RE: Resident Duty Hours

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:

Thank you for contacting the Veterans Health Administration (VHA) on the Accreditation Council for Graduate Medical Education’s (ACGME) requirements for resident duty hours. The Department of Veterans Affairs (VA) has a large stake in the outcome of GME, hosting over 40,000 individual residents per year at our clinical sites, as well as an additional 22,000 medical students. VA also employs over 20,000 staff physicians, with over 1,000 new physicians hired each year.

In general, duty hour limitations have had modest positive impacts on resident satisfaction and fatigue mitigation but negative impacts on resident competency development, health care costs, and patient centered care as outlined in the attachment. VA believes that the negative sequelae of the current duty hour restrictions outweigh the positive and that the current restrictions should be loosened modestly to improve resident development of competencies including professionalism. Resident development of competencies for independent practice should be the overriding consideration.

With regard to the dimensions of resident duty hour requirement, VA recommends that maximum shift lengths should be reconsidered and standardized for all resident levels. In particular, the maximum shift length for interns (16 hours) and time off between shifts should be re-visited. Duty hour monitoring should transition from a punitive stance to a quality improvement stance. “The current tone is compromising resident professionalism by causing residents to choose between falsifying duty hour reports and altruistically caring for their patients after a shift ends” (see Byrne et al, Sept 2015, JGME). In addition, VA recommends that ACGME support schools and sponsoring institutions in developing programs for faculty to enhance skills for teaching in this new discontinuous, time-pressured environment.
VA does not have formal recommendations regarding standards governing key aspects of the learning and working environment, and justification (wherever possible) for these recommendations with evidence.

VA would be delighted to participate in a Resident Duty Hours in the Learning and Working Environment Congress in March. Thank you again for allowing VA to participate in this dialogue about work hour standards. Feel free to contact me if you have any questions.

Sincerely,

Karen M. Sanders, MD
Deputy Chief Academic Affiliations Officer

Attachment
VHA Responses - ACGME Resident Duty Hour Requirements

VHA solicited comments from all VHA Chiefs of Staff and Designated Education Officers. Over a hundred comments were received from all across the country representing multiple specialties and subspecialties. The following comments reflect the consensus opinion from VA sources including several verbatim quotes.

Discontinuities of Care (Handoffs)

The rising number of hand-offs have disrupted continuity of care, disrupted daytime learning activities, decreased resident learning about disease processes and response to treatment and confused patients and families. Attending physicians have become the main source of continuity in the inpatient setting. “For significant portions of the day, the resident responsible for an individual patient’s care is not familiar with that patient and is unable to determine whether their condition has changed or not.” “Internal medicine inpatients may encounter up to three different residents in the first 12 hours of admission if they arrive late in the afternoon.”

Resident Learning

Residents have fewer hours in which to learn and gain technical skills. Respondents felt that second year residents (in medicine) were less prepared to supervise a team and make clinical decisions. In surgery, where some interns no longer take in-house calls, this is impacting competency development and decision making. Procedural competency is reduced from prior years. Some respondents felt that residents were “reporters” and no longer “interpreters” of findings. “This is showing up repeatedly in our peer review process were we find that the resident has failed to recognize early signs that a patient is developing sepsis, respiratory failure, cardiac decompensation, early strokes and other such conditions...” The American Board of Thoracic Surgery reports a tripling of failure rates from 12 percent (2003) to 35 percent (2012). Many respondents noted an increased tendency of surgery graduates to choose advanced training to increase comfort with independent practice. “Attending physicians find that they have little time to teach, largely because residents are not available for teaching sessions due to staggered schedules.” In an unpublished survey at a large VA teaching site, 32 percent of program directors felt that workhour restrictions had negatively impacted trainee preparedness for future professional practice.

Resident Feedback

There is reduced continuity between residents and supervising faculty. “..a resident may overlap with many faculty members during his or her rotation, reducing the likelihood of meaningful feedback that is based upon longitudinal supervision.”

Professionalism
Of all theme areas, this was the subject that garnered the most negative responses. Uniformly, respondents complained that current residents do not have “ownership” of their patients and do not feel responsible for the total care of the patient. This transition to “shift work” has decreased team functioning and collaboration, increased reliance on attending decision-making, and decreased the development of graduated levels of responsibility. “Residents feel obliged to adhere to the hours restriction without regard to impact on their responsibilities…the adverse effect on professionalism may not be reversible.” One author contends that in the current duty hour environment, residents do not need to learn to manage stress well, while stress is a powerful motivator to pay attention, learn, and perform at a high level.

Costs

VA acknowledges a large increase in inpatient care costs directly tied to duty hour restrictions. Following the first set of duty hour standards were promulgated in 2003, VA surveys revealed an average medical center cost of $1 million dollars per medical facility (unpublished data). Since 2011, costs have continued to rise, in some locations tripling. Costs to VA include the hiring of inpatient hospitalists and nocturnists (due to unavailability of resident coverage), hiring of nurse practitioner and physician assistants to staff non-teaching teams, and additional moonlighter costs (many of whom are fellows and chief residents). Respondents mentioned additional administrative personnel are necessary to manage complex house staff schedules. Utilization of consults, radiology and lab tests have increased modestly.

Patient Centeredness

Respondents felt very strongly about this domain considering VA’s long emphasis on patient centered care. The new resident schedules have increased “holdovers” because patient caps are reached for the prior team. This increases patient and family stress when they have to wait to meet “their new doctors.” Family conferences and end-of-life discussions are susceptible to disruption due to the resident shift assignments, and many of these discussions must take place without the primary resident participating. Resident schedules often interfere with VA clinic scheduling and access standards. The resident-patient relationship is in jeopardy, especially in the inpatient setting.