February 1, 2016

Thomas Nasca, MD
Chief Executive Officer
Accreditation Council for Graduate Medical Education
515 State Street, Suite 2000
Chicago, Illinois 60654

Dear Dr. Nasca:

On behalf of the Association of American Medical Colleges (AAMC) and in response to your December 21, 2015, communication to members of the graduate medical education (GME) community, I am pleased to share with you the following comments on key aspects related to resident duty hours and the learning environment in general.

**Overall**
The AAMC’s positions on duty hours and the learning environment in general are based on the belief that residency training should prepare physicians to practice independently by developing both competence and confidence over time. Our positions also are based on the belief that the “highest quality of safe and effective patient care for patients and the highest quality of effective and appropriate education are rooted in human dignity,” as stated in our 2014 “Statement on the Learning Environment” (*Attachment A*). This includes “shaping a culture of teaching and learning that is rooted in respect for all,” including patients, learners, and teachers.

Such objectives necessitate a progression of multiple experiences, a multitude of mastered competencies, and varied levels of supervision/autonomy. The duration and supervision of this progression might vary by individual and specialty. If we move toward competency-based advancement in GME, we likely will see even greater heterogeneity.

The AAMC believes that the supervision and gradual autonomy of trainees should be guided by a core set of objectives: assuring safety and quality care for patients under the care of residents, as well as the safety of learners themselves; developing a physician that is ultimately prepared to practice independently in providing safe, quality, and effective patient care; and instilling in each new physician the responsibility to prioritize their patients’ needs, welfare, and safety above their own. These objectives should incorporate both advances in practice and changes in the delivery system (e.g., increased emphasis on team-based care provided by a range of health professionals).
Any deliberations on how academic medicine might better achieve these objectives should be informed by robust research on a variety of issues, such as (but not limited to) improvements in patient safety and outcomes, resident wellness, and readiness for practice. This effort should include a review of new research and the implementation of new or expanded studies as part of a national research agenda. New studies might address: the impact of applying homogenous standards across all specialties; if/how duty hour limits might instill a “shift-work” mentality among trainees and future physicians; or how the ACGME might better assist program sponsors in applying or enhancing duty hour guidelines, including the reporting, review, and resolution of violations. New studies also might focus on educational studies and skills development that complement residency and instill the value of life-long learning.

**Duty Hours**

As noted above, the AAMC believes that a review of current duty hour requirements should be informed by robust, national research on a broad range of critical issues, including evidence about the relationship between resident schedules and patient outcomes, and educational outcomes, including residents’ preparedness for independent practice. Methods to assess and mitigate the effects of fatigue also should be studied.

The AAMC encourages the ACGME to consider the development and implementation of a rigorous national research agenda. This national research agenda should inform the GME community regarding which actions can help achieve the central goal of producing well-trained physicians who are prepared to provide patients the highest level of safe and quality care. It appears (and is unfortunate) that the measures taken to date have not produced substantial improvements in patient safety and the quality of care. These critical goals of duty hour standards should be prioritized in every part of this proposed national research agenda. The AAMC stands ready to help lead or convene the expertise necessary to craft and launch a national research agenda, and suggests seeking funding from the National Institutes of Health, the Patient-Centered Outcomes Research Institute (PCORI), or other similarly well-positioned entities.

We also wish to reiterate that ultimately, duty hours are not the central issue, and focusing on resident duty schedules will not address—and may distract academic medicine from—the larger issues of detecting and managing fatigue, the quality of resident supervision, the appropriateness of resident workloads, and the effectiveness of information transfer among residents and other members of the patient care team. All of these aspects should be a part of the national research agenda discussed above. Additionally, the AAMC plans to better understand and enhance the resilience of both learners and supervisors by identifying and/or developing new skillsets and resources. If all these larger issues are addressed, the need to regulate resident duty schedules can and should lessen or disappear.

**Monitoring and Enforcement**

The AAMC maintains its position that the ACGME is the appropriate organization to monitor and enforce duty hours. With that said, we believe the ACGME should expand its focus and assume a more “holistic” approach to monitoring that extends beyond the question of whether programs adhere to duty hour standards. It should incorporate the monitoring of resident well-being, a learner’s perceived competence/care quality, and the length of training. The AAMC and other professional organizations should be called upon to assist in the development of this holistic approach, and we welcome the opportunity to participate. All of these elements should be informed by (and inform) the national research agenda discussed above.
The AAMC also encourages the ACGME to evaluate how it might assist program sponsors in continually improving the application or enhancement of ACGME guidelines at the institutional level. The AAMC is particularly concerned about addressing the needs of new teaching hospitals (i.e., “virgin” teaching hospitals and those transitioning from AOA to ACGME accreditation), and welcomes the opportunity to collaborate in developing and disseminating information to these institutions.

**Workload**

Any guidelines or standards for duty hours should appropriately balance an optimal workload with maximal educational value. This includes patient handovers, which are critical to patient safety, the continuity of care, and resident education.

As noted above, policies related to workload should always instill in residents a physician’s responsibility to prioritize their patients’ needs, welfare, and safety (and not foster a shift-work mentality). Additionally, the AAMC encourages the ACGME to include consultation from other members of the GME community as it determines and disseminates guidelines related to resident workloads.

**Supervision**

As noted above, the supervision and gradual autonomy of residents should: assure safety and quality care for patients under the care of residents, as well as the safety of learners themselves; develop a physician that is ultimately prepared to practice independently in providing safe, quality, and effective patient care; and instill in each new physician the responsibility to prioritize their patients’ needs, welfare, and safety above their own. Doing so necessitates a progression and range of varied experiences, mastered competencies, and levels of supervision/autonomy. Similarly, those ranges might differ by specialty and/or individual. We’re likely to see even greater heterogeneity if we move toward competency-based advancement in GME.

The AAMC suggests to the ACGME additional research to better understand and evaluate when (and at what level) supervision is necessitated, with the understanding that it might vary by specialty and learner. A clear understanding of the required competencies for each specialty will help to guide the progression from direct hands-on supervision to increasingly limited/indirect supervision for those residents who have demonstrated skill and appropriate medical judgment. Identifying these competencies also will help guide the current national discussion on whether or not duty hours have adversely affected the physician competencies required to practice independently at the end of a training program. Additionally, we encourage the ACGME to consider any knowledge, skills, and guidelines that supervising physicians should possess in terms of identifying appropriate levels of supervision. This might require research, surveying faculty, or developing tools that can be used at the institutional level.

**Operational and Financial Impact**

New or expanded duty hour standards could have an operational and/or financial impact on sponsoring institutions, which already bear the costs of previous changes put forth by the ACGME. The AAMC believes that additional costs could potentially jeopardize the ability of sponsoring institutions to underwrite training enhancements that improve patient care and educational outcomes. As stated in the past, we believe the financial impact of any changes should be carefully and thoroughly considered, as should the need for external support to offset those costs (*Attachment B*).
In Conclusion
The AAMC appreciates the opportunity to share with the ACGME our perspectives on how the Council might further strengthen efforts to assure patient and learner safety, the provision of quality health care, and a new generation of well-trained and committed physicians. We applaud your organization for continuing to seek the latest relevant research and insight from across the GME community.

As you know, the AAMC’s positions have historically aligned with and supported those of the ACGME. We were active participants with the ACGME in formulating in 2001 and supporting in 2003 the initial duty hour standards and guidelines. When the ACGME revisited its positions in 2009, the AAMC again offered additional insight and comments, and supported the Council’s leadership role in monitoring and enforcement. We continue to strongly believe that this matter is one deserving of thoughtful oversight by our profession rather than regulation by a federal agency. The AAMC greatly appreciates the opportunity to continue our long-standing collaborative work on these critical issues.

We hope the aforementioned themes will help inform the ACGME in its latest review and deliberation of the current standards. We welcome the opportunity to discuss any of these items in greater detail (including the development of a national research agenda), and to be part of discussions or other efforts that might be convened over the next few months.

Sincerely yours,

Darrell G. Kirch, MD
President and CEO
Association of American Medical Colleges
AAMC Statement on the Learning Environment

We believe that the learning environment for medical education shapes the patient care environment. The highest quality of safe and effective care for patients and the highest quality of effective and appropriate education are rooted in human dignity.

We embrace our responsibility to create, support, and facilitate the learning environment shared by our patients, learners, and teachers. In this environment, our patients witness, experience, and expect a pervasive sense of respect, collegiality, kindness, and cooperation among health care team members. This includes all professionals, administrators, staff, and beginning and advanced learners from all health professions. This includes research as well as patient care environments.

We affirm our responsibility to create, support, and facilitate a learning environment that fosters resilience in all participants. It is our responsibility to create an atmosphere in which our learners and teachers are willing to engage with learning processes that can be inherently uncomfortable and challenging.

We affirm our commitment to shaping a culture of teaching and learning that is rooted in respect for all. Fostering resilience, excellence, compassion, and integrity allows us to create patient care, research, and learning environments that are built upon constructive collaboration, mutual respect, and human dignity.

For more information and to view a library of resources, visit aamc.org/learningenvironment.
April 21, 2009

Thomas Nasca, M.D.
Chief Executive Officer
Accreditation Council for Graduate Medical Education
Suite 2000
515 State Street
Chicago IL 60654

Dear Dr. Nasca:

The AAMC has supported limits on resident duty hours since 1988 in the interest of optimal patient care and resident education. We were active participants with the ACGME in formulating the 2003 policy and subsequently have supported the duty hour requirements and the ACGME’s good work in monitoring and enforcing them.

In response to your letter of February 12, 2009, we offer some specific comments on the recent recommendations of an IOM committee about duty hours and related issues below. **In general we believe that resident duty hours and schedules ultimately are not the central issue.** Despite agreement that duty hours are important to consider, there is very little solid evidence that links resident schedules to patient care outcomes. Focusing on resident duty schedules will not address—and may distract academic medicine from-- the larger issues of detection and management of fatigue, quality of resident supervision, appropriateness of resident workloads, and effectiveness of information transfer among residents and other members of the patient care team. If these larger issues are addressed, the need to regulate resident duty schedules can and should lessen or disappear.

**Fatigue assessment (so-called “fitness for duty”) is a more rational and, ultimately, more effective approach than regulating shift lengths.** Not only do individual tolerances for sleep deprivation and long hours on duty vary greatly, but even individuals who are not tired or sleep deprived can make errors. Research efforts should be directed toward improved methods to systematically assess and manage fatigue as an element of an institutional culture of quality and safety that encompasses all members of the health care team. This culture also must be one in which systems are in place to prevent and mitigate the effects of human errors, whether they are attributable to fatigue or to other causes.

Counting hours and clocking in and out are incompatible with the goal of teaching residents the professional ethos of service and commitment, beyond personal comfort or gain, that characterizes medicine. At the same time, professionalism encompasses physicians’
responsibility to report for duty rested and ready to take care of patients and to learn. These elements of professionalism should be incorporated throughout medical education beginning at the undergraduate level.

We believe that the AAMC, the ACGME, and the other ACGME member organizations must communicate more effectively to the public our overriding commitment to patients and to the quality and safety of the care in our institutions. High quality care leads to better patient outcomes and also provides the environment in which future physicians can be educated for high quality independent practice that will affect patient safety for decades to come. Graduated responsibility is an essential component of professional development for physicians – and, with appropriate supervision, is entirely compatible with safe and effective patient care. At the same time, the faculty (attending) physician of record ultimately is responsible for the care provided his or her patients.

As to the specific recommendations of the Institute of Medicine:

**Duty hour limits:** The AAMC supports a maximum of 80 hours of duty per week, averaged over four weeks, limits on continuous duty, and appropriate time off between periods of duty (see pages 6-8 of the enclosed “AAMC Policy Guidance on Graduate Medical Education”). Any additional changes in requirements for resident duty schedules should be informed by research evidence and developed by individual specialties and their residency review committees under the auspices of the ACGME. Schedules should be flexible enough to accommodate differences in the patient care delivery and educational needs among specialties. They also should be flexible enough to accommodate circumstances when residents need to remain on duty longer than the standard provides, and also to accommodate circumstances when they need to be taken off duty because of fatigue or other circumstances that adversely affect patient care or resident well-being. Schedules should provide residents sufficient time for group learning activities and for individual study and reflection on their clinical experiences. They should provide sufficient time for rest and recovery.

**Moonlighting.** The AAMC believes that time spent in moonlighting should be included in the 80-hour limit or prohibited altogether. These activities are not educationally based, cannot be readily monitored, and often are detrimental to residents’ ability to focus on their education programs and associated patient care responsibilities.

**Monitoring and enforcing adherence.** The ACGME, with its specialty and institutional review committees, is the appropriate organization to monitor and enforce resident duty hours. As the AAMC stated in its testimony to the IOM committee May 8, 2008, “The ACGME considers resident schedules in the context of the whole educational program and its institutional environment, as is appropriate.” It assesses adherence in the context of both education and health care delivery. Its deliberations involve all the key constituencies of medical education and medical practice, and its staff has a nuanced understanding of the complexities of education in clinical settings and their relationship to patient safety. The ACGME should continue its practice of responding to resident complaints and surveying all residents about their hours. Institutional sponsors should continue their oversight of duty hours as called for in the ACGME
institutional requirements. Sponsors should provide for confidential, protected resident complaints to an institutional office that is not directly responsible for GME.

**Resident safety: transportation.** Driving when fatigued is a potential risk to residents and the public. Programs and institutional sponsors should take steps to reduce this risk by, e.g., providing residents going off duty a place to nap in the hospital before going home or paying for transportation home. Team members need to help each other decide when not to drive, since the ability to self-assess is itself impaired by fatigue. Handovers of patient responsibility afford opportunities for assessing fatigue.

**Workload.** Workloads of residents, especially in their first year, should be examined, and appropriate limits defined by individual review committees. The types and severity of cases should be taken into account. Resident tasks that are of limited or no educational value should be minimized or eliminated, while the educational value of all resident tasks should be maximized. Duty schedules should be informed, but not determined, by clinical case loads.

**Supervision.** Supervision commensurate with the level of the resident and the condition of the patient strengthens the educational experience and safeguards patients from potential errors. Resident supervision should be enhanced, with measurable standards established by individual review committees. These standards should go beyond defining geographic proximity of faculty to patients or residents. They might include, for example, specific guidelines about when a resident should consult with the attending physician or a more senior resident in person, by phone, or through electronic communication. Or they might call for attending/supervising physicians to “check-in” with residents on duty rather than waiting to be contacted for guidance. They might require that first year residents not be on duty without on-site supervision, and take into consideration the practice in anesthesiology, obstetrics-gynecology, and emergency medicine of having attending physicians on site at all times. In any event, supervision standards should be matched to patient acuity and faculty skills in supervision should be improved through faculty development.

**Patient handovers.** Handovers should include processes that incorporate a robust exchange of information about patient management. These transitions are opportunities for consulting with the supervising physician about the key patient information that needs to be transferred, in the interest both of patient care and education. The effective transfer of information about patients should be an element of the quality and safety programs of hospitals. It is not an issue only for residents and teaching settings, but for all members of the care team as they change shifts or roles in the clinical care of a patient. Specific handover processes should be developed at each institution, with necessary variations to fit the care provided by the different specialties. A best practice is to use handovers as additional learning opportunities for the residents, a means for improving care to the patient, and an opportunity to assess fatigue. Resident schedules should provide for enough overlap between the outgoing and incoming clinician to support best practices in handovers, which may also increase time requirements.

**Resources to support change.** Additional resources would be required to shift non-educational responsibilities to others, and/or to expand the pool of residents in training. (This does not mean that specialties that currently have a greater burden of duty hours should
automatically be expanded. Any change in the size of residency programs should be related to both national and community needs in the context of providing a high-quality training program.) Cost estimates for the use of substitute health care providers in teaching hospitals as a consequence of the changes in resident duty hours proposed by the Institute of Medicine range from $375 million to $1.6 billion per year. **These costs should not fall solely on teaching hospitals, which are already bearing the majority of costs of the 2003 reforms, but should be borne by health care payers.** A lack of external support for these changes is likely to undermine the institutions’ educational effectiveness and further jeopardize their financial health.

**The knowledge gap/research.** The evidence base on which the 2003 duty hours standards were based was weak, and subsequent efforts to evaluate the effects of those standards have been of mixed quality. Most studies were conducted shortly after the standards were implemented, too early to observe important effects; they were limited to small numbers of residents in a single specialty or setting and thus cannot be generalized; and there are multiple intervening variables that make it very difficult to draw cause-and-effect conclusions. Studies of large numbers of patient records have shown little or no change in mortality before and after the 2003 standards were implemented. **Any changes in the standards should be based on the best available evidence about the relationship between resident schedules and patient outcomes.** Research also is needed on educational outcomes, including residents’ preparedness for independent practice. **Methods to assess and mitigate the effects of fatigue should be studied.** Institutions and programs that have implemented policies that are educationally sound and that support safe care, in accordance with the 2003 duty hour regulations, should be studied. **Equally important, evaluation studies should be carried out if any new standards are put in place, so that, five years from now, a better body of evidence will be available on the relationship between resident schedules and duty environments and both patient care and educational outcomes.**

We appreciate the opportunity to share our perspective on these critical issues. The AAMC looks forward to working with the ACGME to review the existing standards, consider the need for new standards, and define a research agenda that will provide better guidance for future action than is available currently.

Sincerely yours,


Darrell G. Kirch, M.D. 
President

Carol A. Aschenbrener, M.D. 
Executive Vice President

Enclosure