SHARE

MEDICAL EDUCATION: PART II

ACGME Sends Mixed Message on Patient Safety and Resident Wellness

Elisabeth Poorman, MD, MPH, and Richard Pels, MD

Dr. Poorman (epoorman@challiance.org) is a primary care physician in Everett, Massachusetts, and a recent graduate of the internal medicine program at Cambridge Health Alliance. Dr. Pels (rpels@challiance.org) is the chief of medicine at Cambridge Health Alliance and current director of the internal residency program, as well as a recipient of the ACGME's Parker J. Palmer Courage to Teach Award.

The Accreditation Council for Graduate Medical Education (ACGME) has recently rolled back its 2011 restrictions on intern work hours, allowing first-year residents to work 28 hours instead of the current limit of 16 hours. In addition, it repealed the absolute requirement that residents have 8 hours off between scheduled shifts and that they must document the reason for 24+ hour shifts.

Advocates for these changes have posed the choice between longer and shorter intern hours as a false dichotomy. We must allow interns to work 28 hours, the argument goes, so that they have sufficient time with patients. Because they will have to work 28-hour shifts as upper-level residents, interns must work 28 hours to learn how to manage sleep deprivation early in their careers. Residents are also told that these 28-hour shifts are also the only way to reliably have a "golden weekend" (i.e., 2 days off) once a month that many find essential for nourishing themselves and their relationships outside the hospital.

None of these propositions are true, and it is time to stop pretending otherwise. Residents spend an average of seven minutes with each patient because of the massive inefficiency of our health care systems and reliance on residents for clerical and administrative tasks. We agree that different schedules for different levels of residents create disruptions in care and resentments, but these problems can be overcome by limiting hours for all residents. The Cambridge Health Alliance internal medicine program decided years ago that research demonstrating the adverse effects of long hours was compelling enough to cap shifts at 16 hours for all residents. We also have one "golden weekend" a month. Our program is able to do this through creative scheduling, night rotations, and a willingness to eliminate unnecessary rotations.

The effects of long shifts on residents are obvious and well documented. Residents may:

- Make serious medication errors and fail to convey important information at change of shift;
- Stop being curious about illness and distance themselves emotionally from their patients;
- Crash their cars more frequently
- Suffer from demoralization and depression; and
- Be more likely to attempt suicide, as sleep deprivation increases suicide attempts threefold; meanwhile, our schools and training programs have been decimated by suicides all over the country.

In response to these concerns, the ACGME took additional action in 2011 to limit the number of hours residents could work. But, duty hours reforms have not solved all patient safety issues and have had unintended consequences, including work compression as admissions increase and the number of residency positions remains unchanged. While limiting duty hours may improve some aspects of resident well being, burnout among our trainees is ever prevalent.

The ACGME rightly identified concerns about work-hour reforms, including work compression, increased patient hand-offs, and less time spent with patients. As a result, it has proposed major new changes to its work life requirements for residents. We strongly endorse a number of the principles underlying these proposed changes, including an emphasis on the importance of team-based care and an acknowledgment of the faulty assumptions underlying 2011 requirements that the intern experience is sufficiently unique to justify greater work hour protections. The ACGME has also recognized that work done by residents at home *must* be considered in total hours worked. Further, it has admitted that current restrictions place trainees in the untenable position of staying at work longer than allowable to complete necessary tasks, and then feeling pressured to lie on ACGME surveys to protect the accreditation status of their programs.

In order to address these concerns, the ACGME considered limiting consecutive hours for all residents to 16 hours, but rejected this proposition both on pragmatic grounds and as "incompatible with the actual practice of medicine" and "potentially disruptive of the inculcation of responsibility and professional commitment to altruism." The "actual practice" alluded to by ACGME is not an ideal practice, rather a sub-optimal practice that is perpetuated by chronic underfunding of the country's training hospitals which provide the bulk of care to our underserved populations.

continued on page 2

continued from page 1

Residents remain cheap labor. Meanwhile, ongoing cuts in GME funding threaten to erode innovations such as the Cambridge Health Alliance staffing model.

The Cambridge Health Alliance model has its limitations and it certainly does not offer a solution for all of the issues that face residencies nationwide. There are still high rates of mental health disorders and difficulty accessing care, as Elisabeth Poorman recently documented in an editorial about her own and other residents' experiences.[1] Workloads continue to increase here as they have in all teaching hospitals. And excessive night-float shifts cause their own sleep disorders and safety issues.

Here at Cambridge Health Alliance, we still have precious little time with each patient compared to the hours spent in documentation (though far better than the seven minute nationwide average). We need more money for physician extenders and more staff to do the work that consumes so much more of our time and keeps us away from direct patient care. And we need wholesale reform of a byzantine health care bureaucracy. Nonetheless, Cambridge Health Alliance has taken a step in the right direction, even as the ACGME has proposed a massive step backward.

Rolling back hour restrictions is tantamount to a denial of the responsibility we have to patients to offer the safest possible care, when the most rigorous studies clearly show an increase in patient care errors and resident safety with longer shifts.[2] In light of our profession's suicide epidemic and the calls by residents and students for major reforms, the revised requirements threaten to erode the ACGME's moral responsibility to protect doctors in training from potentially deadly cultures of abuse. Now is the time for the ACGME to act to protect residents and patients and embrace clear science on safety.

References

1. Poorman E. I felt alone but i wasn't: depression is rampant among doctors in training. http://www.wbur.org/commonhealth/2016/08/19/depression-resident-doctor. *WBUR: Common Health*. Published August 19, 2016. Accessed March 31, 2017.
2. Landrigan C. Effect of reducing interns' work hours on serious medical errors. *N Engl J Med*. 2004; 351:1838-1848.

SGIM