American Hospital Association

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August 6, 2010

Thomas Nasca, M.D.
Chief Executive Officer
Accreditation Council for Graduate Medical Education
Suite 2000
515 State Street
Chicago, IL 60657

Re: Revised Standards on Resident Duty Hours

Dear Dr. Nasca:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 40,000 individual members, the American Hospital Association (AHA) is pleased to comment on the Accreditation Council for Graduate Medical Education's (ACGME) revised standards on resident duty hours. America's hospitals are committed to providing safe, high-quality care, and the new limits on resident duty hours are an important step toward improving both patient care and resident education. **Overall, the AHA supports ACGME's proposed standards; however, we ask that the implementation date be delayed to allow hospitals time to budget and plan for these significant changes.**

RESIDENT DUTY HOURS

Resident duty hours are limited to 80 hours per week, averaged over a four-week period, including all in-house call activities. The revised standards further delineate this policy, incorporating the following changes:

- *Moonlighting:* Internal and external resident moonlighting would count toward the weekly 80-hour maximum limit. Post-graduate year one (PGY-1) residents would be prohibited from moonlighting.

- *Mandatory time free of duty*: Residents would be free from duty for a minimum of one day per week, averaged over a four-week period.

- *Maximum duty period length*: A PGY-1 resident would have a maximum duty period of 16 consecutive hours; all other residents would have a maximum duty period of 24 hours. Residents would be permitted to remain on-site for an additional four hours to help transition the care of the patient. The revised standards offer limited exceptions to this

policy, including allowing residents to voluntarily remain on-site beyond their scheduled period to continue to provide care to a *single* severely ill or unstable patient.

- *Minimum time off between scheduled duty periods*: A PGY-1 resident must have eight hours free between scheduled duty periods. Intermediate-level residents (as defined by the Review Committee) also must have eight hours free between scheduled duty periods and at least 14 hours free after 24 hours of in-house duty. Residents in the final years of education (as defined by the Review Committee) "should" have eight hours free between scheduled duty periods.

- *Maximum frequency of in-house night float*: Residents may not be scheduled for more than six consecutive nights of night float.

- *Maximum in-house on-call frequency:* PGY-2 residents and above may not be scheduled for in-house call more frequently than every third night (averaging is not allowed).

- *At-home call:* Resident time spent on at-home call would count towards the weekly 80-hour maximum limit, but it would not be subject to the every-third-night call limitation. Residents may return to the hospital while on at-home call to care for a new or established patient. This care, however, would not initiate a new "off-duty period."

The AHA supports a maximum of 80 hours of duty per week, averaged over four weeks, with limits on continuous duty and appropriate time off between periods of duty. We are pleased that ACGME is proposing to include time spent moonlighting in the 80-hour limit. Moonlighting can provide additional clinical experiences and income for residents, but it may also result in resident fatigue. We are especially pleased that moonlighting is prohibited for first-year residents, who should remain focused on their educational program and associated patient care responsibilities.

The AHA appreciates both the flexibility and graduated responsibility that the ACGME built into its revised standards. We believe it is appropriate that PGY-1 residents have shorter duty periods and required time off between duty periods, as new residents will need to gain experience in managing their schedules and their patient care responsibilities. We support allowing residents in their final years less than eight hours free between scheduled duty periods, as increasing responsibility is an essential component of professional development for physicians. Finally, we are pleased that residents be allowed the flexibility to remain beyond their maximum duty period. Residents may need the flexibility to provide continuous care for a severely ill patient, or provide humanistic attention to the needs of a family, or to participate in an important academic event – all an important part of resident training. These situations will help residents prepare for the day when they are unsupervised and must care for patients over irregular or extended periods. We believe the new standards put appropriate safeguards in place, including required monitoring of exceptional duty hours by the program director, to ensure this policy is not abused, and that residents can safely continue to deliver high-quality patient care.

The AHA supports extending the length of the maximum duty period to allow a resident four hours to transition the care of the patient over to another team member. Transitions in care are critically important to patient quality and safety. In addition, these "handoffs" provide significant educational opportunities – both in terms of teaching and learning – for the resident. Care coordination is an essential component of delivery system reform, and we applaud the ACGME for allowing residents the necessary time to perfect this skill.

While AHA supports the proposed changes to resident duty hours, we encourage ACGME to continue to examine whether there is a link between resident work hours, resident fatigue and patient care outcomes. As part of the new standards, ACGME calls on programs to encourage residents to use "alertness management strategies," "strategic napping" and other mechanisms to identify when they may be becoming fatigued. We believe these techniques are critically important, and perhaps more important than the structured resident work schedules above, to ensuring residents provide high-quality patient care. Patient errors occur for a number of reasons. While some errors may be due to resident fatigue, others may occur due to excessive resident workloads, poor care coordination, or ineffective resident supervision. By addressing these – and other – issues, the need for the ACGME to regulate resident duty schedules should lessen.

The costs for hospitals to comply with the proposed standards are not insignificant. Residents will likely spend less time providing direct patient care, and hospitals will need to provide additional resources and staff to care for these patients. The proposed July 1, 2011 implementation date for the new standards will be challenging. It will not provide hospitals much time to plan new schedules and identify substitute health care providers. In addition, many hospital budgets already have been finalized. **We encourage ACGME to delay the implementation date or consider phasing in its implementation of the new standards.**

If you have any questions about these comments, please feel free to contact me or Ashley Thompson, AHA director of policy, at (202) 266-2688 or athompson@aha.org.

Sincerely,

Rick Pollack
Executive Vice President