



Committee of Interns and Residents *SEIU*Healthcare®

ACGME Resident Duty Hours in the Clinical and Learning Environment Congress Chicago, IL March 2016

Position Paper Committee of Interns and Residents

February 1, 2016

I. INTRODUCTION

The Committee of Interns and Residents/SEIU Healthcare (CIR) is the oldest and largest resident union in the U.S. CIR represents 14,000 interns, residents and fellows training in all specialties in more than 60 public and private hospitals across the country. Since our founding in 1957, CIR has been committed to improving the care we provide to our patients, as well as the employment conditions, education and training and wellbeing of our members.

CIR recognizes that becoming an excellent physician is, by its very definition, a difficult and life-long process requiring the highest professional behavior and personal sacrifice. It's what we are committed to and what we, as resident physicians, take pride in doing every day. But we also believe that the training of physicians in the United States can – and must – be improved to ensure safer, higher quality care for our patients. We should strive for a learning environment that ensures excellent and thorough training as well as a healthy work-life balance in the lives of resident physicians.

In the spirit of that desire to improve graduate medical education, CIR submits the following comments to the Accreditation Council for Graduate Medical Education. We look forward to participating in the ACGME Duty Hours in the Clinical and Learning Environment Congress in March of 2016.

II. CIR POSITION ON THE CURRENT ACGME RESIDENT DUTY HOURS REQUIREMENTS

CIR has been a leading advocate for duty hours reform for more than forty years because we recognize all too clearly the effect of sleep deprivation on our ability to deliver quality care to our patients and also to care for ourselves. Our efforts led to a successful 1975 campaign to turn every other night on-call schedules to every third for 2,000 residents training in New York City¹ and creation of the 1989 New York State public health work hours regulation following the death of Libby Zion.

One of our members died in a post-call car accident in 1999, giving impetus to our support for federal legislation and an OSHA petition in 2000. That action helped encourage the ACGME to issue its first across the board duty hours limits in 2003. Finally, CIR testified in 2007 before the Institute of Medicine (IOM) panel convened to study duty hours and patient safety.

Our position on the current ACGME duty hours requirements is based on a careful examination of what has and has not changed over decades of reform efforts, and what is required in order to guarantee the health and safety of our patients and, just as importantly, of housestaff.

CIR believes it is imperative that the ACGME stay on the path to improving residency training. We do not support approving waivers of the duty hours rules for research studies whose goal it is to roll back the 2011 limits.² Specifically, we note that:

Best practices already exist that demonstrate rigorous training and education can take place with day and night float shifts of 12 hours (+ 2 for transition), with robust education and rigorous handover practices. Medical educators have gained a better understanding of nighttime work and have adapted resident education so that it is accessible to all residents, not just those working the daytime shifts. This schedule allows essential time off for work/life balance that is critical for both patient and resident safety and wellbeing.^{3,4,5}

However, a 12-14 hour shift - size does not fit all residency programs and flexibility is necessary to preserve. Residency review committees have different requirements for the acquisition of skills and experience. Many residents will tell you they prefer a 24 + 4 hour shift, if only because the several hours of free time post-call are a welcome break from the intense grind of as many as five days in a row of 16-hour shifts.⁶ The Institute of Medicine report recognized that the 24+ hour shift was preferred by many medical educators, particularly in the surgical specialties, and its recommendations allowed for the continuation of extended shifts so long as there were safeguards in place. Yet there are no safeguards in place in the current ACGME rules for these long shifts.

¹ http://www.cirseiu.org/files/2013/02/NY-Times-March-23_reduced.pdf http://www.cirseiu.org/files/2013/02/Daily-News-March-19_reduced.pdf

² Billimoria KY, Chung JW, Hedges L, Allison RD, et al. Development of the flexibility in duty hour requirements for surgical trainees (FIRST) trial protocol: A national cluster-randomized trial of resident duty hour policy. JAMA Surgery. Published online December 30, 2015.

³ Fahrenkopf AM, Sectish tC, Barger IK, et al. Rates of medication errors among depressed and burnt out residents. Prospective cohort study. BMC. 2008;336:488-491.

⁴ Prins JT, van der Heijden FMMA, Hoeksrata-Weebers JEHM, et al. Burnout, engagement and resident physicians' self-reported errors. Psychol Health Med. 2009; 14:654-666.

⁵ West CP, Tan AD, Habermann TM, et al. Association of resident fatigue and distress with perceived medical errors. JAMA. 2009;302:1294-1300.

⁶ Note that a 16 hour shift leaves just 8 hours for getting to and from work, eating, studying, social interaction and sleep.

We need to critically examine the work a resident is expected to do, how that work gets done and how it can be redesigned for maximum patient safety, resident education, and wellbeing. CIR believes employing the tenets and tools of quality improvement – rather than rule change – will produce the most practical and effective change in the years leading up to the ACGME’s next Duty Hours Congress in 2021.

Despite the intense focus on the merits of the 2011 hours reforms, residents today – *most of whom began residency after 2011* – experience a training reality that is remarkably similar to the one that existed in 2003. CIR remains concerned about inadequate time away from the hospital, as well as the lack of safeguards and/or limits on the amount of work a resident is expected to do safely. We note:

1. PGY 2 and above residents are routinely scheduled to work 24 + 4 hour shifts.⁷ These on call shifts are 12 hours longer than the 16 hours proscribed for interns in 2011.
2. Duty hours continue, as in 2003, to be limited to 80 hours per week, *averaged over a four week period*, with Review Committee exceptions allowed for up to 88 hrs per week based on “sound educational ground.”
3. The maximum on-call frequency remains at the 2003 rule of every 3rd night – *averaged over a 4 week period*. According to the ACGME’s FAQs on duty hours,⁸ in a one month period it is entirely permissible to schedule residents to work four every-other-night 28 hour shifts in a seven-day period as long as the above average is not exceeded over a 4 week period.
4. Just as in 2003, residents are still only assured one day off a week – *averaged over seven days*, which means residents can be scheduled to work 14 or more days in a row without a day off from work to rejuvenate. It is not unusual for residents to work for weeks in a row without two consecutive days off.
5. There are still no limits or safeguards on the amount of work a resident is expected to do, e.g. no cap on the number of new admissions, a census cap, or the total number of patients for which an on-call resident must provide cross coverage. This includes residents and fellows who are on home call and who may be awakened multiple times in the night to answer pages. But if they are not called into the hospital at night, those hours awake at home are not included in the 80 hour limit and, irrespective of their being called in, they are expected to work the entire next day.
6. There are still no teaching institution requirements to reduce work that residents routinely do that could or should be done by other health professionals, e.g. securing IV access, routine venipuncture, obtaining cultures, transporting patients, discharge planning, and case management. This is of particular concern in many safety net hospitals where funding is limited and economically disadvantaged patients with complex medical conditions require extraordinary care and much more than the average clinical response.

With so few changes made to modify duty hours in 2003 and 2011, one would not expect to see any improvement in patient safety and resident wellbeing. However, a recently published meta-analysis of 72 high-quality studies concluded, “Most studies that allow enough time for DHR [duty hours reform]

⁷ This 24 + 4 hours for transition of care rule was reduced just two hours from the 2003 rule of 24 + 6 hours.

⁸ <http://www.acgme.org/acgmeweb/Portals/0/PDFs/FAQ/dh-faqs2011.pdf>

interventions to take effect suggest a benefit to patient safety and resident wellbeing, but the effect on the quality of training remains unknown.”⁹

It is *not* surprising, however, that with so little change in duty hours, resident physicians today continue to identify work compression, lack of ancillary support and increased levels of stress, burnout and depression.^{10,11} The problem was so pronounced (three resident suicides within a few weeks of each other in 2014)¹² that ACGME CEO Dr. Thomas Nasca chose to highlight the problem in his address to the ACGME Educational conference in February 2015. He announced plans to convene a taskforce on resident wellness and a by-invitation-only conference was held in November 2015.

As physicians committed to evidence-based medicine, CIR took seriously the 2009 IOM report *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*.¹³ We saw gathered there a significant body of scientific evidence that described the deteriorating performance of fatigued humans,² as well as specific studies on resident fatigue and preventable medical errors.¹⁴ One notable meta-analysis of 60 studies on the effect of sleep deprivation found that the clinical performance of residents and non-physicians, on average, after 24-30 hours of wakefulness was at “the 7th percentile of the comparison group.”¹⁵

The Institute of Medicine report also focused on the harm to resident physicians themselves from acute and chronic sleep deprivation, citing studies showing the connection between resident fatigue and an increased incidence of car accidents, needle-stick exposures to blood-borne pathogens, burnout, and depression.¹⁶

CIR presented testimony to the ACGME Duty Hours Congress in June 2009 urging it to begin implementing the recommendations made by the IOM. We recognized that it would be no easy task and would take many years. We also advocated for additional GME funding to support this change. To help forge a path towards implementation, CIR collaborated with the internationally recognized patient safety leader Dr. Lucian Leape and notable sleep scientists, Drs. Charles Czeisler and Christopher Landrigan, to host a two-day roundtable discussion at Harvard Medical School in June 2010. Our goal was to bring together a group of influential stakeholders¹⁷ to develop a practical road map for how to bring about the imperative of the IOM report. In particular, we included medical educators who had already implemented many of the changes that the IOM recommended, so that we could learn from

⁹ Lin, H, Lin, E, A narrative review of high-quality literature on the effects of resident duty hours reforms. *Academic Medicine*, Vol. 91, No. 1, January 2016.

¹⁰ Auger, KA, et al. Better rested, but more stressed? Evidence of the effects of resident work hour restrictions. *Academic Pediatrics* 12.4 (2012): 335-343.

¹¹ West, CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. *JAMA* 306.9 (2011): 952-960.

¹² AMA Wire. ACGME seeks to transform residency to foster wellness, May 28, 2015. <http://www.ama-assn.org/ama/ama-wire/post/acgme-seeks-transform-residency-foster-wellness> accessed 1/29/16.

¹³ Institute of Medicine. *Resident duty hours: enhancing sleep, supervision, and safety*. Ulmer C, Wolman DM, Johns MME, eds. Washington DC: National Academies Press, 2009.

¹⁴ IOM 2009. Resident duty hours, Chap 6 and 7, pp. 179-252.

¹⁵ Philibert I. Sleep loss and performance in residents and non-physicians: A meta-analytic examination. *Sleep*. 2005; 28:1392-1402.

¹⁶ IOM 2009. Resident duty hours. Chap. 5 pp. 159-175.

¹⁷ 2010 Roundtable participants included (for identification purposes only): James Battles (AHRQ), Maureen Blisognano (IHI), John Brockman (AMSA), Claire Caruso (NIOSH), David Cohen (Maimonides Med Ctr), Jordan Cohen (Past President, AAMC), John Combes (AHA), Edward Dunn (Lexington VAMC), Helen Haskell (MAME), Michelle Lefkowitz (CMS), Arthur Aaron Levin (Center for Medical Consumers), Kavita Patel (New America Foundation), Ann Louise Puopolo (CRICO/RMF), Wendy Reid (UK NHS), Paul Schyve (Jt Commission), Veronica Wilbur (IPRO), Barbara Wynn (Rand Corporation).

their experience.¹⁸ The resulting white paper was peer-reviewed and published in the journal *Nature and Science of Sleep* in June 2011.¹⁹

III. CIR RECOMMENDATIONS FOR FUTURE DIMENSIONS OF RESIDENT DUTY HOURS

In 2010, the ACGME chose to disregard virtually every Institute of Medicine recommendation with regard to duty hours. At the March 2016 Congress, this body will have the opportunity to revisit the evidence on the effects of acute and chronic sleep deprivation collected in the 2009 IOM report and remind its constituents of the Congressional genesis of the report,²⁰ as well as the profession's commitment to act selflessly with the public's well being foremost in its mind.

Patients and their families as well as the public as a whole have a real world understanding of the relationship between fatigue and errors. They understand that fatigued pilots can be the cause of accidents, like the well-publicized 2009 crash outside Buffalo, NY that killed all on board, or the trucker in New Jersey who fell asleep behind the wheel in 2014, causing an accident that critically injured comedian Tracy Morgan and killed his fellow passenger²¹. The public is aware that other industries entrusted with the public's safety (aviation, trucking, nuclear power) have had regulations in place for decades to limit work hours to safe levels. In a 2004 Kaiser Family Foundation nationwide survey of public opinion on the causes of medical errors, 74% of respondents listed overwork, stress or fatigue of health professionals as a "very important cause of medical errors."²²

And the public has stated its preference for rested physicians. In a 2010 poll²³ sponsored by CIR and Public Citizen, only one percent of respondents approved of shifts greater than 24 hours, and four out of five said they would ask for another doctor if they found out that their doctor had been awake for more than 24 hours. This finding was reaffirmed in 2014 in a study of hospitalized patients who reported greater concern about resident fatigue rather than transitions of care.²⁴

These inconvenient truths – that sleep deprivation is a safety issue and that the public is concerned about fatigued physicians – are widely dismissed by the academic medical community. There exists instead a widespread belief that physicians can be trained to defy the biology of sleep and that safeguards are in place so that patients and residents are not harmed by work schedules that are unheard of in any other workplace, let alone a hospital. That belief is most evident today in the FIRST

¹⁸ Examples of medical education innovation and work/learning redesign were highlighted from Summa Health System, Akron, OH, Santa Clara Valley Medical Center, San Jose CA and Maine Medical Center, Portland, ME.

¹⁹ Blum A, Shea, S, Czeisler C, Landrigan C, Leape, L. Implementing the 2009 institute of medicine recommendations on resident physician work hours, supervision, and safety: A report from a conference at Harvard Medical School. *Nature and Science of Sleep*. June 2011: 57-58 Available at: <http://dx.doi.org/10.2147/NSS.S19649>. Accessed January 29, 2016.

²⁰ Dingell JD, et al. Agency for Healthcare Research and Quality. Washington DC: U.S. House of Representatives, Committee on Energy and Commerce, March 29, 2007. <http://www.cirseiu.org/files/2011/08/AHRQ-letter.pdf>

²¹ The truck driver was indicted in December 2015 on first degree aggravated manslaughter <https://www.bostonglobe.com/lifestyle/names/2015/12/24/truck-driver-indicted-crash-that-hurt-comic-tracy-morgan/GqXkrFBpuPPO02yERX2J1N/story.html>

²² Causes of Medical Errors: Public Opinions, Kaiser Family Foundation Nationwide Survey 2004.

²³ Blum AB, Raiszadeh F, Shea S et al US public opinion regarding proposed limits on resident physician work hours. *BMC Med*. 2010; 8:33.

²⁴ Drolet BC, Hyman CH, Ghaderi KF, Rodriguez-srednicki J, Thompson JM, Fischer SA. Hospitalized Patients' Perceptions of Resident Fatigue, Duty Hours, and Continuity of Care. *J Grad Med Educ*. 2014;6(4):658-63.

and iCOMPARE studies that set out to prove that there is no difference in patient outcomes from residents who work 16 or 30 hour shifts. The principal investigators were so convinced that no harm would come of these experiments that they determined it wasn't necessary to obtain informed consent from either patients or residents in the hospitals where the studies were conducted. This determination has been widely disputed and is now under investigation by the Office of Human Research Protections (OHRP).^{25,26}

Moreover, there is an inherent belief that a certain minimum number of hours, weeks, months, and years is required for residents and fellows to achieve proficiency in those disciplines. Yet, from institution to institution (and even within the same institution), the experience of individual residents can vary markedly. There are no feasible means to standardize each resident's exposure to the clinical setting. This makes what is deemed as "minimal clinical exposure" an elusive concept. Other than tradition and present-day financial incentives which have allowed what was once an apprenticeship lasting a few months after medical school to become what is today's several years of training, no available evidence exists for adding even more years to residency or fellowship training.²⁷ Given this reality, we do not agree with the concern that a reduction in daily work hours will inevitably require longer residency programs. Instead, the focus should be on identifying the means to increase high-impact educational opportunities and minimize resident time spent on work that could otherwise be assigned to ancillary staff.

Given a culture that is resistant to any reduction in duty hours and a lack of any financial incentive to make change, we have asked ourselves how we can best improve patient safety, resident education, and wellbeing.

We firmly support the need for limits on the hours that residents are required to work and oppose any weakening of what already exists. We recommend the following:

1. Recognize residents need more time away from the hospital

Guarantee 5 days off each month for ALL residents, i.e. one day off a week – no averaging – and at least one weekend off a month. This is one significant change to the current duty hour rules that CIR believes would fundamentally counteract the stress, burnout, and depression that is so prevalent among residents today. This minimal time off is essential for resident rejuvenation, vitality and work/life balance, which is directly connected to patient and resident safety. It was one of the Institute of Medicine's recommendations for duty hour change. For over 25 years, New York State's Bell regulations have required one day off in a week without averaging.

2. Practice transparency when reporting the duty hours that residents work

a. Gather baseline data to measure change. Require each teaching hospital to report to the ACGME how many of its residency programs in 2015-16 had rotations where residents were scheduled to work 24 + 4 hour shifts. How many of these rotations were residents assigned to in a year? And finally, how many of these shifts were residents scheduled to do in a month? This information is readily

²⁵ <http://www.citizen.org/documents/2283.pdf> accessed 1/29/2016.

²⁶ <http://www.citizen.org/documents/2284.pdf> accessed 1/29/2016.

²⁷ Emanuel EJ, Fuchs VR. Shortening medical training by 30%. JAMA. 2012; 307(11):1143-4.

available to individual program directors, yet today no one knows what percentage of residents nationally, training in which specialties, routinely work these hours.

b. Make this 24 + 4 hour rotation data available on the ACGME website so that 4th year medical students applying to programs, residents looking to evaluate their program's practice – and our patients – will be aware. Transparency is an important part of our profession's commitment to the public.

3. Mandate Redesign of Resident Work and Learning

a. One size does not fit all specialties or residency programs. CIR is not calling for the ACGME to eliminate all 24 + 4 hour on-call shifts. Instead, we want to ensure that patients are safe and maximize the patient and training experience for residents while minimizing fatigue, stress and burnout. This can be achieved in a variety of ways, e.g. a requirement that there be established breaks for rest and/or sleep, limits for on-call work responsibilities, the provision of other appropriate hospital personnel to perform work that would otherwise be left to residents to do and finally a limit on the number of these extended calls in any given rotation. We recommend that the ACGME put these safeguards in place.

b. Require residency programs across the country to use the methodology and tools of continuous quality improvement (e.g. mapping, PDSA cycles) to engage in work and learning redesign to maximize patient safety and resident learning and wellbeing. **This redesign should focus on those rotations that residents identify as the most grueling and/or of the least educational value**, i.e. where their workload is significantly compressed and and/or they remain in the hospital longer than needed because they are doing work that is unnecessary, inefficient, or best done by others. Residents know what these rotations are and should themselves be key participants in any redesign process. The goal should be to encourage multidisciplinary team models which allow for maximum resident education and patient/resident safety. One first step might be to ask residents to anonymously identify these rotations during the CLER visits (see below). As with any other transformative process, redesign will evolve over time.

c. Collect and actively disseminate best practices of the many residency programs in all specialties that have redesigned training to reduce the number of 24 + hour shifts and improved resident education and wellbeing. These early adopters exist,^{28 29 30} and more would follow if their experience and lessons learned were easily available. Publish these redesign efforts on the ACGME website and in graduate medical education and patient safety/quality improvement journals so others can learn both from their successes and their failures.

d. Highlight and celebrate the faculty and resident champions of innovation and change to show that the ACGME values their leadership and urges other programs to follow. There have been multiple reports of single-institution resident-led and faculty-led implementations which have resulted in improvements in continuity of care, patient safety, and overall resident satisfaction along with increased learning opportunities, decreases in length of stay, and improved resident

²⁸ Whiting J Of puppies and dinosaurs: why the 80-hour work week is the best thing that ever happened in American surgery. Archives of Surgery. April 2, 2010.

²⁹ CIR Work Smart Tool Kit 2009. <http://cir.seiu.org/page/-/documents/WorkSmartToolKit.pdf>

³⁰ Cheung JY, Mueller D, Blum, M, Ravreby H, Williams P et al. An observational pre-post study of re-structuring medicine inpatient teaching service: improved continuity of care within constraint of 2011 duty hours. Healthcare 2015.

supervision.^{31,32,33,34} Best practices from implemented changes should be widely shared and adoption should be encouraged.

e. Require that residency programs write up and report out on their redesign changes at each CLER visit. It is important for the ACGME to know which rotations were identified and what changes were implemented, what barriers impeded implementation and what strategies residency program directors, chairs and the C-Suite identified to work towards their goals over time.

4. Address the Resident Workload Issue

a. Identify the financial barriers to change and how the best performing institutions have managed to overcome them. In many situations, a financial case can be made to the C-Suite to invest in redesign because the efficiencies, increased patient safety and physician-patient satisfaction will outweigh the costs. However, putting together this business case requires time-consuming study and is not often done. The ACGME should fund and support this work.

b. Urge each residency review committee to establish workload safeguards with regard to admission limits, cross coverage patient limits, etc. In addition, encourage residency program directors and teaching hospital CEOs to listen and respond to resident reports when work expectations are unsafe for patients and residents.

c. Scrutinize teaching hospitals which do not provide adequate ancillary support, e.g. IV, phlebotomists, social work services, such that residents are not regularly and recurrently doing the work of others. This is better for patient care, better for resident education and will reduce burnout and stress.

d. Implement safeguards for at-home call to protect residents and fellows from work compression which, in many cases, requires them to stay up throughout the night at home responding to pages and calls and then to return to work for the entire next day. The current expectation is that they will be involved in active patient care, including performing procedures, irrespective of the number of continuous hours they have been awake.

5. Handovers – No Excuses

Require that residents in all rotations in every specialty use a hand-over instrument (EMR or paper) for all patient information transfers. Handover best practice research and tools have flourished in the last five years thanks in large part to the ACGME's CLER encouragement.³⁵ Optimizing the efficacy and reliability of transitions of care is necessary to implement, regardless of how many handovers take place in a given period of time.

³¹ Golbus JR, Manly DA, Wonneberger KA, et al. Implementation of a novel, resident-led, nocturnal curriculum. *J Grad Med Educ.* 2015;7(3):417-21.

³² Mann SM, Borschneck DP, Harrison MM. Implementation of a novel night float call system: resident satisfaction and quality of life. *Can J Surg.* 2014;57(1):15-20.

³³ Cheung JY, Mueller D, Blum M, et al. An observational pre-post study of re-structuring Medicine inpatient teaching service: Improved continuity of care within constraint of 2011 duty hours. *Healthc (Amst).* 2015;3(3):129-34.

³⁴ Kohlbrenner A, Dirks R, Davis J, Wolfe M, Maser C. Of duty hour violations and shift work: changing the educational paradigm. *Am J Surg.* 2015;

³⁵ Starmer AJ, Spector ND, Srivastava R., Allen AD, Landrigan CL, I-Pass, a mnemonic to standardize verbal handoffs. AHRQ Patient Safety Network. <https://psnet.ahrq.gov/resources/resource/24319>

IV. CIR RECOMMENDATIONS ON KEY ASPECTS OF THE LEARNING AND WORK ENVIRONMENT

The implementation of the ACGME's Clinical Learning Environment Review (CLER) Pathways in 2012 was a positive step, particularly in its emphasis on the need for teaching hospitals to provide residents training in patient safety, QI (including health disparities) and handovers. However, the CLER site visits fall short with regard to monitoring resident hours and professionalism. CIR recommends the following changes:

1. Broaden the CLER inquiry — CLER site visitors already know that sponsoring institutions have many residency programs, each with their own circumstances and culture. It is important to devise a process whereby CLER visitors speak to multiple residents from each residency program to eliminate biased or coached responses.

2. Insist on Robust Handovers — The lack of clear robust handover and patient communication systems for every residency program rotation should be a major red flag and worthy of an immediate citation and correction plan.

3. Take Resident Safety Seriously — CLER visitors need to show they are truly concerned about resident safety and wellbeing. Very few, if any, probing questions are now routinely asked of residents and this gives them a clear message that their experience is not truly valued by the CLER process. Questions delving into the residents' experience can easily be added to the CLER visit, e.g.

- a. How many residents report post-call fender benders, falling asleep at wheel at red light, a car accident, however minor.
- b. How many residents had a needle-stick in the last 12 months? Did the residents report the stick? If not, why not? Has anyone taken anti-viral meds during their residency? Did residents feel supported by Employee Health and their program?
- c. How many residents report feeling stressed or burned out?
- d. Do residents believe they can speak up without recrimination or retaliation?
- e. Are residents routinely required to do work more appropriately done by other health professionals? If so, in which rotations?
- f. How often in the last six months have residents felt overwhelmed by their work? Is there a particular rotation or rotations where this occurs?

4. Encouraging authentic resident responses to the ACGME resident survey – CIR supports the ACGME's intention to use the resident survey as a means to improve residency training and we know that is possible when residency program directors involve residents in making change.³⁶ However, incentivizing program directors with the ability to view aggregate survey data for their program if and only if there is a 70% resident response rate within their respective program provides for an unfortunate dynamic. Our experience from residency programs at multiple institutions has alerted us to the practice of program directors preemptively coaching their residents through the survey questions and then pressuring them to complete the survey in order to achieve the 70% threshold. The message to residents, however unintentional, is that reporting problems will only create more problems for

³⁶ Erickson JM, Ducan, AM, Arenella P. Using the program evaluation committee as a dynamic vehicle for improvement in psychiatry training. *Academic Psychiatry*. Published on line September 29, 2015.

everyone concerned. This conflict of interest can lead to the collection of inauthentic data, which the ACGME should find ways to discourage.

5. When will the CLER directives actually have an impact? The second round of CLER site visits is already underway, but there appears to be very little if any transparency in reporting the findings within the graduate medical education community or to the public. There is also no definition for what a poor showing is, let alone any repercussions. Hospitals we are aware of who have experienced a second visit were surprised to find it was exactly like the first. And duty hours, work compression, stress and burnout – which formed much of the impetus for the Institute of Medicine report and the 2011 ACGME changes, has settled into virtual obscurity within CLER.

In its official rollout of the CLER construct in 2012 the ACGME wrote, *“The public seeks assurance that GME is effectively preparing the next generation of US physicians to delivery high quality health in an increasingly complex environment.”*³⁷ *CLER is an essential of the NAS, designed to provide components of that assurance to the public we serve, and it is anticipated that the information from the CLER program, over time, will promote performance improvement in the training of the US physician workforce.”* There is little evidence to date that the CLER program has substantially improved the training experience for residents or the care provided to the public. The ACGME’s new initiative – Pursuing Excellence in Clinical Learning Environments³⁸ is a promising effort at developing and disseminating best practices among teaching hospitals, but does not address the problem of what the CLER program is doing right now to intervene when there are safety or training issues.

V. IN SUMMARY

CIR welcomes the opportunity to participate in the ACGME’s Duty Hours Congress. We offer a uniquely independent and broad resident perspective, distinct from any single medical specialty organization or interest group. We have concrete on-the-ground experience creating positive change in our hospitals, working with hospital management, program directors and faculty, whose supervision, advice and mentorship is vital to our professional development and training. We are committed to working diligently to gain the requisite skills and training to become physicians worthy of our profession. Despite the formidable challenges ahead, we believe that continued improvement is not only possible but inevitable: the public demands it. We are eager to play a part in realizing this change.

³⁷ Weiss, K, Wagner, R and Nasca T, “Development, Testing and Implementation of the ACGME Clinical Learning Environment Review (CLER) Program, Journal of Graduate Medical Education. September 2012, p. 398.

³⁸<http://www.acgme.org/acgmeweb/tabid/492/ProgramandInstitutionalAccreditation/NextAccreditationSystem/ClinicalLearningEnvironmentReviewProgram/PursuingExcellenceInClinicalLearningEnvironments.aspx>.