Lines 91-140

We agree with the addition of guidelines that enhance patient safety efforts, such as those that provide for early disclosure of health care errors and policies for improved adverse event surveillance, reporting, and subsequent quality improvement. We encourage the Accreditation Council for Graduate Medical Education (ACGME) to include language on the need to train both residents and faculty in reporting adverse drug and medical device events to the Food and Drug Administration's (FDA's) MedWatch adverse drug and medical device reactions database. [1]

Lines 307-310

As with the 2011 program requirements, the current proposal continues to require programs to "educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients." Requiring residents to be appropriately rested and fit is discordant with the proposed recommendation allowing residents to work 28-hour or longer shifts without sleep every other shift. This improperly places the burden on overworked and exhausted residents to somehow remain functional enough to make critical patient decisions.

Lines 332-333, 342, and 348-350

As with the 2011 program requirements, the proposal states, "Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the … assurance of their fitness for work, including … recognition of impairment, including from … fatigue … in themselves, their peers, and other members of the health care team."

In announcing the 2011 changes, the ACGME report stated that (we are) "reducing the length of continuous duty period to respond to ample scientific evidence about the negative performance effects of long periods of wakefulness" this is as true now as it was then. There is no reason to believe that physician trainees are somehow immune to the ordinary limits of human neurobiology. Consistently pushing residents to these limits results in risk to both our patients and our trainees.

Requiring residents to work hours that have already been scientifically shown to impair cognitive and motor function while also somehow recognizing their own impairment is implausible. As the Institute of Medicine, citing three studies, observed in its landmark 2009 report, *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*: "Although residents are at high risk for fatigue-related car crashes, they, like many other healthy but sleep-deprived adults, often fail to recognize their degree of impairment." [2]

Lines 357-359

As with the 2011 program requirements, the proposal requires residents to accurately report their work hours. In order to reliably implement policies/procedures and evaluate the effects, resident duty hours need to be reported accurately, and the duty hour limits need to be enforced consistently, neither of which has been done systematically to date with the *current* work hour program requirements. Despite efforts to promote an environment of honest reporting and adherence to the current duty-hour requirements, residents continue to underreport or falsely report hours to their programs. In a national survey published in 2013, nearly half (43%) of 6,202 residents stated that they had falsely reported their duty hours at some point, including 19% who did so at least once or twice a month.[3] 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 a 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.

Lines 367-434 (Section VI.C. "Well-Being")

We welcome the newly added section of the proposal that aims to address resident "well-being." However, while this language is intended to address a pressing concern in medical education, we do not see how any of these efforts to address resident "well-being" can be achieved while elsewhere in the proposal the limited protections on the hours that residents can work without sleep are disregarded.

The ACGME acknowledges these mental health risks experienced by residents during their training by listing them at the forefront of the text: "In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician." However, the language also notes that programs have a responsibility to give "attention to scheduling, work intensity, and work compression that impacts resident well-being."

Again, we see this new proposal contradicting itself; seemingly offering the support and working conditions that residents need during their training. But then we look further into the document and will see that the ACGME is proposing to simultaneously allow, and even encouraging, programs to require interns and other residents to work shifts of 28 hours or longer, which are known to harm residents' mental and physical well-being and safety. If the ACGME truly intended for programs to be attentive to scheduling as it related to resident well-being, then the option of a 28 hours or longer shift would not even been an acceptable option in terms of scheduling. This section also notes that programs need to be proactive in identifying cases of burnout, depression, suicidal ideation, and other adverse psychological conditions in residents and to provide access to self-screening tools and mental health services. While we welcome these required resources and vigilance as it pertains to identifying mental health issues, we want to note that by proceeding with the proposed weakened resident duty-hour limits there would be an increase the number of residents suffering from the mental health conditions focused on in this section on well-being.

Lines 390-391

The proposal includes a requirement that programs evaluate "safety data" and address "the safety of residents and faculty members in the learning and working environment." The "Background and Intent" box notes: "issues to be addressed include, but are not limited to, monitoring of workplace injuries, patient violence, vehicle collisions, and emotional well-being after adverse events." Allowing interns to work for 28 hours or longer without sleep contradicts the fact that the ACGME is requiring programs to address the safety of residents in the learning and working environment. Extensive research has shown that acute and chronic sleep deprivation are not only detrimental to learning[4,5,6], which is a primary goal of residency training; but that there is also overwhelming evidence that these effects also result in

medical errors[7,8], needlestick and other injuries[9,10], depression[11], motor vehicle accidents[12, 13], and adverse pregnancy outcomes[14,15].

Line 403

The proposal acknowledges and aims to address the serious problem of resident depression and suicide[16]. While the attempt to address this pressing issue is present and we recognize the ACGME for performing as if to help remedy it, it also appears that they are simultaneously negating any potential attempt to address this issue via resident work hours. By allowing and encouraging programs to work residents 28 hours or longer at a time, this is merely contributing to the already unfavorable effect that the culture of medicine has on any provider who might face a mental health issue[17].

Lines 504-507

The proposed program requirements' new language that "each program must ensure continuity of patient care, consistent with the program's policy and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness" is received with caution. If a resident is too fatigued, they will likely not speak up for fear of ridicule or appearing "weak" secondary to the culture of medicine bestowed upon them. How then will their peers or their attendings be trained in identifying fatigue in other residents? The provisions in the proposed requirements that claim to address fatigue mitigation are yet another diversion from the central thread of the proposal: to influence interns and residents to work longer hours without sleep.

Lines 516-521

This comment addresses the Background and Intent explanatory language that follows the text of the proposed section VI.F.1. The ACGME states that its "Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for adverse accreditation action." As was previously stated in the comment to lines 357-359, 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. We hope that this strategy might remove some of the potential for coercion by programs and the fear of retaliation from programs. We support a 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

Lines 568-571

Residency is our very best opportunity to build a strong foundation upon which we will build a career rooted in a commitment to excellence and lifelong learning. With that being said, it is counterintuitive of the ACGME to rollback work hour restrictions when extensive research has shown that acute and chronic sleep deprivation are detrimental to learning, the primary goal of residency training[4,5,6]. As previously mentioned and cited before under the comments regarding lines 390-391, not only does sleep deprivation affect learning, but it also has been reported to result in medical errors, needlestick injuries, depression and motor vehicle accidents – thus posing a threat to safety of both patients and residents themselves.

Aside from the main goal of learning in residency, there is also the responsibility to provide high-quality, safe patient care presenting itself 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[18, 19, 20]. It has been proven that as empathy and mood of residents providing care to patients declines, so then do patient care practices[21, 22].

AMSA remains unwavering 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 any year of training, including time for transfer of patient care and education.

Lines 637-638

This comment addresses the Background and Intent explanatory language that follows the text of the proposed section VI.F.5.a, as well as the proposed section of VI.F.5. The ACGME states that "The requirements regarding time off between clinical and educational work periods have been eliminated in support of providing programs with increased flexibility in scheduling. It is emphasized that programs are expected to comply with the 80-hour weekly limit, averaged over four weeks." As was previously stated in the comment to lines 357-359, we already see programs not adhering to resident work hour restrictions. By not requiring, per the ACGME, a specified amount of time for resident recovery between shifts, this opens a loophole for programs to continue to abuse their power and to force residents to work elongated shifts without ample time to rest, recover and tend to their activities of daily living. This provision will produce dangerously fatigued residents who have not had ample time to rest, as would be required per the ACGME requirements, thus setting them up for failure to meet their professional responsibilities of adhering to the common program requirements and putting not only themselves, but their patients in danger simultaneously.

Lines 688-690

We agree with the proposal to include clinical responsibilities performed at home toward the 80-hour average weekly limit.

General Comments:

Transitions of Care

One of the recurring critiques of resident work hour restrictions is that shorter shift lengths would lead to an increase in number of handoffs and thus would lead to decreased continuity of care. This concern is valid, but the perception that shorter shifts must come at the expense of patient safety due to the increased number of handoffs is just that, a perception. It is not the number of transitions but rather the quality of transitions that is critical to ensuring patient safety. Even at the end of 28-hour shifts, transitions of care still occur and these come at a time when residents are more likely to leave out information they deem "unimportant" as they have reached and surpassed the point of exhaustion.

AMSA is of the belief that residency programs should have structured and monitored processes in place to teach safe and effective transitions of care. Training for safe and successful transitions of care should exist not at odds with limitations on duty hours, but rather in conjunction with them. In our training we have seen patients become medically more complex and have experienced transitions of care between specialists, between floors of the same hospital and between physicians changing shifts. It is of the utmost importance then that our residency programs begin to require training in this important skill of

transitions of care, as we are likely to see them more and utilize them ourselves during training and practice.

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