This document was prepared in July/August 2010 by the APPD Board of Directors with input from the membership of the APPD. The membership has actively participated by sharing views and comments via conference calls and web-based discussion boards over the last 30 days. The APPD is an organization consisting of over 2,700 pediatric educators within 203 accredited pediatric training programs. These educators include pediatric subspecialty fellowship directors, associate program directors, medical school department chairs, program directors and coordinators, and other educators. The APPD is a member of the Federation of Pediatric Organizations (FOPO). The APPD wishes to offer this document as a consensus statement from our membership.

Executive summary:

The APPD Leadership and members have given significant thought to the IOM Committee’s recommendations and to the recent ACGME’s proposed changes to the “Common Program Requirements” written by the ACGME Duty Hours Task Force. Our organization appreciates the ACGME’s receptiveness to our input over the last 18 months, including the opportunity to testify before the Task Force over the last 18 months. Understanding the challenges facing the ACGME Task Force in formulating the proposed changes to the requirements, we appreciate the thoughtful process utilized in developing the proposed standards. APPD members wholeheartedly concur with most aspects of the ACGME proposed changes to the Common Program Requirements document, which clearly aims to improve supervision, enhance professional formation with an emphasis on personal responsibility, and to assure patient safety. We are, however, highly concerned with the planned timeline. The ACGME’s proposed requirements call for changes that will clearly require longer than 9 months to implement safely; serious negative consequences to both education and patient safety will occur without proper planning and resources.

While we agree with the majority of the ACGME’s proposed changes, the APPD will outline in this document a number of points that we strongly believe must be re-written, modified or not implemented at all. The APPD supports the thorough study and analysis of any changes that will be made, as there is little evidence to support any improvement in resident education, trainee work-life balance and/or patient safety after the 2003 requirements were implemented. We would like to emphasize the fact that many of the new requirements could not be implemented
without sufficient funding, resources and workforce requirements. The changes proposed are significant and will result in unprecedented large and complex alteration of patient care processes. Patient safety evidence supports that elective changes of this magnitude should not be done without careful, site-specific piloting, analysis and follow-up with reflection and appropriate modifications to those changes in a Plan-Do-Study-Act fashion.

As outlined in this document, the APPD has strong consensus about four areas of concern. The APPD has confidence that the ACGME will thoughtfully consider these points. However, the APPD will acknowledge the areas in the proposed changes that we agree with.

**Areas of Agreement:**

The APPD understands the complex and multi-factorial pressures on the ACGME to modify the current work hours based on the IOM report. In general, the sections on professionalism, patient safety, transitions of care, and personal responsibility demonstrate thoughtful deliberations and reinforce the essential core components of graduate medical education and patient care.

Much of the APPD’s response to the ACGME regarding the IOM Report, Resident Duty Hours: Enhancing sleep, supervision and safety \(^1\) is reflected in the ACGME Task Force on Quality Care and Professionalism\(^2\) proposed changes. The APPD appreciates the thoughtfulness regarding levels of supervision, ability to be flexible with number of days of consecutive night float and the minimum time off between scheduled duty sessions; the APPD requested these proposed elements as part of the ability to provide continuous care and sustained educational quality. Generally, our membership was in agreement with most of the proposed changes.

**Areas of Concern-SUMMARY:**

There are several of the ACGME proposed changes, described in detail below, that are of concern to the APPD membership. These are issues which pose a significant risk to patient safety, educational outcomes or workforce issues. We respectfully submit our reasons for disagreement and propose possible alternatives.

1. The APPD strongly disagrees with the requirements limiting the intern shift to 16 hours. The intern 16 hour limit (VI.G.4.a) should be modified to a 16+4 hour Rule to allow transition of care and time for education.
2. The short timeline for implementation is unrealistic. Delay full implementation until 2012; utilize quality improvement science to improve patient care and education during the 2011-2012 academic year. Require institutions to fund any pilot studies to develop evidence regarding work hours for quality care and education.

3. The APPD feels strongly that subspecialty fellows are implicitly different from pediatric residents. Clarify the research requirements in terms of duty hours for subspecialty program directors and fellows.

4. The loss of occasional averaging to every third night is detrimental for the work-life balance of our residents and fellows. Preserve averaging of q3 call for PGY2 and above residents and fellows to allow flexibility in scheduling.

Area of Concern-DETAILS:

1. The APPD strongly disagrees with the requirements limiting the intern shift to 16 hours. The basis of this recommendation is grounded in limited data where the degree of validity evidence is in question. This data has not been reproduced in other settings. Limiting shifts to 16 hours will not allow for appropriate time for reflective learning, follow-up of patients and hand-over of care, or attendance at team rounds. The 16 hour limitation will result in fractionation of patient care, increased risks to patient safety and decreased educational success. We strongly believe that mandatory shift work for the interns will impede their development towards becoming competent supervisory residents by the beginning of their PL-2 year. Pediatric education has made great strides in competency based education over the last 10 years, but not in quality of education of residents on night-only shifts. We have appreciated the significance and importance of reflective learning. We strongly believe in the overarching importance and pressing need for time for reflective learning, interaction with supervisors/teachers and meaningful interaction with patients. This principle, as a touchstone for training (pediatrics specifically and graduate medical education in general) and professional formation, cannot be ignored. The APPD membership is open to considering the study of alternative methods of producing supervisory and competent pediatric residents and graduates; at this time we do not have evidence that the development of a pediatric resident can be successfully achieved without this continuity. Likewise, there is no evidence regarding the safety of multiple handovers without team rounding.

The APPD proposes that the intern duty hour limit be extended an additional 4 hours for the purpose of participating on rounds. Patient care rounds offer the opportunity to participate in
and contribute to a detailed handover, learn from others, and communicate with care team members and family members; assuring a smooth transition in care without errors. With four additional hours, programs could create schedules that would allow interns to work from 4 or 5 p.m. until the next a.m. and continue to participate in rounds as a learner. Interns could be present to observe faculty-patient interactions, expert management of parental concerns and fears, bringing them increased exposure to the myriad of skills required for learning the “art” of medicine. Interns would be able to learn from and take responsibility for patients that they admit overnight through communication with team members. Most program directors in Pediatrics agree that the experience of being on a night team in the hospital and then following the newly admitted patient’s clinical course the next morning is important. Further, while there is no evidence to support the above practice, there is no evidence to support that an intern learning, yet not writing orders, nor involved in direct patient care, for four more hours is an unsafe practice. As pediatric patients generally have a short length of stay, being present as a disease process rapidly evolves and resolves is crucial. Limiting time for learning to a 16 hour shift will undoubtedly have a significant negative impact on intern education in pediatrics.

The APPD fears the unforeseen consequences of the 16 hour rule which may include: a decrease in personal responsibility, less direct time with patient care resulting in a slower progression to competency, the need for additional training and therefore funding for that training, dissatisfaction with shift work and a worsened family life balance. The APPD membership is gravely concerned about the marked increase in patient handovers that will occur with this 16 hour intern rule. The requirements emphasize limiting handovers, yet the intern required shift work will clearly result in an increase.

The proposed standards will require an increased number of staff in order to safely provide patient care. While some programs may be able financially to hire new staff to cover the 25% reduction in intern service coverage, it is not clear that there are available providers in the workforce that could be hired and trained to replace the already well-functioning intern-resident-attending physician teams. Redesign of healthcare delivery teams needs to be approached very carefully and is well documented as a source of risk to patient care. Pediatric Residency Program Directors are very familiar with the delicate nature of the operations of healthcare teams, and recognize the importance of careful piloting and studying any healthcare team changes. The reality of the significant financial impact institutions throughout the country will bear must be considered. There may be substantial unforeseen consequences to rural and small programs given their hiring abilities and locale. Careful study and projection of cost should be clear prior to defining a timeline for implementation (see concern #2).
Given all of these concerns voiced from our membership regarding education, intern work-life balance, patient care and funding, we propose that:

**APPD Recommendation #1:**

The intern 16 hour limit (VI.G.4.a) should be modified to a 16+4 hour Rule. The 4 hours would not allow patient-care activities but rather would reinforce handover safety, improve continuity of patient care and allow for educational opportunities.

a. The APPD proposes that interns be allowed to remain for 4 additional hours after 16 continuous clinical hours in order to continue their education. During these 4 additional hours, activities would be limited to: educational rounds with an attending, didactic conferences, and further transfer of care communications. During the “+4 hour time” PL-1s would not be allowed to enter orders nor be responsible for medical decision-making. This would allow interns the opportunity to learn on rounds, ask questions, reflect and interact with more senior resident role models and remain on the team as a regular member rather than floating in for sporadic care.

b. The additional four hours will not solve issues of funding for additional personnel or other concerns about hiring and piloting timelines (see Concern#2).

c. The APPD firmly believes that this concept of 16 plus 4 hours for interns will promote high quality learning and safe care as sought after by the ACGME and the public in their process of regulating and limiting work hours.\(^{12}\) We strongly believe that this modification is consistent with the philosophical spirit of the IOM report.

2. **The short timeline for implementation is unrealistic.** The APPD is very concerned that the challenges in adjusting to these changes may limit potential gains to patient safety and resident professional formation. The IOM Report stated that “Without the necessary restructuring in resource allocation, attempts to implement the recommendations will fail to have desired benefits and could even reduce patient safety.”\(^1\)\(^{296}\) The economic impact on institutions (medical schools and children’s hospitals) has not been studied. The ACGME is commissioning an outside agency to perform an “economic impact assessment”,\(^13\) however that report will be completed after institutions will need to start the process of recruitment of additional personnel to fill the estimated 25% reduction in Intern service. Realistically, the process to hire
will require greater than one year, from start to finish. Additionally, in order to budget for these changes, the community should have the benefit of the ACGME’s appraisal of the economic assessment report. Hospital administrators should also be allowed the time to write the budgetary changes into fiscal year planning.

As mentioned above, small programs and rural programs may have greater difficulty in hiring and retaining the additional work force. Our membership is highly concerned that, even in large programs in large cities, the population of ancillary personnel and practitioners that will be needed does not fully exist.

The ACGME should consider studying the implementation at the programmatic level. Studies could include data on handover errors, patient satisfaction, length of stay, readmission rates, medication errors, safety events reported (all degrees, not just those causing harm), resident perception of educational experience, resident performance in each of the core competencies, the number of patients and degree of patient care continuity experienced by individual resident. These projects could occur on a voluntary basis through programs that choose to delay implementation until 2012. These programs would be expected to apply quality improvement science to improve patient care and education during the 2011-2012 academic year. Programs would document patient care and educational outcomes with such an approach; evidence based institutional adjustments could be made based on these pilot studies. Unintended consequences of the changes in duty hours such as the increased fractionation of patient care, loss of patient care resources and additional handovers could be recognized through such study and subsequently mitigated. Detailed reports of these studies would inform the ACGME and the public about the relative risk of hours worked vs. continuity and reduced patient care handovers. There is significant risk that those unintended consequences may affect patient safety to a greater degree than the potential risk of working more than 16 hours with appropriate supervision. This information would benefit the patients, medical education community and the ACGME; allowing for evidenced based policy changes in the future.

Given the many unknown factors, budgetary issues and the potential for unintended risks to patient safety, the APPD favors a more realistic approach to implementation, that allows for both flexibility amongst institutions and programs, while providing accurate information on the state of the changes and the outcomes.
APPD Recommendation #2:

Change the proposed implementation date from July 2011 to July 2012. Allow programs the following option during the 2011-2012 transitional academic year. Programs can select to either:

1) provide their respective RCs with quality improvement information and documentation regarding their step wise implementation of the new requirements and their response to unforeseen consequences. This process information could be included in the already required program improvement plan or

2) collect data regarding agreed upon standards which might include: handover errors, patient satisfaction surveys, LOS, readmission rates, medication errors, safety events reported (all degrees, not just those causing harm), resident perception of educational experience, number of patients and degree of patient care continuity experienced per resident. Require institutions to provide resources and financial support for these pilot studies. Further, medical schools and institutions could utilize an organized and integrated approach to these studies amongst various local subspecialties.

This process would allow:

a. Programs to safely implement changes necessitated by the new Common Program Requirements.

b. The community to deal with unintended outcomes and identify strategies to remedy unforeseen and negative outcomes.

c. Health systems, institutions, and programs the ability to realistically address the issues of hiring additional staff in a more informed, deliberate manner.

3. The APPD feels strongly that subspecialty fellows are implicitly different from pediatric residents. We submit that pediatric fellows are more akin to junior faculty. They must learn to balance their time, work, and family life; making choices that allow them to be comfortable with this balance. There must be some flexibility with the manner in which an individual fellow deals with time management for their research, clinical time and productivity in scholarship. It may be that a fellow feels strongly about checking in on their lab each day of the week, which would violate the “one day off in seven” rule. With more flexibility in regard to the research and
non-patient care aspects of fellowship training Fellows could “practice” for their careers as clinician scientists. We recommend allowing each RC the flexibility to decide how to report and cite for what seems unreasonable demands on fellows clinical time.

**APPD Recommendation #3:**

Do not hold the Pediatric Subspecialty Fellows to the same standards as proposed for residents in the common program requirements. In particular, clarify the research requirements regarding duty hour for subspecialty program directors. Allow Fellows the ability to make reasonable decisions in regard to their research work, particularly when it has no interaction or effect on patient care.

a. Fellows should have a minimum of 8 hours free of required clinical duties prior to the beginning of a 24+4 hour clinical shift.

b. Research activities and other non-clinical activities that follow a clinical shift can be indefinite, but reasonable in length. The length of these activities is to be regulated by the fellow and is a critical part of the maturation of a physician scientist (subspecialist).

c. Each RC will mandate how the above must be reported and what are grounds for citation.

4. The loss of occasional averaging to every third night is detrimental for the work-life balance of our residents and fellows. This concern was adamantly and consistently voiced on all of the APPD calls. Program directors, who know their learners well and talk with them regularly, were very concerned at the potential outcome of this new rule (VI.G.7). This will have serious negative impact on work-life balance, as well as resident and fellow morale. This requirement will force trainees to miss major life and family events, further isolating them from their support systems. Program directors typically schedule residents and fellows every fourth night, however, trainees’ and their peers switch call to allow for longer stretches off, or for flexibility in light of personal reasons. Fellows, in particular, want to have the flexibility to move calls and average to every third night call for personal and life related reasons. Both residents and fellows will likely no longer be able to travel to educational conferences if call averaging is not allowed. We heard time and again that residents and fellows would dislike this new rule and perceive it as a way to limit their free time.
APPD Recommendation #4:

Maintain the in hospital on-call frequency as it has been, that call must be no more frequent than every third night “on average”. This rule would not pertain to PL-1s with the intern requirements (which we advocate for a 16 plus 4 rule). There is no evidence to support this change and it will have negative unintended consequences for trainees’ work-life balance and their perception of training flexibility.

In summary

The Association of Pediatric Program Directors (APPD) agrees with many of the proposed changes to the common program requirements, however, there are some we cannot agree with, as outlined above. The areas we disagree with and most adamantly oppose have the potential to destabilize safe patient care. We appreciate the ACGME’s responsiveness to our past concerns and expect similar receptiveness and dialogue regarding this iteration of the requirements. We appreciate the Task Force’s efforts, time and thoughtful explanations. Likewise, we applaud the leadership and guidance of Dr. Nasca in these times of great change and innovative advances in Graduate Medical Education. The pediatric program directors throughout the country are a group committed to developing the best pediatricians in a system that provides exemplary care to children. In many cases, the children’s hospitals and institutions that sponsor pediatric training provide care for complex, chronically ill children who are unable to receive care in non-teaching hospital settings. The delicate and balanced patient care delivery operations in our academic training centers is one that all pediatric program directors appreciate. We implore the ACGME to measure, analyze and evaluate outcomes of proposed changes. It is absolutely necessary to provide the community with evidence based recommendations about how to conduct graduate medical education programs in productive, safe and effective ways.

References:


