American Hospital Association

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Dr. Thomas Nasca
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Dear Dr Nasca:

When the Accreditation Council for Graduate Medical Education (ACGME) adopted its standards for resident duty hours in 2003, a review after five years was promised. The American Hospital Association (AHA) is delighted that the ACGME has now undertaken a comprehensive review.

The primary purpose of all hospitals is to provide patients with medically appropriate, safe services of high quality. For hospitals that provide residency training, an additional purpose is to provide physician-in-training with the clinical education, experience and supervision necessary to develop into physicians capable of practicing independently. Teaching hospitals simultaneously pursue both of these goals without diminishing their performance in either area.

The introduction of specific standards for resident duty hours in 2003 was a significant break with tradition for most residency programs. The standards addressed a clear public concern that at least some residents were providing services during long duty periods when their clinical judgment and learning capacity could be impaired. The ACGME provided genuine leadership in setting these standards, and the AHA supported the standards and their implementation. The AHA also supports the ACGME's evolving initiatives to monitor compliance with the duty hour standards.

The AHA recognizes that only five years has passed since implementation of the duty hour standards. As a result, some specialties have yet to have a cohort of residents complete programs under the new standards while others have had only a couple of cohorts complete their programs. Thus, there is not a long history or extensive base of data to use in evaluating the 2003 standards. As an example, for many programs, there are not yet available performance data such as specialty board scores.

In evaluating the standards, the AHA recognizes that the primary interest of society is in assuring that residents have had sufficient sleep so that the medical care they provide is safe and of high quality. Since our society views the time outside one's work or training program as personal

time, we use duty hours as an implied proxy for measuring sleep and alertness. This is at best an inadequate proxy because the hospital and residency program director have no information on what the resident actually did during the hours not on duty.

Because a quantitative standard for duty hours is a less-than-ideal proxy for the resident's alertness, the preferred approach presently available for assessing resident alertness to both provide safe patient services and learn from the experience is on-site observation of the resident by more senior residents and by faculty. It should not be assumed that all residents under all conditions are able to provide patient care or learn effectively just because they are within the 80 hour standard and its sub-standards. Moreover, because residents in their initial year of training generally require more time to perform diagnostic and treatment services, it is especially necessary to observe their performance and judge their alertness and capabilities.

The generic sleep research literature suggests that mental alertness and task performance decline after about 16 hours of time or after 4 consecutive night shifts for most persons. However, it is unclear if these general findings are applicable to physicians-in-training who are young and intellectually engaged in their activities. Until further research is available, it is reasonable to use this information to inform the evaluation of the present standards. At the same time, if the duty hour standards are modified to incorporate these limitations, it is critically important that their impact on resident education and competence be assessed. Finally, it is also reasonable to include "moonlighting" time within the standard so that the assumed rest of non-duty hours is not compromised by on-duty (and often unsupervised) moonlighting.

The issue of duty hours has implications for several other issues in graduate medical education, including:

- Whether resident programs will have to be lengthened to provide adequate clinical experience?

- What impact has the limitation on duty hours had upon the resident's concept of personal responsibility for the patient?

- When resident hours are limited, how can handovers from one resident to another be improved to assure the receiving physician has complete knowledge of the patient condition and treatment plan?

The ACGME should encourage these related topics to be studied as part of its review of resident duty hours.

Many of the hospitals that participate in graduate medical education are operating at a loss or with very small margins. As a result, some hospitals are considering reducing the number of residency positions or substituting either employed physicians (such as hospitalists) or Advance Practice Nurses for residents. Should the ACGME adopt changes in the duty hour standards that increase residency program costs, it is important that the ACGME clearly state the financial impact of the new standards so that it is clear to society and health care payers.

In sum, the AHA believes:

1. Hospitals participating in graduate medical education must assure that residents have the breadth and depth of experience necessary to develop into independent practitioners and provide organize patient care so that it is safe, appropriate, and of high quality.

2. Restful sleep is a good proxy for the resident's likely alertness; duty hours are a much weaker measure of alertness because no attention is given to what the resident does during non-duty hours.

3. The present research data on the relationship between resident duty hours and the safety and quality of patient care services is underdeveloped and inadequate. In particular, studies should be undertaken to determine if the generic sleep research showing degradation of performance after 16 hours consecutive duty and four consecutive nights holds for physicians-in-training.

4. The duty hour standard of 80 hours per week when averaged over four weeks continues to be an appropriate standard. The standard should include on-site and off-site "moonlighting" because the resident clearly is not resting during that time.

5. There is very limited information to set standards for the frequency of in-house call, at-home call, or mandatory unassigned time (or time off). Therefore, the AHA finds no basis for changing the 2003 ACGME standards of no more than every third night for in-hospital call or one day off per week at this time.

6. If the ACGME makes changes to the duty hour standards, it is important to assure that the several components, when taken together, are logistically coherent and capable of measurement. Given that hospitals provide care 24 hours a day and seven days a week, it is critical that duty hour standards fit within these operational requirements and do not disrupt them.

7. The AHA recognizes that patients and residents are not homogeneous. Regardless of the standards adopted, there needs to be flexibility to meet the needs of patients for continuity of care and residents for continuity of case experience provided that on-site supervision is adequate to limit the responsibility of a fatigued resident.

8. The AHA recognizes that programs with a larger number of residents have an easier time accommodating any standards for resident duty hours.

9. If the ACGME makes changes in the duty hours that increase the cost of operating the graduate medical education programs, it is essential that the ACGME clearly identify the expected increase and its potential, if unfunded, to result in a decline in the number of residency positions available.

The AHA appreciates the opportunity to comment on the review of duty hour standards and will continue to work with and support the ACGME's efforts to set and enforce reasonable standards that protect patient safety and promote resident learning.

Sincerely,

James Bentley

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