Excerpts from American Osteopathic Association Testimony
on the ACGME Section VI of the Common Program Requirements
March 16, 2016

Looking back over the past 30 years, the resident learning environment has evolved considerably. The residency environment has matured as a result of regulatory and accreditation requirements. GME accreditation authorities, both MD and DO, responded to patient safety concerns by implementing policies to appropriately constrain and restructure the learning environment including:

- Limiting duty hours,
- Clarifying supervision responsibilities,
- Elucidating goals and minimizing errors in transitions of care,
- Protecting fatigued residents from harming themselves or others as they drove home exhausted,
- Codifying the privilege of progressive authority, and
- Integrating the larger concept of patient safety into graduate training.

…to name a few. Much has been accomplished and it is expected that the learning environment will continue to evolve as we learn from the CLER visits and the goal of integrating GME into the fabric of quality initiatives at each training institution.

While patient safety is paramount, we must also be sensitive to ensure that accreditation requirements do not harm the learning environment. We do not want to produce physicians who are really incapable of independent practice. This would not serve the patient either. So the question is, are today's residents being too restricted in their exposure and experience to progress into independent practice? As you are aware, the meta-analysis by Bolster and Rourke in the September 2015 JGME, reviewed 27 studies on resident duty hours from 2010 and 2013 with half

showing no impact on patient care and 47% with no impact on resident well-being. So the real question is, Do residents benefit from the level of restriction imposed by the current requirements, especially in light of all the other controls that have been put in place?

The AOA believes that there should be some consideration in changing duty hours because autonomy and responsibility, in most training programs, is progressive from training year to training year. And there are better controls on the other dimensions of residency training that we could allow a little more flexibility in duty hours. We believe that, with the other learning environment requirements, with the implementation of the Next Accreditation System and with the implementation of Milestones, a first year resident is less likely to commit patient safety errors. The AOA offers several suggestions for consideration. First, the AOA supports the 80-hour work week, averaged over four weeks. Gone are the days of surgical residents doing 120 hours week in and week out. Second, PGY-1 residents should be limited to a 24-hour shift plus one additional hour for continuity activities, and all other resident levels are permitted a six-hour window following their 24-hour shift. We believe this would enhance the learning experience without jeopardizing patient safety because, with all the oversight and requirements, first year residents today do not have the same autonomy and responsibility that they had thirty years ago. Third, we would offer consideration that procedural based specialties should have differing duty hour requirements than other specialties. To do this, the Task Force should consider removing duty hours from the Common Program requirement and placing them in the individual specialty requirements after consideration of both the benefit to the patient and to the resident's education and training. The ACGME Board of Directors plays an important oversight role in the appropriate of training requirements and so the review committees are not without oversight. Fourth, we would suggest consideration that duty hour requirements be less restrictive as residents advance through training.

This would be in line with progressive education as the resident grows from student to independent practice.

Thank you for this opportunity to present this information.