

# Common Program Requirements The Learning and Working Environment (Duty Hours)

## Individual Perspectives

The revisions to the ACGME Common Program Requirements in Section VI (approved in 2017) were informed by perspectives from the medical education community, including leadership, program faculty and staff members, and residents and fellows, and the public at-large. Some of these perspectives are offered below.



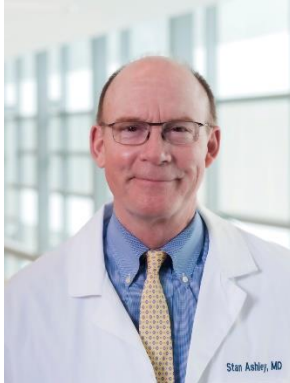
### **Dr. James A. Arrighi**

**Member, Phase 1 Task Force**

**Director of Graduate Medical Education, Rhode Island Hospital  
Professor of Medicine, Warren Alpert Medical School of Brown University**

The 2017 Common Program Requirements represent an iterative improvement in the requirements, based on research data, [the Task Force membership's] collective experience in the GME community, and expert opinion. I view this version, and probably future versions, as iterating towards an ideal construct. We may never reach the ideal or perfect state, but we always are striving for it. In the case of the 2017 Section VI requirements, the great step forward, in my view, is the linkage of all subsections (patient safety, professionalism, well-being, fatigue mitigation, teamwork, and clinical experience inclusive of work hours) and the recognition that each is equally important in progressing towards an ideal learning environment. It is the "total package" that matters. Individual programs must be allowed to construct their own clinical and educational structure in a manner that works best for their patients and trainees; some freedom in this regard will foster innovation. Micromanagement or excessive regulation of any one of these subsections would not have been wise. Programs must, however, work within this framework. I do not view the 2017 revisions in any way as a "relaxation" of the requirements. In fact, the expectations are quite high that the GME community focuses on each of these subsections, and I envision that we will learn much and see progress in each of these areas, including in well-being, which was not emphasized so specifically in prior versions.

It is important to note that the responsibility for implementing program requirements effectively rests with the GME community. As a Director of GME at my institution, I am eager to take on the responsibility of ensuring that the spirit, and not just the details, of these new requirements is followed. I appreciate the balanced approach to the clinical learning environment that is reflected in these new Common Program Requirements.



### **Dr. Stan Ashley**

**Member, Phase 1 Task Force**

**ACGME Board of Directors**

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**Frank Sawyer Professor of Surgery, Harvard Medical School**

Although some specialties were not impacted by the 2011 Requirements, for others, particularly those with a significant focus in inpatient care, the changes decreased the flexibility of programs and residents to create schedules that fit their patients' illness or their own learning. The consequences of this well-intended change were a significant *increase* in the number of patient hand-offs, the amount of time engaged in "hold-over" care (i.e., the proportion of care being provided to patients that the residents had not admitted and did not know well), the number of times a resident had to leave an operation mid-course, and the number of sometimes stressful transitions between day and night shifts. Furthermore, opportunities to observe the natural history of an illness and the consequence of clinical decisions were reduced by the shorter shifts. Rather than improving the working environment and trainee well-being, as might have been expected, the 2011 Requirements resulted in residents feeling a diminished sense of connection with their patients and a loss of professional mission, and this too often translated into residents experiencing less satisfaction with their jobs and education. Although the prior versions of the Common Program Requirements have suggested that residents must be integrated, and must actively participate in, interdisciplinary clinical quality improvement and patient safety programs, the results of the first cycle of CLER visits suggest that programs and institutions still have much room for improvement. The 2017 Requirements seek to invigorate these efforts by describing specific aspects of quality improvement and patient safety that must be taught through didactic and experiential learning opportunities, including robust processes for reporting, investigating, preventing, and disclosing patient safety events. It is my sense that these changes will have far more impact on patient safety than any alterations in clinical work hours.



### **Dr. Jessica L. Bienstock**

**Member, Phase 1 Task Force**

**Chair, ACGME Review Committee for Obstetrics and Gynecology**

**Associate Dean for Graduate Medical Education and Designated**

**Institutional Official**

**Johns Hopkins Medicine**

The new requirements in Section VI of the Common Program Requirements encourage training programs to teach new physicians how they can be effective participants and leaders of team-based patient care that is the standard of health care today. The revisions also allow residents and fellows at all levels to benefit from the personal and professional satisfaction and sense of accomplishment that comes with professional commitment to patients.

For example, when managing a patient during labor and delivery, it is very disconcerting to the patient when a new team comes on. These requirements ensure that residents are an integral part of that team for continuity of care.

Counting work done from home in resident duty hours is very important. As we increasingly use electronic medical records, more work is being done from home. Residents need to be allowed to have personal time, and it is not fair to have them working at home during that personal time.

The new requirements directly address how Sponsoring Institutions and training programs can enhance resident and fellow well-being, and teach them the personal skills they will need to thrive throughout their career in medicine. It is the responsibility of the program to teach those skills from the beginning. Residents need to learn to take care of themselves for a lifetime in practice.



**Dr. Kim Burchiel**  
**Co-Chair, Phase 1 Task Force**  
**Professor of Neurological Surgery**  
**Oregon Health & Science University**

The making of future doctors is a difficult, but extremely important task. It is an essential mission, and the very future of American health care hangs in the balance. There is no way to squeeze the amount of learning and experience into a traditional 40-hour week. Doing that would effectively double residency training which for some programs (neurological surgery, for example) would mean a 14-year period of training. This, of course, would put untenable burden on the residents in training who already have families and educational debt, and on the funding mechanisms for residency training (largely Medicare/Medicaid). The ACGME is charged with creating a structure that supports this intense training while maintaining patient safety, resident and faculty well-being, accountability, and quality improvement. It is a tall order, but this was the intent of the Task Force charged with revision of Section VI. These requirements will also evolve in the future, but we have taken important steps to secure the success of future doctors, and for US health care. The 2017 requirements preserve the emphasis on patient safety, and further developed the area of quality improvement for health care systems. Patient safety, resident wellness, and QI represent the three-legged stool of graduate medical education, and the new revision strengthens all three of these elements.



**Dr. Peter Carek**  
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**Department of Community Health and Family Medicine**  
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Patient safety in a teaching setting is dependent upon several key factors: a resident with the appropriate knowledge, skills, and attitude; the supervision by knowledgeable and experienced attending physicians; an entire medical team of physicians, nurses, pharmacists, and many others providing and monitoring the medical care of individual patients; and the understanding that the well-being for all members of the team is fundamental. The 2011 Common Program Requirements in some way addressed all of these critical elements; the 2017 further emphasize their essential nature to successful patient care and physician education.

In family medicine, all members of the team will now be working with the same requirements. First-year residents will be able to work more closely with their more experienced resident and faculty colleagues and be available to provide the care on a more continuous basis to patients.

These revisions are based upon years of experience with patient care and medical education by generations of physicians who seek to provide the highest level of patient safety and best educational experience in the clinical setting in an environment that values the well-being of all health care workers. Taken in total, the revised requirements are a result of generations of physicians coming together to better address the care and safety of patients as well as the education and well-being of learners.



**Dr. Ricardo Correa**  
**Resident Member, Phase 1 Task Force**  
**Internal Medicine-Endocrinology**  
**National Institute of Health – Warren Alpert Medical School of Brown University**

This new set of Common Program Requirements was created to provide a flexible environment in which resident and fellow physicians will have more control within their learning environment. Extensive review of the literature, plus reviewing the input of many organizations, led to a conclusion that flexibility with protection is key for residency and fellowship training. A focus on resident/fellow wellness as part of the learning environment was a focus for the Task Force. We proposed some basics, but hope that programs will feel free to add more information and to provide feedback to the ACGME. The new Common Program Requirements are holistic and do not focus just on one area of the pie—our goal is to provide the standards that will enable programs to provide the best training possible in the best possible setting, taking into account all the stakeholders that this process involved. Residents and fellows will benefit from these Common Program Requirements because they will see the learning process as a combination of time, wellness, and balance--and not just duty hours.



**Dr. David A. Forstein**  
**Member, Phase 1 Task Force**  
**ACGME Board of Directors**  
**Dean and Professor**  
**Touro College of Osteopathic Medicine**

Residents, particularly early on, need supervision and to function as part of a team. When they had to leave at 16 hours, while the rest of the team was still working, they didn't feel more tired than their senior residents, they felt like they were letting them down. Another unintended consequence was a small increase in hand-offs. On clinical services, like obstetrics and gynecology where a night float system is used, these extra hand-offs usually occurred on the weekend when there were fewer faculty members and residents around. I believe that due to the diligence of the residents and nurses, along with a compensatory reflex to be more stringent about hand-off education and supervision that there were few or no extra increased harms to patients. In the end, the increased number of hand-offs made us all focus more on hand-offs and we became better at them. I don't believe this was part of any master plan, just the profession stepping up with professionalism to address a need. Most residents do

not work up to the 80-hour limit. This didn't change in 2011, but we did see an increase in the number of hours the mid-level (PGY-2-3) residents worked as the first-year residents' hours decreased slightly. The biggest issue was that the interns often had to leave the clinical environment before they were ready – they missed conferences, educational activities, and patient care opportunities.

I believe the sense of resident teams will be restored and emphasized. This sense of really belonging will help the first-year residents immensely. Fewer hand-offs of patients will lead to less lost information. Residents will be more likely to see a patient through their hospitalization so they can provide better care through greater continuity. Current first-year residents are excited [about the revisions]. They think this will relieve some of the pressure on the mid-level residents, will restore more golden weekends for the interns, and limit the disruptions in their education.



**Dr. Jeffrey P. Gold**

**Member, Phase 1 Task Force**

**ACGME Board of Directors**

**Chancellor, University of Nebraska Medical Center**

The 2017 Common Program Requirements revisions will benefit patients, as well as the residents and fellows of today, and those who will be practicing for decades to come. The revised requirements specifically focus on work-life balance and resident well-being, requiring significant institutional and program-specific resources and access to services for all residencies and fellowships. The enhanced flexibility created by the alignment of the clinical work hours and the ability to recognize clinical work done outside of the hospital or ambulatory care facility will further enhance resident well-being and the continued development of decision-making professionalism.

The lengthy process of data-driven decision-making to enhance the Common Program Requirements has enhanced the process and the outcome considerably. The ongoing research into the development of the competent, independent, practicing physician continues to shape the determinations of optimal resident education from a curricular assessment and learning environment perspective. As more information has become available on the importance of the clinical learning environment and work-life balance, the Program Requirements continue to mature and reflect this information.

The wealth of experience reviewed since the implementation of the 2011 Program Requirements was foundational to the thought process and finalization of the 2017 Requirements. It is clear that over time, additional research and experience will shape the next generation of Common Program Requirements and Institutional Requirements used to educate America's physician workforce.



**Dr. Dink Jardine**

**Chair, ACGME Council of Review Committee Residents  
ACGME Board of Directors**

I began my training in July 2011 just as the new hours came into effect and was immediately struck by the “us against them” mentality that developed among the trainees because of the differences in the way that the interns and the residents were scheduled. We did not come in together nor did we leave together. We did not eat together, sit around the table together, or sometimes even turnover together (there was a separate intern turnover in the evenings since the residents were still on the 24-hour cycle). As a result, we did not build a cohesive working team. There was little incentive for a senior resident to take an intern under their wing to show them how to take care of things overnight because they weren’t part of the team – they were just “another intern” who would be there part-time. As interns, we felt the frustration of and rejection by the residents but could not do anything about it. If you remember that medicine is a team sport – regardless of the specialty – then it makes sense that when you impact the ability of the team to feel like they are actually a team that things would start to fall apart. This is what happened in 2011. By bringing the inpatient team—which is really where these hours have the most impact; i.e. scheduling for inpatient/in-hospital care—back into the forefront, we are allowing interns to learn from their senior residents. We are allowing teams to reconnect and be a team again. Senior residents are incentivized to groom interns – because they are now “their interns.” Groomed interns make for better junior residents. And those groomed junior residents, who have been modeled that as they rise through the ranks their job is to take the intern on your team under your wing, will do just that. And then the team can finally start to work together like a team.



**Dr. George A. Keepers**

**Member, Phase 1 Task Force  
Carruthers Professor and Chair, Department of Psychiatry  
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The revised Program Requirements provide a dramatically enhanced focus on the ACGME’s and the profession’s core values: excellence in the safety and quality of care rendered patient in our health systems today and in the future; professionalism characterized by devotion to patient care; intellectual rigor and the advancement of science, and an absolute commitment to the well-being of students, residents, and all members of the health care team. The requirements that promote resident and faculty member well-being are critical to the creation of a healthy learning and working environment.



**Dr. Benjamin Kennedy**  
**Resident Member, Phase 1 Task Force**  
**Neurological Surgery Fellow**  
**The Children's Hospital of Philadelphia**

It is true that well-being is improved when reducing work hours from 120 hours/week to 80 hours/week. However, there is much more to the well-being of a resident than exactly how many hours are worked. It is the *conditions* of work and the *meaning* of work that determine well-being within a reasonable hour limit. When shift length limitations disrupt teams, patient care, and learning, these conditions worsen, and some meaning is lost. When residents are sent home during a surgery, or in lieu of an educational experience rounding with a faculty member, meaning is lost, and conditions worsen. The residents I know are not interested in working as little as possible, but in doing *meaningful* work in proper working *conditions*. I see the biggest change in the 2017 revisions as the focus on resident well-being. It is time for the GME community to refocus their attention from work hours to resident well-being. The new requirements set new standards for, among other things, providing mental health services, allowing residents the ability to seek medical care, and emphasis on the conditions of work for residents.



**Dr. Lynne Kirk**  
**Member, Phase 1 Task Force**  
**ACGME Board of Directors**  
**Professor, Internal Medicine**  
**UT Southwestern Medical Center, Dallas**

The new requirements are much more explicit about the expectations for programs to assess and provide resources to enhance residents' well-being. We have started using such an assessment tool in my own program. This has helped us learn about what we can do to improve residents' work lives and take steps to address those issues. The new requirements are also much more detailed about expectations for teaching and promoting patient safety, which will produce physicians who are very capable to provide health care that is of high quality and safe for patients. The new requirements contain adjustments in clinical work hour periods, but not overall work hours. They also allow residents to count some activities done from home as work hours, which they had not previously been able to do. Working up to the maximum allowed clinical work hours will only occur in those specialties which haven't further restricted duty hours. In those programs in which the maximums occur, they will only occur on a subset of inpatient rotations—those with very ill, high-need patients. The updated requirements are structured in a way to allow residents to develop the skills to meet the needs of all of their patients as they go forward into their careers.



**Dr. Anai Kothari**  
**Resident Member, Phase 1 Task Force**  
**General Surgery Resident**  
**Loyola University Medical Center**

In many ways, the 2011 Common Program Requirements placed residents in the challenging position of choosing between their responsibility to patient care and their professional responsibility for accurately reporting work hours. The requirements really pushed programs to pay close attention to work hour restrictions and solidified the “80-hour work week.” They have impacted patient safety in ways that are difficult to measure, however as a trainee it is impossible not to recognize that we now work in very rigid “shifts.” It is challenging enough to provide the absolute best care to the patients we serve in our complex health care environment without also competing against the clock. For the first time, there are now clear requirements for what residents should expect from their programs and institutions to support their well-being during training. The importance of this cannot be understated. The new requirements ensure that well-being becomes an integral part of GME and an essential part of training physicians. The updated requirements place greater emphasis on the elements of training that most directly impact patient care. Bolstering requirements in the areas of supervision, professionalism, and team-based care will allow residents to train in environments that maximize patient safety both now and in the future. Residents will have flexibility to optimize their clinical educational experience within a simplified framework. The requirements will allow residents to shift their focus away from the clock and instead to the bedside, their personal well-being, and the care of their patients. I sincerely believe that even though most early interest is in the work hour changes, these will become less important when the requirements are operationalized by programs. The requirements on well-being and patient safety will be what truly changes major parts of residency.



**Dr. Sandeep Krishnan**  
**ACGME Board of Directors**  
**Internal Medicine – Interventional Cardiology Fellow**

I began my training before the 2011 restrictions were put in place for first year residents to work more limited hours. Since we all worked the same hours, the residents and fellows worked as a team and backed each other up. It was a great learning experience and I really enjoyed the fact that we could take care of patients in a team-based setting amongst the RTs, the nurses, and the other intern and resident I worked with. After the 2011 standards went into place I was responsible for a team where first year residents worked more limited hours.

This led to a number of unintended consequences where the first year residents' schedules were disjointed with the team. They went home at odd hours which disrupted their sleep schedules. It also meant they worked more, shorter shifts which sometimes made it difficult to get their work done and had to finish the work at home. It also resulted in the transfer of their residual work to the team that remained in the hospital, which meant that the remaining team had even more responsibility and less man-power, thus hindering our ability to carry out patient care in a safe and effective manner. The new standards will allow for a return to flexibility to the process, and will give programs the flexibility to come up with innovative ways to help incorporate their interns into synchronized medical teams while still ensuring that all residents and interns remain well-rested and on a predictable schedule.





**Dr. Philip Shayne**

**Member, Phase 1 Task Force**

**Chair, ACGME Review Committee for Emergency Medicine**

**Professor, Emergency Medicine; Assistant Dean for Graduate Medical Education;**

**Associate Designated Institutional Official**

**Emory University School of Medicine**

The 2011 Common Program Requirements were a mixed bag of sorts. They protected interns' sleep schedule and avoided full 24-hour shifts, but at a cost to their confidence, team cohesion, and ability to follow decision-making through to the conclusion. Their restricted hours impaired their ability to follow a patient's course and understand the journey of care, and placed more pressure on upper-level residents, negatively impacting their well-being. While well-intentioned, the 2011 changes in the end did more harm than good. The 2017 revisions provide greater flexibility for residents, give these residents more discretion and empowerment over how to use their time, and require that programs allow residents time for proper self-care. Additionally, the 2017 Common Program Requirements recognize the insidious creeping of the Electronic Medical Record into residents' home life and require programs to monitor the extent to which that occurs as part of their schedule.



**Ms. Claudia Wyatt-Johnson**

**Public Member, Phase 1 Task Force**

**ACGME Board of Directors, Public Member**

As a public member on the Common Program Requirements Phase 1 Task Force, my primary responsibility was to ensure that the public was well-served by the new requirements. Learning to provide the highest level of patient care is the fundamental priority of graduate medical education, therefore additional requirements were included to ensure patient well-being and a culture of safety and quality improvement. Optimal patient safety requires clearly defined levels of accountability, which grow with experience, evaluation, and effective supervision. Again, the new requirements include enhanced focus on accountability and supervision. Residency must reinforce the special role of the physician while protecting both the patient and the resident. The new requirements in Section VI focus on meaningful requirements to ensure that mutual protection. There is no requirement to work more. That is a myth. The new requirements offer residents more control over their time, still within the same maximum weekly hour requirements, and give greater protection to both patients and the residents who care for them.



**Dr. Rowen Zetterman**  
**Co-Chair, Phase 1 Task Force**  
**Chair, ACGME Board of Directors**

Resident physicians devote much time and attention to patients and their families, including the discussions of illness and potential outcomes. The rapport that is developed between the resident and the patient and/or family sometimes supersedes that of the supervising physician. We heard from resident physicians that during end-of-life care of a dying patient, the prevention of the resident being present simply because they had reached the end of a 16-hour shift was emotionally wrenching and prevented the availability of a most important caregiver during a crucial time for the patient and their family. The new Section VI requirements permit the resident to stay beyond their planned time of care for just such a need. Though these additional hours still count toward the 80-hour total, this new choice gives residents an important aspect of control during their training and adds to their understanding of the importance of continuity of care.