



MEMO

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The ACGME Common Program Requirements Section VI revisions have been approved by the ACGME Board of Directors to be implemented during the 2017-2018 academic year.

At the heart of the new requirements is the philosophy that residency education must occur in a learning and working environment that fosters excellence in the safety and quality of care delivered to patients both today and in the future. An important corollary is that physician well-being is crucial to deliver the safest, best possible care to patients.

In keeping with this philosophy, the changes are supported by [testimony](#) from a wide range of physician specialty educators and intended to:

- place greater emphasis on patient safety and quality improvement;
- more comprehensively address physician well-being;
- strengthen expectations around team-based care; and,
- create flexibility for programs to schedule clinical and educational work hours within the maximums currently utilized in the US.

These revisions were developed as part of the ACGME's periodic review of all program requirements to ensure that professional preparation of physicians adequately addresses the evolving and growing needs of patients. This review began in 2015 and, over the last year, the Common Program Requirements Phase 1 Task Force reviewed the published scientific literature on the impact of existing standards on the quality and safety of patient care, resident and fellow well-being, and resident and fellow clinical care and education hours.

The ACGME's Commitment to Patient-Centered, Clinically-Driven Standards

The new requirements further reinforce the patient safety framework already in place in the Common Program Requirements as it pertains to total hours in clinical care and education, required levels of supervision, and the graduated level of responsibility given to residents and fellows as they gain experience. The revisions now provide additional safeguards by:

- counting work at home as part of the 80 hour weekly maximum;
- optimizing the quality of care transitions and hand-offs;
- ensuring that residents and fellows can be relieved of responsibilities when needed;
- defining the need for direct oversight of first-year residents;
- making sure that patients and the entire health care team know who to contact; and,
- eliminating moonlighting for first-year residents and ensuring that if more senior residents/fellows moonlight, it will not interfere with their patient care duties.

The requirements also recognize the significant risk of burnout and depression for physicians. They stress the need for both programs and institutions to prioritize physician well-being for faculty members as well as residents, ensuring protected time with patients and minimizing non-physician obligations. This reflects the ACGME's obligation to help physicians find meaning and joy in their work, while also providing them with the resources necessary to care for themselves and their patients.

Flexibility within a Maximum

Core elements from the 2003 and 2011 ACGME Common Program Requirements capping the total number of clinical and educational hours for residents and fellows have been preserved, based on a nationally-supported framework, averaged over four weeks, of:

- a maximum of 80 hours per week;
- one day free from clinical experience or education in seven; and,
- in-house call no more frequent than every third night.

Research conducted over the past five years confirms that the cap of 80 hours worked per week (first established in New York State and adopted by the ACGME in 2003), which remains in place today, provides the best balance between simulating real world experiences residents may encounter under direct supervision in their first year of residency with their ability to be properly rested.

Each specialty and subspecialty has its own unique demands and skill set requirements. Some require that physicians work for extended periods of time in order to admit, stabilize, and hand off critically-ill patients. The American public deserves to know that starting on Day One, physicians in practice already have the real-world experience they need to ensure high-quality patient care. Residents and fellows also have the right to develop such experience under appropriate supervision so as to manage the lifetime of demands and stress that come with the privilege of patient trust.

Residents Are Part of a Health Care Team Delivering High Quality Patient Care

The necessity for physician education to simulate real-world practice cannot be overemphasized. Just as drivers learn to drive under supervision on the road, residents and fellows must train in real patient care settings for the situations they will encounter after graduation. The educational program infrastructure includes appropriate levels of supervision tailored to the experience and competence level of each physician learner.

This means that residents, fellows, and faculty members must work with other health care colleagues in well-coordinated teams, using shared methodologies—such as consistent reporting and disclosure of adverse events and unsafe conditions—to achieve institutional patient safety goals. Equally important, residents and fellows must develop the skills and the confidence to manage challenging situations under supervision, and while learning to care for patients over extended hours, including night-time hours, as these are circumstances they will likely encounter after graduation.

The revised requirements return first-year residents to the same schedule as other residents and fellows, re-establishing the commitment to team-based care and seamless continuity of care while also ensuring professionalism, empathy, and the commitment of first-year residents to their patients. The cap for first-year residents will return to 24 hours, a cap that has been in place nationwide for all other residents and fellows, plus up to four hours to manage necessary care transitions.

The public response to the proposed changes is focused largely on the matter of first-year residents' schedules, despite the fact that the total number of hours they work has not changed, nor have any of the core standards capping hours for residents and fellows. However, the Task Force has determined that the hypothesized benefits associated with the changes made to first-year resident

scheduled hours in 2011 have not been realized, and the disruption of team-based care and supervisory systems has had a significant negative impact on the professional education of the first-year resident, and effectiveness of care delivery of the team as a whole.

It is important to note that 24 hours is a ceiling, not a floor. Residents in many specialties may never experience a 24-hour clinical work period. Individual specialties have the flexibility to modify these requirements to make them more restrictive as appropriate, and in fact, some already do. As in the past, it is expected that emergency medicine and internal medicine will make individual requirements more restrictive.

An Evidence-based Process Focused on Patient Outcomes and Physician Well-Being

The 21 members of the Phase 1 Task Force charged with development of these clinically-driven requirements over the past 18 months include leaders in the graduate medical education community, residents, fellows, and the public. The standards were not arrived at lightly. The Task Force spent over 4,200 hours formulating the new requirements, including systematically reviewing over 1,000 published articles and extensive input from all stakeholders.

The Task Force also looked at new research from the past five years, including relevant multicenter research trials, as well as position statements from more than 120 organizations and individuals, including specialty societies, certifying boards, patient safety organizations, resident unions, and medical student organizations. In March 2016, a national meeting was convened to let Task Force members hear comments from these organizations, experts, and members of the public to inform their deliberations.

The Task Force's decision on clinical experience and education hours was evidence-based. The preponderance of evidence from a number of studies (cited in this [letter](#)) conducted after the current 16-hour cap was implemented in 2011 suggest that it may not have had an incremental benefit in patient safety, and that there might be significant negative impacts to the quality of physician education and professional development. To further investigate these issues, the ACGME provided support for two national, large, independent, multicenter trials. The iCOMPARE trial for internal medicine and the FIRST trial for general surgery were designed so that researchers were able to compare control groups using the 16-hour cap with test groups following more flexible work hour requirements.

While the iCOMPARE trial is still underway, the findings from the FIRST trial [published](#) February 2016 in *The New England Journal of Medicine* is the first-ever national randomized trial comparing the 16 work hour requirements with more flexible policies "demonstrated that allowing for some flexibility in the 16-hour limit did not worsen patient outcomes among general surgical patients and did not adversely affect overall resident well-being. Rather, residents in the flexible arm of the study noted several benefits with respect to patient care, continuity of care, and resident training." A subsequent follow-up survey of FIRST trial residents [published](#) in the *Journal of the American College of Surgeons* found "they strongly prefer work hour policies that allow them the flexibility to work longer when needed to provide patient care over standard, more restrictive work schedules."

The ACGME is committed to ongoing review of all of its requirements as new evidence becomes available.

The question of work hour standards appropriately provokes great emotion in both the graduate medical education community and among segments of the general public. For its part, the ACGME is committed to a learning environment that serves the best interests of both patients and residents, and will pursue that commitment with open-minded, evidence-based policy making. The ACGME's oversight of the professional preparation of the next generation of physicians to care for the American public requires nothing less.