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Dear Members of the Graduate Medical Education Community,

The Phase 1 Task Force has completed its work on Common Program Requirements Section VI, and the proposed requirements, along with an impact statement, are now available for Review and Comment through Monday, December 19, 2016. Based on this input, the Task Force will submit the final proposed requirements to the ACGME Board of Directors for approval, with implementation targeted for the 2017-2018 academic year.

This letter provides an overview of the proposed requirements, including significant additions and changes in the subsections addressing patient safety, physician well-being, and clinical experience and education hours. For those new to this process, this letter also outlines the purpose of the Common Program Requirements, as well as the process used by the Task Force.

Introduction to Common Program Requirements

The ACGME is charged with the oversight of the professional preparation of the next generation of physicians to care for the American Public. A component of this responsibility entails establishing consistent standards, and evaluating compliance with these standards by the programs and institutions in which physicians learn and train. The Common Program Requirements define the framework for resident/fellow professional education and development with a focus on the delivery of high quality, safe, and effective patient care in a clinical learning environment characterized by a spirit of inquiry, respect, and professionalism. Within this framework, specialty-specific requirements further define the detailed and rigorous expectations unique to each specialty or subspecialty.

In the fall of 2015, the ACGME Board of Directors set in motion[1] the periodic review and revision of the Common Program Requirements. The work was divided into two phases. The Phase 1 Task Force has focused on Section VI, which addresses: Professionalism, Personal Responsibility, and Patient Safety; Transitions of Care, Alertness Management/Fatigue Mitigation; Supervision of Residents; and Clinical Responsibilities in areas of Teamwork and Resident Duty Hours. The Phase 2 Task Force was appointed in the fall of 2016, and will consider revisions to Sections I-V.

The Phase 1 Task Force received extensive input on the elements addressed in Section VI. It reviewed the published scientific literature on the impact of standards on the quality and safety of patient care, resident well-being, and resident/fellow clinical experience and education hours, especially new research over the past five years, and the opinions of experts, the graduate

medical education community at-large, and the public. The ACGME invited position statements from more than 120 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.

2016 Common Program Requirements Overview

The proposed revisions to Section VI of the Common Program Requirements emphasize that medical education is professional education. Residency must promote knowledge growth and skill development and, most importantly, must inculcate professional values and altruistic behaviors the public expects of physicians. Residents must have the opportunity to learn and participate in patient care in an environment that provides an appropriate level of supervision, customized to the needs of the patient care context and the level and ability of the individual resident.

The intent is to create a context for implementation of specialty-based educational programs that makes possible the achievement of excellence in both patient care and education. This requires some degree of flexibility, in recognition of the complexity and diversity of the clinical care environments where education is provided, differences in context and content for the various clinical specialties, the need to promote learners' professional development, and consideration for the well-being of all physicians.

Residency training is based on an experiential model of education, supplemented by didactics and simulation, with appropriate levels of supervision when residents provide care to patients. Just as drivers learn to drive under supervision in real life, on the road, residents must prepare in real patient care settings for the situations they will encounter after graduation. Residents must develop the skills and the confidence to manage challenging situations, under supervision, and must learn to care for patients over extended hours, and during night-time hours, because these are circumstances they will encounter after graduation. There are real differences in how individuals function with different amounts of sleep,[2] and under stressful or emotion-laden circumstances. Residents must have these experiences in training to be able to assess their personal limits and expand their capacity to support others in challenging circumstances, under the guidance of more senior clinicians, and to learn how to evaluate their own performance and ability to care for patients. Residents must also learn to be reflective and committed to continuous improvement of the care they provide throughout their careers. Thus, the ACGME is placing greater emphasis on systems of, and experiences in, team care, patient safety, quality of care, and physician well-being. The requirements are intended to support programs, residents, and faculty members as they strive for excellence in clinical care, while simultaneously ensuring ethical, humane residency education.

Patient Safety and Quality Improvement

The proposed requirements define the need for a culture and clinical learning environment focused on resident education and faculty development in patient safety and quality improvement. Specific expectations regarding analysis of the

quality of care being rendered by residents and faculty members have been added, including expectations that residents evaluate the specialty-specific quality metrics and benchmark data related to their patients.

Residents and faculty members must consistently work in a well-coordinated team, using shared methodologies to achieve institutional patient safety goals, such as consistent reporting and disclosure of adverse events and unsafe conditions. Residents must learn both to identify the causes of patient safety events, and to work in interprofessional teams to institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

Supervision is an essential dimension of graduate medical education in ensuring the provision of safe and effective patient care, as well as effective teaching and learning. Appropriate supervision ensures each resident's development in the skills, knowledge, and attitudes essential to enter unsupervised practice. Revisions to the supervision requirements emphasize the expectation that an individual resident's level of training and ability, as well as the patient's complexity and acuity, must factor into decisions regarding supervision. This ensures that supervision is appropriate for each patient, and recognizes the need for customization of supervision as residents grow in ability and experience.

Resident and Faculty Well-Being

New requirements for resident and faculty member well-being address the emerging evidence that physicians are at increased risk for burnout, and perhaps depression. Burnout and depression impair a physician's ability to provide excellent care. Self-care is an important aspect of professionalism, and a skill that must be learned and nurtured under the guidance and role modeling of faculty members. It is essential that faculty members role model, and that residents learn, the importance of well-being in the context of a supportive culture with resources that promote well-being. Programs have the same responsibility to address well-being as they do to ensure and monitor other aspects of resident competence.

Promotion of meaning in residents' work provides an opportunity to improve resident education and quality of care. PGY-1 and PGY-2 residents have the least experience managing the demands of caring for patients and making decisions about when it is appropriate to utilize flexibility. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that the direct patient load assigned is manageable, residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

Clinical Experience and Education Hours

The terms "clinical experience and education," "clinical and educational work," and "work hours" have replaced the terms "duty hours," "duty periods," and "duty" in the proposed revisions to emphasize that residents' responsibility to the safe care of their patients supersedes any duty to the clock or schedule.

The revised requirements do preserve core elements from the 2003 and 2011 ACGME Requirements, including a weekly limit of 80 hours, averaged over a four-week period, a 24-hour limit on continuous assigned clinical and educational work, the requirement that residents receive one day in seven free of all duties, and that in-house call be scheduled no more frequently than every third night. Of note, other accreditors, namely the American Osteopathic Association, have adhered to the 2003 requirements, and New York State has consistently used 80 hours as the limit for all residents.

Across a range of studies, an 80-hour limit on weekly duty hours has been shown to balance the multiple competing considerations in the learning environment.[3] These include the primacy of safety and quality of patient care, resident learning, resident safety, well-being, and a balance of professional and personal pursuits. There has also been a dramatic culture change within the profession. In the 1980s, 1990s, and early 2000s, many members of the profession opposed limits on resident hours. In 2016, everyone who provided testimony to the Task Force or submitted written position papers supported the weekly 80-hour limit, with only two specialties requesting an option for rotation-specific waivers to allow a 10% increase issued by the Review Committee. Similarly, there was uniform support for one day in seven free of duty when averaged over a four-week period, and for in-house call no more frequent than every third night. This suggested to the Task Force that a consensus exists within the organizations of the profession that these requirements should be sustained, and that in circumstances where programs violate these requirements, action by the applicable Review Committee should be significant.

After careful consideration of the published literature,[3-18] the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the existing requirement limiting PGY-1 residents to 16 hours of consecutive time on-task. It is important to note that the absence of a common 16-hour limit does not imply that programs may no longer configure their clinical schedules in 16-hour increments if that is the preferred option for a given setting or clinical context. No action is required by programs that choose to continue this configuration. Furthermore, the language permits individual specialty Review Committees to modify the Common Program Requirements to make them more restrictive. As in the past, it is expected that emergency medicine, anesthesiology, and internal medicine will make individual requirements more restrictive. Currently, emergency medicine and anesthesiology have more restrictive “time on-task” requirements, and internal medicine does not permit averaging of the frequency of overnight call.

The proposed requirements include a limit on consecutive time on-task of 24 hours, plus four hours to manage transitions in care (this is unchanged from the 2011 iteration). Residents, in unusual circumstances and of their own accord, after signing out the care of their patients, may remain to care for a single patient, and the prior onerous documentation burden for this activity was removed. This promotes professionalism, empathy, and commitment. In unusual circumstances, and by their own choosing, residents may remain after signing out the care of their patients for an educational or research purpose. This time must count in calculation of compliance with the 80-hour weekly limit.

It is important to note that studies show that in any 24-hour/seven-day industry, under almost any model of work hour scheduling, including a completely "shift-based" approach, some individuals must work at their circadian nadir, with associated consequences for their performance and well-being. There is an emerging science on how to use scheduling patterns to mitigate this decrement, but it is not possible to completely eliminate it.

The goal of high-quality, safe patient care is achieved in the proposed requirements by a focus on training residents to develop a sense of professionalism, rather than by imposing unnecessarily restrictive rules. This is achieved by encouraging resident decision-making based on patient needs and their own well-being, rather than out of fear they may jeopardize their program's accreditation status.

The proposed requirements emphasize the role of residency programs and their Sponsoring Institutions in designing programs that enable residents to gain requisite educational and clinical experience and professional development, while allowing reasonable opportunities for rest and personal activities. The requirements establish the baseline priority for institutions and programs to provide residents with a consistent opportunity to experience interdisciplinary, team-based approaches to patient care, safety, physician well-being, and education. The ACGME will continue to foster work in domains contained in the Common Program Requirements, and to rely on the creativity and commitment to excellence of the broad graduate medical education community.

I would like to personally, and on behalf of the profession, thank the members of the Task Force for their time, energy, experience, and wisdom. This truly is the selfless work of diverse, dedicated individuals committed to service of the American Public.

I am confident that by working together we will continue to evolve graduate medical education to anticipate public need. Revising the Common Program Requirements is an important step. We appreciate your positive feedback and constructive comments as we continue this journey into the future.

Sincerely,

Thomas J. Nasca, MD, MACP
Chief Executive Officer
Accreditation Council for Graduate Medical Education
ACGME International

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