February 1, 2016

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

Dear Dr. Nasca:

On behalf of the Organization of Program Director Associations (OPDA) and the Council of Medical Specialty Societies (CMSS), we are pleased to provide input to the Accreditation Council for Graduate Medical Education (ACGME) as you review accreditation requirements for resident duty hours, including key dimensions of the learning and working environment. Convened by the Council of Medical Specialty Societies (CMSS), OPDA is comprised of a representative from the program director society for each specialty with a distinct Residency Review Committee (RRC). We solicited written feedback from members as well as verbal feedback during a conference call convened to discuss the four items for which our input was requested.

We applaud and are deeply grateful for the leadership and guidance of the ACGME as we all strive to ensure safe, high quality training and patient care, and at the same time ensure physician well-being. We recognize that each specialty has unique training needs, patient populations, and local and national training and practice environments. It is clear that the impact of the duty hour requirements has been different for different specialties and that a one-size-fits-all approach is not working and will not work. Members reported that much of their evidence has been anecdotal, and all agree that more carefully designed, specialty-specific studies need to be conducted.

We understand that each specialty organization will be submitting detailed letters outlining their specific concerns and current evidence, if available, for their recommendations. We will not attempt to repeat those communications here, but we enthusiastically support the specialty-specific recommendations you will receive from the different specialty organizations and stakeholders best equipped to assess their unique training needs and environments. With this letter, we appreciate the opportunity to highlight and summarize common concerns and recommendations from our member program director organizations.

**Position on current ACGME resident duty hour requirements:**

There are common standards for which the philosophical and ethical application should be universal. These should be designed to safeguard the health and well-being learners and their current and future patients, and ensure that trainees are prepared for practice. However, programs have not yet had the chance to develop standards outside the current restrictions. We recognize that limited evidence was available when the 2011 Duty Hours were implemented and that the results of the FIRST and iCOMPARE trials are not yet available. It is unclear if current requirements have improved patient safety/outcomes or resident well-being.
The consensus is that the well-intended duty hour requirements have had unintended consequences including:

- increased hand-offs
- shift mentality with reduced ownership, continuity of care, and professional responsibility
- reduced clinical and surgical experience, graduated autonomy, and preparation for practice
- reduced time for education and teaching

These impacts are not limited to GME - UME is also affected as medical schools and the LCME adopt standards which mirror the ACGME requirements. We believe current requirements should be revised to minimize unintended consequences and to allow, as appropriate, more flexibility. Requirements should be based upon carefully designed, specialty-specific studies. We look forward to the results of the FIRST and iCOMPARE trials. Importantly, OPDA members from other specialties would welcome the opportunity to help develop and participate in additional studies for their respective fields.

**Recommendations regarding dimensions of resident duty hour requirements:**

We recommend flexibility for training programs to adapt to local patient, clinical, and educational microsystem needs and resources. We support specialty-specific recommendations which will be submitted by the specialty organizations which may recommend further flexibility or restriction, as appropriate, for their respective disciplines and environments.

However, in general, we recommend the following:

- **Continue to restrict duty hours to 80 per week, on average, but allow sufficient, appropriate, and safe flexibility within those limits.**

  Currently, programs and residents adhere rigidly to these rules and are fearful of any violations even though both trainees and supervisors report instances when they wish residents could remain onsite to engage in educational activities (including conferences and independent practice in simulation labs) or the management of rare medical cases, long surgical cases, critically ill patients, or patients with whom trainees have forged a deep relationship and with whom other team members will discuss end of life issues, complicated informed consents, or bad news.

- **Allow all residents (including PGY 1) to work for up to 24 hours with appropriate supervision, fatigue management and mitigation practices in place.** Allow an 8 hour minimum period between duty periods for all levels and extend to PGY2-3 residents the opportunity to return to the hospital for the activities and circumstances already defined. Allow up to an additional 6 hours for educational purposes or transition of patient care.

  Limiting interns to 16 hour work periods and longer intervals between duty periods inhibits the development of skills related to time management and mitigation of fatigue. Ironically and appropriately, interns are the most closely supervised. Limiting their work hours limits the opportunity for them to share buddy call and work closely with their supervising residents and faculty after hours when unusual or acute cases typically present.

  Under current restrictions, when PGY1 residents transition to the 2nd year, they are not prepared to work for up to 24 hours, have had less exposure to medical and surgical cases, and have had less supervised
contact time with teaching residents and faculty. Increasing work periods to 24 hours would improve continuity of patient care which would reduce the number of handoffs and improve professionalism by reducing shift worker mentality. It would increase supervised contact time, education, and preparation to manage acute and rarer cases. It would ensure appropriate graded autonomy over the entire training period.

Under the current requirements, graduated autonomy has been necessarily compressed in the intermediate and advanced training years. The result is more stress, less confidence, and steeper learning curves experienced by intermediate residents and reduced preparation of advanced residents prior to entering practice. Exit “boot camps” and additional on-the-job training or supervision by employers and fellowship directors have had to be implemented to address this.

**Recommendations regarding standards governing key aspects of the learning and working environment:**

We applaud the efforts the ACGME has made through the Clinical Learning Environment Review (CLER) program to raise learning environment standards that directly and indirectly impact resident training and patient care. In particular, CLER has both fostered and focused strategic dialogues and partnerships across stakeholders in our institutions. Multiple factors and structural components influence the environment and contribute to the work conditions and the ability of individuals and teams to perform at their best.

Given the complexity of the clinical learning environment, research on duty hours, safety, and outcomes should also focus on the impact of workspace and workload interventions including, but not limited to:

- additional personnel to support clinical care (e.g., resident assistants and advanced care providers)
- electronic medical records and physician order entry
- patient caps
- resident/patient ratios
- redundant documentation requirements
- observation and guided reflection
- engagement of faculty in teaching, and
- physician stress at all levels

We believe that resident and faculty surveys, as well as discussions with site visitors during CLER visits, will identify the issues of concern. In particular, our members highlight concerns about reduced time and support for teaching, and reduced graduated autonomy of residents who are less confident and less prepared for practice.

Once again, we recognize that each specialty and healthcare system will have unique challenges, resources, needs, and populations. One size will not fit all. We eagerly look forward to the Pursuing Excellence Initiative being launched by the ACGME. We believe this bold, important project has the potential to identify and address these concerns in a transformative way which will improve both the quality of patient care and of education.
**Participation in a Resident Duty Hours in the Learning and Working Environment Congress:**

OPDA would be honored to participate in the Congress to be held in Chicago in March 2016. We look forward to the opportunity to join ACGME and other organizations to discuss these important topics. We thank you, again, for the invitation.

Sincerely,

Norman Kahn MD  
Executive Vice-president and CEO  
Council of Medical Specialty Societies

Tara Uhler MD  
Chair  
Organization of Program Director Associations

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