duty hours.11. Their study of the decade 2000-2010 found that resident outpatient visits declined by 17.2% (PGY3 declined the most, 21%), inpatient visits declined 22.4%, NP/PA visits/FTE increased by 12.7%, and total core faculty FTE increased by 12%. While they acknowledge that electronic health record (EHR) and Patient Centered Medical Home (PCMH) implementation co-occurred with duty hours, the aggregate impact was a reduction in resident clinical productivity, especially for senior residents, and a transfer of activity to faculty and NPs and PAs.

To understand resident perspectives about the 2011 ACGME Common Program Requirements, an anonymous, electronic resident survey was sent to 123 Designated Institutional Officials in December 2011 for distribution to residents.12. Sixty-one family medicine programs participated (potentially 2,956 family medicine residents) and nearly 1/3rd of family medicine residents (928, 31.4%) responded. The survey coincided with the implementation of the 2011 ACGME policies allowing a pre-post evaluation of responses (recognizing that interns in that year would be PGY2’s the following year, thus reporters shifted during implementation). The authors report nearly half (47.4%) disapproved of the 2011 changes and nearly a quarter (24.6%) approved of the changes. PGY1 family medicine residents were more likely to report improved rest, patient safety, education, and overall approval than were PGY2/3, but across the whole sample, more than half thought the change was worse for preparing residents for senior resident role (56.6%) and for senior resident quality of life (53.2%). The majority thought that it made senior resident lives harder (68.5%), and 77.9% thought handoff frequency increased. The majority felt that availability of supervision (72.7%) and patient safety (52.2%) were unchanged. Several studies in different specialties...
corroborate this shift of work to more senior residents and faculty, from both the 2003 and 2011 work hours policies.\textsuperscript{13,14} In 2007, a survey of family medicine residency faculty (55\% response rate) 19\% felt that (2003) duty hour policies had increased faculty work hours and nearly the same percentage (20\%) were considering leaving academics related to this change.\textsuperscript{15}

Our specialty societies recently endorsed family medicine Entrustable Professional Activities (EPAs). Our colleagues in the Society of Teachers of Family Medicine who helped lead this activity made a special plea for specialty flexibility with duty hours in order to support implementation of the EPAs. Specifically, they believe that strict duty hours tread on \textit{continuity}, a core EPA shared across primary care specialties, and a facilitator of other EPAs that build upon enduring healing relationships. Robert Woollard, commenting on the similar duty hour policies put in place in Canada, referred to this duty-hour problem as a \textit{dilution of relationships} that is unsupportive of the need for health care institutions to become complex adaptive systems.\textsuperscript{16} Dr. Woollard calls for a return to “effective healing relationships that endure over time and over place of care,” that are sine qua non of family medicine, and to “enduring generalist relationships.” Knowing the value of continuity to the Triple Aim for Healthcare, we endorse this proposition that duty hours should not trump opportunity to preserve and learn from continuity relationships across care delivery settings.\textsuperscript{17,18}

We are also concerned about the risk to \textit{comprehensiveness}, another tenet of primary care, and one that is associated with lower healthcare spending.\textsuperscript{19} A study of family medicine graduates in South Carolina immediately before (1999-2003) and after (2005-2009) the initial ACGME duty hours found significant reductions in family physician preparedness for office-based surgery (OR=0.50), reduction in specific procedures or care settings (reduced ICU care, nursing home care, and hospital care, flexible sigmoidoscopy, central line placement, and ventilator management), and reduction in taking after-hours call (22.3\% vs 8.6\%).\textsuperscript{20}

Dr. Joseph Gravel, current ABFM board member, and other leading residency directors in 2011 raised the concern that as duty hour rules (2011) diminished the effective amount of training time, “we owe it to our residents and the public to honestly and actively study the length of family medicine residency training to minimize the unintended impact of duty hour restrictions.”\textsuperscript{21} The ABFM recognizes the safety, ethical, and political concerns that led to the 2003 and 2011 ACGME duty hours policies; however, the ABFM is concerned that the pendulum has swung too far and risks producing a primary care workforce that has less appreciation for continuity, less ability to provide comprehensive care, and less capacity to coordinate the complex care needed in order to achieve the Triple Aim for Healthcare. This was also the opinion of the majority of Family Medicine Program Directors in 2009.\textsuperscript{22} The ABFM agrees with the majority of family medicine residency directors (83\%) and residents that 60-80 hour work-weeks are desirable for residents and that there is a role for duty hour policies.\textsuperscript{23,24} We also believe that most family medicine residency programs have demonstrated sufficient fidelity to duty hours policy and implementation of tracking mechanisms that they can be verifiably trusted to manage more flexible duty hour rules. The ABFM formally requests that the ACGME consider modification of the Common Program Requirements to allow sufficient flexibility to balance needs for adequate rest while permitting greater continuity, comprehensiveness and care coordination goals for training. The ABFM also calls for better research to support and evaluate next-generation duty hours rules.


