

1 Accreditation Council for Graduate Medical Education (ACGME)
2 **Report of the ACGME Work Group on Resident Duty Hours**
3

4 **June 11, 2002**
5

6 **Addressing Resident Duty Hours**

7 In response to changes in health care delivery and concerns that restricted sleep could have a detrimental
8 effect on patient safety, education and resident safety and well-being, the Accreditation Council for
9 Graduate Medical Education (ACGME) in September 2001 appointed the Work Group on Resident Duty
10 Hours and the Learning Environment. This document provides the Work Group's recommendations. The
11 goal is to emphasize the responsibilities of programs, sponsoring institutions, and the accrediting body
12 relating to safe patient care and an appropriate learning environment for residents. The recommended
13 mechanisms to achieve these goals include the following: a set of common requirements that define a
14 minimum standard that must be met by all accredited programs; enhanced requirements for institutional
15 oversight and support; and strengthening the system for compliance.
16

17 **The Common Accreditation Standards**

18 The standards address three areas: (1) placing appropriate limits on duty hours; (2) promoting institutional
19 oversight; and (3) fostering high-quality education and safe patient care. A synopsis of the requirements is
20 provided below; the proposed language for the requirements is shown on lines 144 – 206 of this document:
21

22 *Duty Hours*

- 23 ■ Residents must not be scheduled for more than 80 duty hours per week, averaged over a four-week
24 period, with the provision that individual programs may apply to their sponsoring institution's
25 Graduate Medical Education Committee (GMEC) for an increase in this limit of up to 10 percent, if
26 they can provide a sound educational rationale;
- 27 ■ One day in seven free of patient care responsibilities, averaged over a four-week period;
- 28 ■ Call no more frequently than every third night, averaged over a four-week period;
- 29 ■ A 24-hour limit on on-call duty, with an added period of up to 6 hours for inpatient and outpatient
30 continuity and transfer of care, educational debriefing and didactic activities; no new patients may
31 be accepted after 24 hours;
- 32 ■ A 10-hour minimum rest period should be provided between duty periods; and
- 33 ■ When residents take call from home and are called into the hospital, the time spent in the hospital
34 must be counted toward the weekly duty hour limit.
35

36 *Institutional Oversight*

- 37 ■ Monitoring of programs' policies governing resident duty hours by the sponsoring institution;
- 38 ■ Requiring a sound educational justification of any increases above the 80-hour limit;
- 39 ■ An annual report to the sponsoring institution's governing body on duty hour compliance;
- 40 ■ Institutional policies on patient care activities external to the educational program ("moonlighting"),
41 prospective approval of these activities, and monitoring their effect on performance in the
42 educational program;
- 43 ■ Counting time spent in patient care activities external to the educational program that occur in the
44 primary program and institution toward the weekly duty hour limit;
- 45 ■ Requiring programs and their sponsoring institutions to have policies and procedures to monitor and
46 support the physical and emotional well-being of residents;
- 47 ■ Requiring sponsoring institutions to monitor the demands home call places on residents in all
48 programs, and making adjustments as necessary to address excessive demands and fatigue; and
- 49 ■ Patient care support services for IV, phlebotomy, and transport activities to reduce resident time
50 spent on these routine activities.
51

52 *High-Quality Education and Safe and Effective Patient Care*

- 53 ■ Priority of clinical and didactic education in the allotment of residents' time and energies.

- 54 ▪ Schedules for teaching staff structured to provide ready supervision and faculty support/consultation
55 to residents on duty;
- 56 ▪ Duty hour assignments that recognize that faculty and residents collectively have responsibility for
57 patients' safety and welfare;
- 58 ▪ Monitor residents for the effects of sleep loss and fatigue by the Program director and faculty, with
59 appropriate action when it is determined that fatigue might affect safe patient care or learning.
- 60 ▪ Education of faculty and residents in recognizing the signs of fatigue and in applying preventive and
61 operational countermeasures; and
- 62 ▪ Appropriate backup support when patient care responsibilities are difficult and prolonged, and if
63 unexpected needs create resident fatigue sufficient to jeopardize patient care.

64
65 The recommendations call for the ACGME-wide program requirements related to duty hours to be placed
66 within the ACGME "Common Program Requirements," and for the standards delineating the sponsoring
67 institution's responsibilities to be incorporated into the Institutional Requirements. In the case that a
68 specialty believes it cannot conduct its educational activities within the proposed constraints, an exemption
69 beyond the 10 percent increase that can be granted by a sponsoring institution will require the approval of
70 both the ACGME Program Requirements Committee and Board of Directors. Such exemptions may be
71 granted only if the specialty can demonstrate that there would be a significant detrimental effect on the
72 clinical training and education. The goal of the proposed approach is to encourage residency programs and
73 sponsoring institutions to collectively implement programs that maintain a balance of education and service,
74 and to collaborate on monitoring their effect on patient safety, learning and resident well-being.

75 76 **Strengthening the Systems for Compliance**

77 The recommendations for strengthening the compliance programs are based on three principles: increasing
78 the amount of information collected related to resident duty hours; shortening the ACGME's response time
79 in cases of alleged non-compliance with the standards; and fostering accountability on the part of programs,
80 sponsoring institutions and the accrediting body for consistent compliance with the duty hour standards.
81 The elements of this enhanced system for promoting compliance include:

- 82
83 ▪ Collecting comprehensive, uniform information related to duty hour compliance;
- 84 ▪ Significantly shortening the review cycles for programs and sponsoring institutions that fail to
85 comply with the duty hour standards;
- 86 ▪ Use of an expedited institutional review process for potential serious violations or continued failure
87 to comply by a program or a sponsoring institution, with the threat of withdrawal of accreditation
88 from all accredited programs sponsored by the institution;
- 89 ▪ Invoking the ACGME procedure for Rapid Response to Alleged Egregious Accreditation Violations
90 or Catastrophic Institutional Events for likely very serious duty hour violations; and
- 91 ▪ Monitoring of the ACGME's compliance activities to ensure consistent enforcement of the
92 standards through increased training of site visitors, concurrent monitoring of the data on duty hours
93 and the compliance process by a dedicated ACGME Subcommittee on Resident Duty Hours, and
94 retrospective review of RRCs' practices by the ACGME Monitoring Committee.

95
96 The demands of patient safety and resident well-being require that the new standards be implemented
97 without delay, while giving residency programs and sponsoring institutions time to make needed changes.
98 To accommodate these objectives, the recommendations call for the new standards to be implemented July
99 1, 2003. Prior to this, there will be a period of "initial response," during which RRCs will provide
100 constructive feedback on duty hours, but will not take adverse accreditation action.

101
102 The goal of simultaneously fostering high-quality education and safe patient care provides the rationale for
103 the ACGME's standards and the systems that foster compliance. The recommendations related to duty
104 hours in this report are far-reaching and many of them, once endorsed, will require further elaboration and
105 definition toward implementation. Collectively, the standards and enforcement processes reflect that the
106 primary goals of residency are education of residents and provision of safe and effective patient care, and
107 that merely meeting patient service obligations is secondary.

I. The Rationale for the ACGME's Approach

In recent years, increased patient acuity, concerns about patient safety, and information about the effect of excessively long hours on cognitive performance and functioning have increased interest in limiting resident duty hours. As the accrediting body for 7,800 allopathic graduate medical education programs in 118 specialties and subspecialties, the ACGME is the entity to which the medical community looks to address the issue. The current efforts build on a 20-year history of addressing duty hours, during which the ACGME has made enhancements to the standards and achieved gains in compliance. The central focus of the recommendations is a set of ACGME-wide duty hour requirements that apply to all accredited specialties, and consistent, rigorous enforcement. For this purpose, duty hours encompass all time in the educational program: (1) patient care activities that meet educational objectives, including time spent on inpatient call; (2) patient care activities that are necessary to acquire and maintain skills and to meet patient care demands; and (3) didactic activities, such as conferences, grand rounds and one-on-one and group learning in clinical settings.

Sleep loss and fatigue are serious matters, and the proposed standards and enforcement practices treat them as such. At the same time, how standards for resident duty hours should be formulated continues to be the subject of unresolved debate. This includes whether patient safety and resident well-being are best protected by a weekly limit on duty hours, or whether medical professionalism and continuity of care expectations should determine the number of hours. The proposed standards include a weekly limit, which has the benefit of providing an easily understood metric. A weekly limit alone, however, may be inadequate because it fails to account for differences in intensity and patient demands between comparable time periods. Thus, the recommendations also limit continuous duty hours and establish required rest periods. In addition, education and patient care are influenced by multiple factors, and the existing ACGME standards for all accredited specialties specify educational content, supervision, a balance between education and patient service, and institutional and program resources. The standards emphasize that supervision and faculty involvement in care are as critical as attention to duty hours in ensuring safe patient care and resident learning. This reflects that residents are individuals in a formal educational program, and the level of responsibility and supervision assigned to them must reflect their knowledge and skill levels.

The recommendations call for ACGME-wide standards that define programs' obligations to be placed within the ACGME "Common Program Requirements," and for the standards delineating the responsibilities of the sponsoring institution to be incorporated into the Institutional Requirements. The goal is to encourage residency programs and sponsoring institutions to collectively implement programs to maintain a proper balance of education and service, and to collaborate on monitoring the effects of duty hours on patient safety, learning, and resident well-being.

Proposed ACGME Minimum Requirements for Resident Duty Hours and Supervision

(Existing requirements are shown in regular text, **new requirements in bold face.**)

Duty Hours

- **Residents must not be scheduled for more than 80 hours per week, averaged over a four-week period, with the provision that individual programs may apply to their sponsoring institution's Graduate Medical Education Committee (GMEC) for an increase in this limit of up to 10 percent if they can provide a sound educational rationale.**
- Residents must have at least one full (24-hour) day out of seven free of patient care duties, averaged over four weeks.
- Residents must not be assigned call more often than every third night, averaged over four weeks.
- **Continuous time on duty (call) is limited to 24 hours, with additional time up to six hours for inpatient and outpatient continuity, transfer of care, educational debriefing and formal didactic activities. Residents may not assume responsibility for new patients after 24 hours.**
- **Residents should have a minimum rest period of 10 hours between duty periods.**
- **When residents take call from home and are called into the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit.**

162 *Institutional Oversight*

- 163 ▪ **Promoting patient safety and education through duty hour assignments and faculty**
- 164 **availability is the obligation of each sponsoring institution.**
- 165 ▪ Sponsoring institutions must monitor that each residency program establishes written policies
- 166 governing resident duty hours that foster education and the safe care of patients. Duty hours must
- 167 be consistent with the Institutional Requirements, the Common Program Requirements and all
- 168 applicable Program Requirements, and apply to all institutions to which residents rotate.
- 169 ▪ **Sponsoring institutions that wish to grant increases up to 10 percent above the 80-hour weekly**
- 170 **limit must develop written protocols through their Graduate Medical Education Committee**
- 171 **that detail the process for providing an educational rationale for the increase. Institutions'**
- 172 **practices in granting these increases will be assessed during the Institutional Review.**
- 173 ▪ **The designated institutional official (DIO) should annually report to the sponsoring**
- 174 **institution's governing body on program and institutional compliance with the duty hour**
- 175 **standards.**
- 176 ▪ The program and sponsoring institution must develop policies on patient care activities outside the
- 177 educational program (moonlighting); these must be provided to residents and available to the RRC.
- 178 ▪ **Patient care activities that are external to the educational program (moonlighting) and that**
- 179 **exceed the weekly limit on resident duty hours are often inconsistent with sufficient time for**
- 180 **rest and restoration to promote the resident's educational experience and safe patient care.**
- 181 **Therefore, these activities require prospective permission from the program director and**
- 182 **sponsoring institution. Their effect on resident performance must be monitored, and**
- 183 **permission be withdrawn if the activities adversely affect resident performance.**
- 184 ▪ **Patient care activities external to the educational program that occur in the primary program**
- 185 **and institution must be counted toward the weekly limit on duty hours.**
- 186 ▪ **The program and sponsoring institution must have procedures and policies in place to**
- 187 **monitor and support the physical and emotional well-being of residents to promote an**
- 188 **educational environment and safe patient care.**
- 189 ▪ **Sponsoring institutions must monitor the demands of home call in their programs, and make**
- 190 **scheduling adjustments as necessary to address excessive service demands and/or fatigue.**
- 191 ▪ Patient care support services for IV, phlebotomy, and transport activities must be available to reduce
- 192 resident time spent on these routine activities.

193
194 *High-Quality Education and Safe and Effective Patient Care*

- 195 ▪ Didactic and clinical education must have priority in the allotment of residents' time and energies.
- 196 ▪ On-call schedules for teaching staff must be structured to provide that supervision and faculty
- 197 support/consultation is readily available to residents on duty.
- 198 ▪ Duty hour assignments in teaching settings must recognize that faculty and residents collectively
- 199 have responsibility for the safety and welfare of patient.
- 200 ▪ **Faculty and residents must be educated to recognize the signs of fatigue and to apply**
- 201 **preventive and operational countermeasures. The program director and faculty must monitor**
- 202 **residents for the effects of sleep loss and fatigue, and respond in instances when fatigue may be**
- 203 **detrimental to resident performance and well-being.**
- 204 ▪ Programs must provide residents appropriate backup support when patient care responsibilities are
- 205 especially difficult and prolonged, and if unexpected needs create resident fatigue sufficient to
- 206 jeopardize patient care during or following on-call periods.

207
208 The standards define a minimum to be met by all accredited programs, with the goals of promoting patient
209 safety, resident well-being and learning. The recommended approach attempts to reflect the “real life”
210 practice of medicine, while promoting safe patient care and high-quality education. The new common
211 standards do not detract from the existing program requirements in specialties that have established more
212 stringent duty hour limits, and the ACGME strongly expects these standards to be maintained and further
213 refined. Instead, the goal is for the common duty hour standard to serve as a “floor” on which RRCs define
214 standards that reflect the patient safety and educational considerations of their discipline. The standards
215 provide for a 10 percent increase above the 80-hour weekly limit, which may be applied only in cases where

216 there is a convincing rationale that the education of the residents requires more than 80 weekly hours. The
217 Institutional Review Committee will define the principles and procedures for sponsoring institutions'
218 GMECs to review these requests, and institutions' practices in approving them will be examined during the
219 institutional review. In the rare case that a specialty believes it cannot conduct its educational activities
220 within the proposed constraints, the ACGME provides for opportunity to petition for an exemption, if the
221 specialty can demonstrate that an 80-hour limit would have a significant detrimental effect on clinical
222 training and education, and if it can show how its approach will promote safe patient care, high-quality
223 education and resident well-being. Such an exemption requires the approval of the ACGME Program
224 Requirements Committee and Board of Directors.

225

226 ***Acute Sleep Loss and Chronic Sleep Deprivation***

227 The standards take into consideration the difference between acute sleep loss and chronic sleep deprivation.
228 They address acute sleep loss by placing an ACGME-wide limit of 24 hours on continuous duty periods. No
229 new patients may be accepted after the 24-hour period, and the existing ACGME requirement for
230 availability of "backup if sudden and unexpected needs create resident fatigue sufficient to jeopardize
231 patient care during or following on-call periods" also applies. To address the issue of chronic sleep
232 restriction, the standards place a limit on weekly duty hours and establish standards for required minimum
233 rest periods between duty periods.

234

235 The Work Group recognizes that its recommendations may necessitate changes in residents' duty hour
236 patterns in some programs. In programs with long duty hours due to educational demands, such changes
237 may include decreasing the frequency of call to no more than every fourth night or implementing night float
238 systems, in which some residents' work 8 to 12 hours nightly to cover the evening and overnight hours. The
239 required 10-hour rest period accommodates specialties that use "duty shifts" and night float. To ensure that
240 home call is not used inappropriately to replace in-house call duties, the requirements define that home call
241 is exempt from the count of duty hours except for the time individuals spend in the hospital after being
242 called back. The requirements also make programs and sponsoring institutions responsible for appropriate
243 scheduling of call, monitoring the demands home call places on residents, and making scheduling
244 adjustments to prevent excessive service demands and fatigue.

245

246 ***The Importance of the "Morning Post-Call"***

247 A goal of residency education is for residents to learn how to provide patient care independently and how to
248 facilitate patient "hand-off," the process of transferring the care of their patients to other physicians at the
249 end of the duty period. The requirements recognize the importance of the transfer of care and educational
250 debriefing by allowing up to six hours for these activities at the end of the 24-hour duty period. The
251 standards also emphasize that residents and faculty collectively have responsibility for continuity of care.
252 The additional six hour period preserves flexibility in scheduling didactic activities and minimizes exclusion
253 of post-call residents from formal educational offerings, by allowing them to return for scheduled lectures if
254 the total time of call, transfer, educational debriefing and didactic activities does not exceed 30 hours.

255

256 ***Education about Sleep Restriction and Fatigue***

257 The recommendations expand the role of program directors, faculty, and resident colleagues in identifying
258 and intervening in instances of residents exhibiting signs of fatigue. To prepare them for this, program
259 directors, faculty and residents must be educated about the effects of sleep loss on performance and well-
260 being, and how to recognize fatigue and apply countermeasures. This should also enable residents to
261 recognize their own limits and request to be relieved when those limits have been reached. Programs must
262 institute the necessary changes in their informal learning environment to allow tired residents to request to
263 be relieved.

264

265 ***Patient Care Activities Outside of the Educational Program ("Moonlighting")***

266 Patient care activities outside of the educational program (moonlighting) contribute to resident hours and
267 may produce fatigue that affects performance. Thus, together with efforts to reduce hours in the educational
268 program, the ACGME must consider moonlighting and its effect on patient safety and resident well-being.
269 This is achieved by requiring that program directors prospectively grant permission for all moonlighting

270 activities, monitor their effect on resident performance, and withdraw permission if the activities adversely
271 affect resident performance Program directors and sponsoring institutions should also educate residents, who
272 may not be aware of the legal implications, risks or contribution to fatigue inherent in moonlighting.

273

274 **II. Strengthening Enforcement of the Duty Hour Standards**

275 The ACGME promotes adherence to all of its standards by monitoring and citing programs that fail to meet
276 them and taking adverse actions in cases programs' failure to comply substantially with the requirements,
277 after appropriate due process. Several RRCs have already stepped up their duty hour compliance activities
278 by requiring programs with violations to submit immediate progress reports that detail the steps they will
279 take to come into compliance. Enforcement of the duty hour standards is as important as enhancing the
280 standards themselves, and the Work Group's recommendations call for: (1) intensifying information
281 collection related to duty hours; (2) dramatically shortening the review cycles for programs and institutions
282 that violate the duty hour standards; (3) invoking the ACGME procedure for Rapid Response to Alleged
283 Egregious Accreditation Violations or Catastrophic Institutional Events if indicated by the seriousness of a
284 likely duty hour violation; (4) generally enhancing programs' and institutions' accountability for
285 compliance; and (5) monitoring the ACGME's compliance systems to foster consistent enforcement of the
286 standards through increased training of site visitors, concurrent review of information on duty hours by a
287 dedicated ACGME Subcommittee on Resident Duty Hours, to be established in the coming months, and
288 retrospective review of RRCs' practices by the Monitoring Committee. The intent of the enforcement
289 provisions is to make programs, institutions and residents partners in complying with the standards.

290

291 **Recommendations to Promote Compliance with the Duty Hour Standards**

292

293 *Enhancing Information Collection*

- 294 ■ The ACGME will collect information on compliance with the duty hour standards via a resident
295 survey fielded to all programs being site visited
- 296 ■ The ACGME will provide additional training to its Field Representatives and Specialist Site Visitors
297 (SSVs) regarding collection of information on duty hours, and will standardize the questions related
298 to duty hours asked during the accreditation site visit.

299

300 *Shortening the Review Cycles*

- 301 ■ RRCs will request immediate progress reports from programs that have been cited for violation of
302 the duty hour standards, and request information on plans for coming into compliance within 6
303 months after the citation was issued.
- 304 ■ The Institutional Review Committee (IRC) will request immediate progress reports from institutions
305 that have been cited for violation of the duty hour standards. This will request information on the
306 plans for coming into compliance within 6 months after the citation was issued.
- 307 ■ For more serious violations, the RRC may conduct a resident survey 6 months after the citation to
308 assess whether the program has come into compliance. The RRCs and the IRC may also conduct
309 focused follow-up reviews to assess progress, with programs being charged for these reviews.
- 310 ■ A significantly shortened process will be used for withdrawing accreditation from programs that fail
311 to address the duty hour citations.
- 312 ■ At each meeting, the IRC will review sponsoring institutions with significant duty hour compliance
313 problems (defined as repeat citations in one program or multiple programs with citations). From
314 these, the IRC will solicit reports that detail the steps to correct the citations within 6 months.
- 315 ■ The RRC or IRC may recommend an expedited institutional review process with the potential for
316 withdrawal of accreditation from all accredited programs for repeated, serious violations or
317 continued failure to comply.
- 318 ■ For likely very serious duty hour violations, the ACGME will invoke the procedure for Rapid
319 Response to Alleged Egregious Accreditation Violations or Catastrophic Institutional Events.

320

321 *Enhancing Institutional Accountability*

- 322 ■ The DIO is charged with raising the awareness of the institutional leadership on the issue of duty

323 hours, through activities that summarize institutional and program compliance efforts in this area.

324
325 *Promoting Consistent Enforcement*

- 326 ■ ACGME Field Representatives and SSVs will receive increased training in how to assess programs
- 327 and sponsoring institutions for duty hour violations.
- 328 ■ Monitoring of the ACGME's efforts to promote compliance with the duty hour standards
- 329 concurrently by a dedicated ACGME Subcommittee on Resident Duty Hours and retrospectively by
- 330 the ACGME Monitoring Committee.

331
332 The first step in enhancing the enforcement of the duty hour standards is to collect detailed, accurate
333 information about residents' duty hours. During its accreditation site visits, the ACGME interviews 12,000
334 to 15,000 residents annually about their educational experience, and a resident survey will soon reach all
335 residents of programs scheduled for accreditation review in a given year. From these residents, the ACGME
336 plans to collect broad information about programs' compliance with the duty hour standards. Enhancing the
337 data on compliance with these standards will also require that all ACGME site visitors receive additional
338 training to promote their collection of this information in a comprehensive and consistent fashion.

339
340 The second critical element of an enhanced compliance effort is shortening the time frame for addressing
341 duty hour citations, by all RRCs requesting progress reports and action plans from programs that have been
342 cited. These must detail the steps and the time frame for bringing the program into compliance, capped at
343 approximately 6 months from the date the citation was issued. This shortened time frame is critical to
344 enhancing the likelihood that residents are not subjected for an extensive period to a program that violates
345 the duty hour standards. In addition, because institutional support will often be critical to a program's
346 ability to address these citations, the sponsoring institution will be involved in the formulation of the
347 progress report and will sign off on the document. Simultaneously, the IRC will review sponsoring
348 institutions with significant duty hour compliance problems, and reassess compliance within 6 months.
349 RRCs and the IRC may conduct repeat resident surveys and/or focused reviews to evaluate compliance with
350 the duty hour standards, and a special fee will be charged for the focused site reviews. Programs with two
351 successive duty hour citations can receive an adverse accreditation action, with the plan to initiate expedited
352 withdrawal of the program if the deficiencies have not been addressed within 6 months of the second
353 review. The proposed approach is in keeping with the ACGME's intent to use accreditation to foster
354 improvement and expediting the process for bringing programs into compliance, while allowing correction
355 of citations made in error.

356
357 The third element, to be used for likely very serious violations, involves invoking the procedure for Rapid
358 Response to Alleged Egregious Accreditation Violations or Catastrophic Institutional Events. If an
359 egregious violation is believed to have occurred, this provides a mechanism for an immediate site visit, and
360 the potential for the most serious consequences to the accreditation of programs and sponsoring institutions
361 if the allegation is confirmed.

362
363 The fourth pillar of the system to enhance compliance is to emphasize the obligation of sponsoring
364 institutions for creating an appropriate learning environment. Sponsoring institutions' role is not limited to
365 coordinating and monitoring programs' compliance, and these institutions play a vital role in creating an
366 environment within their residency programs that promotes safe patient care and high-quality learning.
367 Institutions are asked to assume additional responsibilities, including educating residents in recognizing the
368 signs of fatigue and facilitating the application of preventive and operational countermeasures. These
369 activities will be informed by the medical education community's growing knowledge and understanding of
370 the effects of long duty hours and fatigue on patient safety and learning.

371
372 The final element for further enhancing the functioning of the accrediting process related to the resident duty
373 hour standards involves the formation of a dedicated ACGME Subcommittee on Resident Duty Hours, and
374 charging the ACGME Monitoring Committee with monitoring the performance of the RRCs and the IRC in
375 fostering compliance with the duty hour standards. The Work Group encourages both Committees to think
376 of added ways in which the accrediting body can effectively monitor performance in this important area.

III. Implementing and Communicating the New Standards

The demands of safe patient care, and protecting residents' well-being and their ability to learn require that the new common duty hour standards be implemented without delay. The first step is unwavering enforcement of the existing ACGME duty hour standards. At the same time, the ACGME recognizes that the proposed new standards will necessitate changes in many programs and sponsoring institutions. The dual demands of timely implementation, while giving programs time to adapt, suggest an implementation date of July 1, 2003. Prior to this, following final approval of the standards by the ACGME, there should be a period of "forming the initial response," during which RRCs will issue constructive feedback to programs, but will not take adverse accreditation actions in instances where programs fail to comply with the new standards. During this period, RRCs are also expected to provide individual responses to the ACGME detailing how they will implement the new standards.

Communicating the new standards and their rationale is vital to promoting adherence and relieving concerns that "the medical community has not adequately addressed the issue of duty hours and its effects on patient safety and resident safety and well-being." To complement its communication activities, the ACGME sees a role for the academic community, including its five member organizations, and the organizations appointing to its RRCs, in emphasizing how the enhanced standards contribute to a system that promotes safe patient care and high-quality education. The Work Group's charge also included exploring how the ACGME can broadly collaborate with other organizations in the academic community to build systems to foster safe patient care and education, including efforts to re-engineer the patient care processes in teaching settings. Identifying and disseminating information on innovative approaches is an important element of potential collaborations between the ACGME and members of the academic community. Research on the effects of different duty hour models and scheduling patterns is beginning to produce results, and the ACGME looks to these findings to generate potential future refinements to its standards. In addition, research into new models of care in teaching settings that rely to a lesser extent on residents is also being conducted. The findings will contribute to an expanded range of options for institutions intent on addressing the issue of duty hours in the context of creating an appropriate patient care and learning environment.

IV. Costs

Implementation of the recommended standards will necessitate change in many programs and sponsoring institutions. It would be disingenuous to understate the added costs of these changes, or the challenge that securing the added funds will present for many sponsoring institutions. The costs are real, but they are justified by the enhanced promotion of safe patient care, resident well-being and educational goals.

For many programs and institutions and their faculty, the adoption of the new duty hour standards may create financial and/or operational hardships. Recognizing this, the ACGME will solicit feedback from the involved constituencies to monitor and assess the extent of these hardships, and will report the findings to its Board of Directors, member organizations and appropriate federal entities.

V. Conclusion

The goal of simultaneously fostering high-quality education and patient care and resident well-being provides the rationale for the ACGME's standards and the systems that foster compliance. The recommendations related to duty hours in this report are far-reaching and many of them will require further elaboration and definition toward implementation. Beyond a need for additional resources, and changes in systems and procedures, for some programs, the new requirements will necessitate a change in culture. The only way residency programs and their sponsoring institutions can achieve a true "education" program as well as provide high quality clinical care, is by attending to the issue of resident duty hours and by placing a higher value on resident education and safe patient care than on meeting service demands. Successful implementation of the new standards and enhanced compliance system will require the cooperation and collaboration of the entire residency education community, and enlisting the support of all of its members in this undertaking is the final critical task to be accomplished.

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