I am Sunny Yoder, Director of Health Care Affairs and executive secretary of the Group on Resident Affairs of the Association of American Medical Colleges. I have no conflicts of interest to disclose. My remarks are drawn directly from our letter (Tab 35), which was approved by the AAMC board.

In the matter of resident duty hours, first and foremost the AAMC believes that great caution is in order. The evidence to support any change from the current standards is weak at best. Beyond that, 1) the cost of further duty hour limitations is great, 2) resources are limited, and 3) the impact on learning and continuity of patient care are of concern.

The AAMC has supported an 80 hour limit on residents’ weekly hours since 1988 and continues to do so. However, with very little solid evidence linking resident schedules to patient care outcomes, we believe that resident duty hours and schedules ultimately are not the central issue. Focusing on duty schedules may even distract academic medicine and divert resources from more important issues.

We believe that if four central issues, all noted in the IOM report, are effectively addressed, the need to regulate resident duty schedules can and should lessen or disappear. If these more central issues are addressed, the need to regulate resident duty schedules can and should lessen or disappear:

1 Detection and management of fatigue
Management of fatigue should be a matter of professional responsibility, both for the individual resident physician and for the patient care team.
- Individual tolerances for sleep deprivation and long hours on duty vary greatly
- While some studies may show a relationship between sleep deprivation and performance on cognitive or motor tasks, there is little or no evidence of any relationship to errors in patient care or adverse patient outcomes
- Research efforts should be directed toward improving ways to assess and manage fatigue for all members of the health care team.
- Systems need to prevent and mitigate the effects of human errors, whether they are attributable to fatigue or to other causes
• As professionals, residents are obligated to report for duty rested and ready to take care of patients, and to learn; consistent with this position, resident moonlighting should be included in the 80 hour limit.

2 Quality of resident supervision
Resident supervision should be enhanced, with measurable standards established by individual review committees. The standards should go beyond defining geographic proximity of faculty to patients or residents, e.g.
• guidelines about when a resident should consult with the attending physician or a more senior resident in person, by phone, or through electronic communication
• guidelines about when attending/supervising physicians should “check-in” with residents on duty rather than waiting to be contacted for guidance
• guidelines that first year residents not be on duty without on-site supervision
Whatever the standards, faculty skills in supervision should be assured and improved as needed through faculty development.

3 Patient handovers.
Handovers should include a robust exchange of information about patient management. Specific handover processes should be developed at each institution, with necessary variations to fit the care provided by the different specialties.
As best practices,
• Handovers should be learning opportunities for residents
• Handovers should be a means for improving care to the patient
• Handovers should be an opportunity to assess fatigue.
Resident schedules should provide for enough overlap between the outgoing and incoming clinician to support best practices in handovers

4 Resident Workloads
Duty schedules should be informed, but not determined, by clinical case loads. Resident workloads, especially in the first year, should be examined, and appropriate limits defined by individual review committees.
• The types and severity of cases should be taken into account
• Resident tasks that are of limited or no educational value should be minimized or eliminated
• The educational value of all resident tasks should be maximized.

As the ACGME considers whether to modify its requirements, it needs to take special note of two issues: 1) significant gaps in the evidence base and 2) the resources that change would require.

1) The knowledge gap
Major research efforts are necessary to close the knowledge gap.
• Any changes in the 2003 standards should be based on reliable evidence about the relationship between resident schedules and patient outcomes. Current evidence at best is weak.
• Research also is needed on educational outcomes, including residents’ preparedness for independent practice.
• Research is needed on methods to assess and mitigate the effects of fatigue if any.

If new standards are put in place, independent evaluation studies should be carried out so that, five years from now, a better body of evidence will be available on the relationship between resident schedules and duty environments and both patient care and educational outcomes.

2) Resources to support change
Additional resources would be required to shift non-educational responsibilities from residents to others, and/or to expand the pool of residents in training. These costs should not fall solely on teaching hospitals, which are already bearing the majority of costs of the 2003 reforms, but should be borne by health care payers. Absent external support for these change, sponsoring institutions’ educational effectiveness and financial health will be in jeopardy.

We appreciate the opportunity to share our perspective on these critical issues. The AAMC looks forward to working with the ACGME and the academic medical community to review the existing standards, consider the need for new standards, and define a research agenda that will provide better guidance for future action than is available currently. We are committed to helping develop and disseminate best practices in supervision—especially faculty development—and in communication during transfers of patient responsibility. The Group on Resident Affairs will address these topics at the AAMC Annual Meeting in November.