January 31, 2016

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

Dear Dr. Nasca,

Enclosed please find our response to your December 21, 2015 request for the formal positions of the American Medical Student Association (AMSA) on components of the Common Program Requirements addressing Resident Duty Hours in the Work and Learning Environment.

This paper was created by members of AMSA’s national leadership, led by our National President and including: Alison Case, MD, MPH, AMSA Education and Advocacy Fellow; Aliye Runyan, MD, AMSA Graduate Trustee; and Perry Tsai, AMSA Vice-President for Program Development. This position statement is a reflective account of our committee’s knowledge, experience, and research related to this issue. We speak for our national office, Board of Trustees, and nearly 40,000 physicians-in-training across the country.

AMSA’s response is relevant to all physicians in training. It focuses on effective methods for residents to work and learn in safe environments, and represents our concerns for the health, well-being, and safety of physicians-in-training.

In response to your inquiry regarding our organization’s willingness to participate in a Resident Duty Hours in the Learning and Working Environment Congress, AMSA would be happy to participate. We welcome any questions that you may have about our positions, and look forward to opportunities to engage with the ACGME further on our shared goals of protecting and improving public health by promoting excellence in training.

On behalf of AMSA’s Board of Trustees and our members, we thank you for the opportunity to contribute to this important discussion.

Sincerely,

Deborah V. Hall, M.D.
AMSA National President, 2015-16
Positions of the American Medical Student Association on key components of the Accreditation Council for Graduate Medical Education’s Common Program Requirements for Resident Duty Hours in the Learning and Working Environment

The American Medical Student Association (AMSA) is the nation’s oldest and largest independent organization of physicians-in-training; and our mission is built upon the commitment of our members to advocate for high-quality health care, for excellence in physician training, and for protection and promotion of the welfare of physicians-in-training. To this end, AMSA has historically engaged with the Accreditation Council for Graduate Medical Education (ACGME) to advocate for program requirements and recommendations that reflect these core principles.

AMSA fully supports the ACGME’s position that residency training should ultimately be designed to produce competent, autonomous, caring physicians\(^1\). Toward this end, residents must each develop a sense of professional identity and responsibility, a set of leadership and teamwork skills, and an ethical framework within which to practice and deliver high-quality care. More specifically, a professional identity encompasses the concepts of professional responsibility, accountability for fitness for duty, dedication to lifelong learning and continuous quality improvement, and maintenance of their capacity for empathetic, patient-centered care\(^2,3\).

As outlined below, the following positions of the American Medical Student Association are established from the principles of our organization of nearly 40,000 members and are drawn from a review of the relevant literature, interviews of key informants and experts, and a broad base of evidence.

Regarding resident duty hours and the learning and working environment, AMSA supports the following positions.

1. There is a continued need for resident duty hour limits as part of our shared obligation to resident well-being and high-quality patient care.
2. Within this model, transitions of care and supportive supervision are critical opportunities in graduate medical education to instill professionalism, communication, and teamwork in health care.
3. Graduated learning by residents should emphasize acquisition of high-yield competencies above hours in service.
4. Both enforcement and evaluation of resident duty hours are necessary in maintaining and enhancing the quality of resident medical education and the quality of patient care.

The Continued Need for Resident Duty Hour Limits

Responsibility to provide high-quality, safe patient care is at the forefront of resident duty. Sleep deprivation and fatigue have been well documented to result in deleterious effects on mood and attitudes toward patient care\(^4,5,6\). Relatedly, there is concern that excessive duty hours contribute to resident burnout and loss of empathy\(^7,8\). The documented range of resident burnout is stated to fall between 27% – 76%, with such residents reporting “sub-optimal patient care practices”\(^9,10\).
In the ACGME’s publication of the 2011 standards the continuous duty period requirements were crafted “to respond to ample scientific evidence about the negative performance effects of long periods of wakefulness”\textsuperscript{11}. It is the position of the American Medical Student Association that resident duty hours requirements should be based on the most current research on sleep, learning, patient safety and care, and resident well-being. The current requirements are based on recommendations that reflect what is known about sleep and the effects of fatigue from robust neurobiological and occupational research\textsuperscript{11,12,13,14}.

Extensive research has shown that acute and chronic sleep deprivation are detrimental to learning\textsuperscript{15,16,17} which is a primary goal of residency training. There is overwhelming evidence that these effects also result in medical errors\textsuperscript{18,19}, needlestick and other injuries\textsuperscript{14,20}, depression\textsuperscript{5}, motor vehicle accidents\textsuperscript{11,12}, and adverse pregnancy outcomes\textsuperscript{21,22}. The Institute of Medicine concluded in 2009 that excessive work hours were harmful to residents and to patients\textsuperscript{23}. We are obligated to use the current literature as our guide in formulating duty hour limits to ensure high-quality resident medical education and the safety of both patients and residents.

Therefore, AMSA remains resolute in our recommendation that the number of hours a resident physician may work per week should not exceed 80, without averaging the hours over a period greater than 1 week. The number of hours worked per shift should not exceed 16 for residents in all years of training, including time for transfer of patient care and education. Time off-duty between scheduled shifts should be at least 10 hours. Resident physicians should have at least 1 full continuous 24-hour period off-duty out of every 7 days, without averaging over a period of greater than 7 days, and 1 period of 48-hours off-duty per month.

With regard to moonlighting, AMSA supports moonlighting as a beneficial and legitimate practice but does not regard it as a solution to inadequate housestaff salaries or to the inefficient allocation of healthcare workers. Moonlighting hours should still be counted as a part of the 80-hour work week and thus obey the same restrictions as other resident work periods.

We also acknowledge the need for resident physicians to assess and adjust their own periods of rest in order to remain fit for duty, as noted in the common program requirements. Institutions must commit to proactive wellness programs that promote methods to achieve work/life balance and team environments which support accountability and self-monitoring.

\textit{Transitions of Care and Supportive Supervision: Opportunities for Professionalism, Communication, and Teamwork}

As progress in medicine continues to accelerate and as patient populations become older and more medically complex, practicing excellent transitions of care will become increasingly imperative. Physicians will be expected to transfer care of patients between healthcare providers frequently, whether that be from a primary care provider to a specialist, from one hospital floor to another, from an ICU to a step-down unit, or between two physicians changing shifts. There is no reason that safe training environments, including reasonable limitations on duty hours, should be at odds with patient safety, including safe and effective transitions of care\textsuperscript{24,25,26}. Transitions of care are and will continue to be an
integral part of practicing medicine. Resident training ought to reflect the growing importance of this essential skill that requires communication, professionalism, and teamwork.

Therefore, AMSA supports the current ACGME requirements stating that teamwork and interdisciplinary collaboration are critical components of both medical professionalism and patient safety, that residency programs should have structured and monitored processes in place to teach safe and effective transitions of care, and that residents must have competence in the communication skills needed to facilitate these transitions.

However, the daily lived experience of physicians still continues in silos, with communication and coordination between disciplines occurring rarely. To illustrate this, a survey of over 1,000 physicians revealed that “two thirds thought they had received inadequate training in care coordination and patient education,” indicating that these skills are not currently strongly represented in graduate medical education curricula.

Interprofessional training programs have been successfully developed and delivered through simulation models and case-based studies to address this issue; and they have demonstrated resulting increases in the understanding of individual roles and responsibilities as well as participant comfort level in dealing with interdisciplinary conflict. Increased levels of shared responsibility for patients have also led to a lower number of adverse events in specific chronic diseases; and an association between cooperation and decreased burnout has been established.

Another opportunity for increased communication and collaboration is in the relationship between residents and supervisors. In order for residents to progress through the levels of graduated autonomy necessary for independent practice, they must have supportive supervision from mentors. These mentors may include attending physicians, upper-level residents, or other healthcare professionals such as nurse practitioners or physician assistants; and supervision encompasses not only high-quality instruction, but also availability, tolerance, and promotion of a safe, approachable learning environment. Residents should not feel shame or fear when seeking support they need. One factor in miscommunication between residents and supervisors may be the lack of clear expectations among residents and supervisors defining the conditions under which contact is warranted or even required. Programs should promote increased communication and openness between faculty and residents to prevent this miscommunication. An environment of support and cooperation should prevail in resident education; and there should be no opportunity for fear of retaliation, humiliation, or other negative consequences to keep residents from speaking up and asking for help when necessary.

Studies have shown that increased resident supervision appropriate for level of training improves education outcomes, though more studies are needed to both validate and explore the optimal models for resident supervision and faculty training. Innovative models to encourage faculty involvement by providing incentive to participate as a supervisor in resident education have been piloted elsewhere.

AMSA supports increased supervision of residents as is necessary to provide adequate graduate education, and we support further study of incentives to involve faculty in resident supervision and further studies of models to train faculty to provide optimal supervision and improve resident training.
Graduated Learning Based on High-yield Competencies, not Hours

Over the past decade, many residency programs have adopted the graduated milestone model in evaluating resident competency. This model is based on achieving proficiency in a number of skills and competencies based on requirements set by specialty boards and not based on a set number of hours. AMSA supports a graduated milestone or competency-based model over an hours-based model, as it appropriately brings the focus of resident education back to relevant patient care and away from hours logged. Programs have already begun assessments of this model, and we encourage new requirements to include an emphasis on further validation and study by programs themselves.

In line with the goal of producing competent, autonomous, caring physicians, resident education should be high-yield, focused on clinical, technical, and administrative skills in proportion to their applicability to practice and to their difficulty to master. These clinical skills and entrustable professional activities should be given priority over other tasks that may be more appropriately assigned to other healthcare workers. It would be expected, for example, that a surgical resident should spend time mastering a common procedure in order to become proficient; however, it is less clear that the same resident requires many hours of patient transfer orders and follow-up scheduling to master those skill sets.

AMSA believes that residency programs should actively monitor resident workload and prioritize resident learning time toward high-yield competencies and to ensure that workload compression does not take the place of active learning. One way that this can be achieved is by the appropriate use of interprofessional teams.

Several case studies have emerged showing promise and innovation in meeting the multiple aims of the teaching hospital environment. These studies have demonstrated that a safe limit on duty hours, as recommended by the IOM, by no means needs to come at the expense of safe workloads or resident learning.

Further Evaluation and Enforcement of Resident Duty Hour Limits

AMSA is committed to evidence-based training that reflects best practices for both learning and safety. High-quality data should continue to be collected on measurable indicators of knowledge and on resident, faculty, and patient perception of competency in order to determine the impact of duty hours and models on resident education. Some studies have already assessed indicators of competence and the utility of new models, including simulations, in achieving expertise. AMSA strongly encourages the ACGME to adopt more formal guidelines and requirements for research in these areas.

In order to realize any of the benefits of resident duty hour limits or to reliably evaluate the effects, resident duty hours need to be reported accurately, and the duty hour limits need to be enforced consistently. Despite efforts to promote an environment of honest reporting and adherence to the current duty-hour requirements, residents continue to underreport hours to their programs. This occurs for a variety of reasons including fear of retaliation or fear of a negative impact to their program if it were to be penalized by the ACGME.
AMSA believes that an independent process for evaluating duty hours that bypasses reports from the program and goes directly from residents to the ACGME is needed. New York State and the Institute of Medicine’s recommendations provide starting models. We hope that this strategy might remove some of the potential for coercion by programs and the fear of retaliation from programs. We support the ACGME’s current policy of on-site visits and resident surveys to collect as much information as possible in order to allow continuous quality improvement in resident education. Data from a direct process should be made available in a de-identified and complete format to enhance continuous quality improvement.


