

New ACGME Rules for Supervision and Duty Hours: Resident Commentary

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The recently approved Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements including new Standards for Resident Supervision and Duty Hours will take effect July, 2011.¹ These new requirements revise the initial regulations implemented by the ACGME in 2003 and respond in part to recommendations set forth by the **Institute of Medicine (IOM)** in 2008.²⁻⁴ The changes are proposed to ensure three main objectives: patient safety and quality of care in teaching hospitals, patient safety and quality of care provided by current residents in their future independent practice, and maintenance of a “safe and humanistic educational environment” for residents to learn.⁵

As residents, we applaud the ACGME’s continued efforts to promote resident education, monitor resident workload, and ensure patient safety. These new standards have drawn attention from both the public media and medical professionals. Yet, despite very admirable goals, the actual impact of many of the changes has been questioned by residents and faculty alike. Our purpose is to summarize the 2011 ACGME Common Program Requirements for resident supervision and resident duty hours and discuss how we believe they may impact resident education and quality of life.

The new Common Program Requirements cover 15 headings: (1) Supervision; (2) Clinical Responsibilities; (3) Teamwork; (4) Professionalism, Personal Responsibility, and Patient Safety; (5) Transitions of Care; (6) Alertness Management; (7) Maximum Hours of Work Per Week; (8) Maximum Duty Period Length; (9) Maximum In-Hospital On-Call Frequency; (10) Minimum Time Off between Scheduled Duty Periods; (11) Maximum Frequency of In-Hospital Night Duty; (12) Mandatory Time Off Duty; (13) Moonlighting; (14) Duty-hour exceptions; (15) Home Call.

To simplify the proposal we have created a framework for these changes within four headings: Supervision, Duty

Hours, Call, and Other. We have chosen to narrow our discussion to the changes we believe will have the most impact on residents: supervision, duty hours, and call.

SUPERVISION

Increasing supervision and faculty teaching time is important for improving resident education. Both anecdotally and empirically, patients are safer when residents receive an appropriate level of supervision.⁶⁻⁸ However, we have concern regarding the proposal to change the oversight of PGY-1 residents such that supervision must be immediately available at all times. We feel this level of supervision is not warranted in every setting or throughout the entirety of the intern year.

A PGY-1 resident in the first few months of residency clearly requires greater supervision, and in most cases, should have a more senior resident or attending immediately available at all times. However, in order to insure that residents in the first year of training develop the skills necessary to supervise others on July 1, consideration should be given to “graded and progressive responsibility”¹ for residents over that critical first year of postgraduate training. Sheltering the PGY-1 resident for an entire year risks creating a less independent, less well trained PGY-2. How can a PGY-2 resident be expected to provide supervision to PGY-1 residents if he or she is unprepared to act independently by the end of the intern year?

Consideration should be given to a more graded level of supervision, with immediately available supervision for the early months of the PGY-1 year followed by more indirect supervision (i.e., the supervising physician is available by phone and able to come within a reasonable time period if needed). Ideally, the level of necessary supervision would be left to the discretion of the Program Director, based on an individual resident’s performance and achievement of core competencies.

Similar decisions are already made by Program Directors in determining when a resident is able to perform a certain procedure independently.

DUTY HOURS

Maximum Hours of Work per Week and Duty Hour Exceptions:

No changes have been made in these areas. Residents remain limited to an 80-hour work week, averaged over four weeks. Including external and internal moonlighting hours within the 80 hour work limit is unlikely to make a significant impact on many residents.

Mandatory Time Free of Duty:

The new Requirements maintain the rule that all residents must have one day off in seven, averaged over a four-week period. The 2008 IOM recommendations included a mandatory five days off per month with one 48-hour consecutive time period off per month. We feel this would be a major positive change for resident quality of life and would recommend that this change be considered in future revisions.

Maximum Duty Period Length:

The new requirements will limit the maximum shift length of PGY-1 residents to 16 hours. This is the most dramatic of the proposed changes and will likely cause the most impact on residents and training programs alike. A shorter PGY-1 shift length marginalizes the educational experience of interns as well as the interns’ direct involvement in and impact upon patient care. A duty period limited to this length opposes the concept of the ‘resident’ physician as it negates any true in-house call for interns. Interns will no longer experience and learn from a 24-hour call period when they can follow the course of a patient’s exam and the evolution of illness. Additionally, they will be less well prepared to function in more senior roles when they are required to take longer call periods and supervise the work of others without a transitional period.

This regulation will allow the intern less continuity of patient care than third or fourth year medical students. Medical student call hours remain unregulated in order to prepare senior medical students for the responsibilities of residency. Additionally, this change merely defers a greater call burden to the more senior residents. Junior level responsibilities will be transferred to more senior residents as interns are taken out of the call schedule, negatively impacting both education and quality of life for the more senior residents. This change is in direct opposition to two of the fundamental goals of the proposed changes.

Admittedly, the first overnight call nights as an intern are exhausting and intimidating, but these are not experiences that should be shifted to the second year of residency. In addition to adjusting to the intellectual and emotional challenges of residency, interns should be exposed to the rigors of a physician lifestyle where they must be aware of their fatigue and able to utilize strategic napping. To defer this opportunity for personal growth to the second year only takes away from the learning experience of the intern year. Additionally, shifting programs to a night float schedule to accommodate the PGY-1 limits will limit attendance at daily lecture series and conferences for residents in all levels.

The change of post-call transitional periods (to four hours from six hours) will not likely have a significant impact on patient care. However, the proposal to no longer allow residents to participate in clinic or didactic sessions after a 24 hour work period may significantly limit the amount of time residents are able to commit to a continuity clinic or educational sessions. As clinics are a fixed requirement in most specialties and gaining knowledge of management of patients in the ambulatory setting is a goal of nearly all training programs, this schedule change will further complicate the complex schedules in existence to insure that residents meet all requirements within the training period.

Minimum Time Off Between Scheduled Duty Periods:

The new regulations require a minimum of eight hours between duty periods, with a recommended ten hours of rest. Additionally, 14 hours free of duty

are required following 24 hour in-house call. The 2003 restrictions stated that residents *should* have ten hours between duty periods, with no discussion of time off following prolonged in-house call periods. This is a positive change. This more strictly enforced time off is crucial for residents to be well rested.

CALL

Maximum In-Hospital On-Call Frequency:

The final version of the ACGME 2011 Common Program Requirements again regulates the maximum in-hospital on-call frequency to no more than every third night and continues to allow averaging over a four week time period. The proposal originally submitted by the ACGME suggested no longer allowing averaging. We commend the decision to continue to allow residents this flexibility in scheduling.

At-Home Call:

Home call remains minimally regulated by the ACGME. Although many subspecialty residencies and fellowships rely on home call to function, it has the potential to negatively affect patient safety and resident quality of life. Home call residents are, by default, less readily available to see new or established patients in the middle of the night. Furthermore, home call schedules are sometimes as frequent as six days in a week. Even if the resident is not actually called into the hospital, being awoken frequently to answer calls and simply knowing the potential to be called into the hospital exists, prevents a restful out-of-hospital experience. These situations have not yet been addressed by the ACGME.

Maximum Frequency of In-House Night Float:

The new Program Requirements limit in-house night float to a six night maximum. There is currently no limitation on the maximum number of in-house night float shifts. Limiting in-house night float to a six night maximum has the potential to make scheduling difficult for programs who are currently using one week (seven night) blocks for their night float system. This limitation may require some programs to utilize an additional resident from the day shift to cover the seventh night.

CONCLUSIONS

The ACGME's new common program requirements were designed to improve patient safety, resident education and quality of life. The changes will take effect in July 2011.

In order to optimize patient safety, we must find a way to balance continuity of patient care with management of resident fatigue. Despite evidence showing an increase in medical errors with fatigue, definitive improvements in quality of care and patient safety have not been demonstrated following implementation of the 2003 duty hour regulations, which limited residents to 80 hours per week.⁹⁻¹¹ The new changes will increase the frequency of "handoffs," despite evidence connecting medical errors with more frequent transitions of care.¹² The reality is that there are few data on the impact of existing regulations on the quality or safety of care provided to patients in teaching hospitals. The possibility that residency training will need to be lengthened in order to insure competency for graduates is a concern to many resident groups.¹³

A recent survey of more than 2500 residents in allopathic residency programs throughout the US demonstrated concern as to the implications of the changes on the duration and quality of residency training.¹⁴

The ACGME should monitor the impact of the 2011 revisions to ensure that their adoption is backed by solid academic research demonstrating improved patient safety and resident lifestyle, without compromising the quality of residency training in the US. The impact of all duties in residency training—including at-home call responsibilities—should be monitored and reassessed with outcomes measurements related to the changes in duty hours and supervision.

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Disclosure of Financial Interests

The authors are some of the resident representatives to the Rhode Island Hospital Graduate Medical Education Committee.

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