Duty Hours and Documentation

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Professor of Surgery
Disclosures

• None
History

• Patient goes to ED with fevers & chills
• Intern prescribes Demerol
• Patient combative
• Later patient restrained
Libby Zion Law

High Quality Content by WIKIPEDIA articles! New York State Department of Health Code, Section 405, also known as the Libby Zion law, is a regulation that limits the amount of residents physicians work in New York State hospitals to roughly 80 hours per week. The law was named after Libby Zion who died at the age of 18 under the care of overworked resident physicians and intern physicians. In July 2003 the Accreditation Council for Graduate Medical Education adopted similar regulations for all accredited medical training institutions in the United States. Although regulatory and civil proceedings found conflicting evidence about Zion's death, today her death is widely believed to have been caused by serotonin syndrome from the drug interaction between the phenelzine she was taking prior to her hospital visit, and the meperidine administered by a resident physician. The lawsuits and regulatory investigations following her death, and their implications for working conditions and supervision of interns and residents were highly publicized in both lay media and medical journals.

Libby Zion Law

Frederic P. Miller, Agnes F. Vandome, John McBrewster (Ed.)

Libby Zion Law
Residency (medicine), Accreditation Council for Graduate Medical Education, Serotonin syndrome, Pethidine, Phenelzine, Drug interaction
ACGME

• **2003:** Duty hour restrictions – 80 hours

• **2011:** More restrictions:
  – Minimum time off (10 or 8 hour rule)
  – Shorten length of shift
  – Intern supervision

• **David Leach, M.D.**
ACGME rules

• 80 hours per week (max 88)
• Moonlighting not permitted for PGY-1
• One day free per week
• PGY-1: no more than 16 hours on duty
• PGY-2: up to 24 hours
• Mandatory naps
• At least 8 hours between shifts
ACGME rules

• **Nightfloat:**
  – no more than 2 successive months
  – no more than 4 months per year
  – Max duration: 8 months for 2-year fellow or 15 months for 5-year residency

• **On call:**
  – No more than every third night
  – Reasonable home call to allow free time
Duty Hour Documentation

- Residents are responsible for log
- PD responsible for monitoring
- Duty hour violations reported to GMEC
- Habitual violations not tolerated (examples made of well-known programs)
- Effect of moonlighting
Duty Hour Violations

• It is understood that exceeding hours can *and* will occur from time to time
• Most common violation: not enough rest between shifts
• Some specialties given more latitude?
Resistance to Rules

• No evidence that the 80-hour week improved care or outcomes
• Duty hours created a new problem: hand-offs
• Many surgeons voiced concerns about duty hour problems:
  – Lack of ownership/continuity
  – Shift mentality
Early impact of the 2011 ACGME duty hour regulations on surgical outcomes

Christopher P. Scally, MD, Andrew M. Ryan, PhD, Jyothi R. Thumma, MPH, Paul G. Gauger, MD, and Justin B. Dimick, MD, MPH, Ann Arbor, MI

Background. In 2011, the Accreditation Council for Graduate Medical Education (ACGME) implemented additional restrictions on resident work hours. Although the impact of these restrictions on the education of surgical trainees has been examined, the effect on patient safety remains poorly understood.

Methods. We used national Medicare Claims data for patients undergoing general (n = 1,223,815) and vascular (n = 475,262) surgery procedures in the 3 years preceding the duty hour changes (January, 2009–June, 2011) and the 18 months thereafter (July, 2011–December, 2012). Hospitals were stratified into quintiles by teaching intensity using a resident to bed ratio. We utilized a difference-in-differences analytic technique, using nonteaching hospitals as a control group, to compare risk-adjusted 30-day mortality, serious morbidity, readmission, and failure to rescue (FTR) rates before and after the duty hour changes.

Results. After duty hour reform, no changes were seen in the measured outcomes when comparing teaching with nonteaching hospitals. Even when stratifying by teaching intensity, there were no differences. For example, at the highest intensity teaching hospitals (resident/bed ratio of ≥0.6), mortality rates before and after the duty hour changes were 4.2% and 4.0%, compared with 4.7% and 4.4% for nonteaching hospitals (relative risk [RR], 0.98; 95% CI, 0.89–1.07). Similarly, serious complication (RR, 1.02; 95% CI, 0.98–1.06), FTR (RR, 0.95; 95% CI, 0.87–1.04), and readmission (odds ratio, 1.00; 95% CI, 0.96–1.03) rates were unchanged.

Conclusion. In Medicare beneficiaries undergoing surgery at teaching hospitals, outcomes have not improved since the 2011 ACGME duty hour regulations. (Surgery 2015;158:1453-61.)
National Cluster-Randomized Trial of Duty-Hour Flexibility in Surgical Training

Karl Y. Bilimoria, M.D., M.S.C.I., Jeanette W. Chung, Ph.D.,
Larry V. Hedges, Ph.D., Allison R. Dahlke, M.P.H., Remi Love, B.S.,
Mark E. Cohen, Ph.D., David B. Hoyt, M.D., Anthony D. Yang, M.D.,
John L. Tarpley, M.D., John D. Mellinger, M.D., David M. Mahvi, M.D.,
Rachel R. Kelz, M.D., M.S.C.E., Clifford Y. Ko, M.D., M.S.H.S.,
David D. Odell, M.D., M.M.Sc., Jonah J. Stulberg, M.D., Ph.D., M.P.H.,
and Frank R. Lewis, M.D.
<table>
<thead>
<tr>
<th>Requirement Category</th>
<th>Standard-Policy Group</th>
<th>Flexible-Policy Group</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Standard ACGME Policies</td>
<td>Adherent Programs†</td>
</tr>
<tr>
<td></td>
<td>no. (%)</td>
<td>Policies‡</td>
</tr>
<tr>
<td>Maximum shift length</td>
<td>PGY 1 (interns): Duty periods may not exceed 16 hr</td>
<td>59 (100)</td>
</tr>
<tr>
<td></td>
<td>PGY 2–5 (residents): Duty periods may not exceed 28 hr (24 hr plus 4 hr for transition)</td>
<td>59 (100)</td>
</tr>
<tr>
<td>Minimum time off between shifts</td>
<td>Residents must have ≥8 hr off between shifts but should have 10 hr off between shifts</td>
<td>59 (100)</td>
</tr>
<tr>
<td></td>
<td>Residents must have ≥14 hr off after 24 hr of continuous duty</td>
<td>57 (97)</td>
</tr>
<tr>
<td>Maximum work hr/wk</td>
<td>Residents must not work &gt;80 hr/wk, averaged over 4 wk§</td>
<td>—</td>
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<tr>
<td>Mandatory time free of duty</td>
<td>Residents must have 1 in every 7 days off from all educational and clinical duties, averaged over 4 wk§</td>
<td>—</td>
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<tr>
<td>Frequency of on-call duty</td>
<td>Residents must not be on call more frequently than every third night§</td>
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* ACGME denotes Accreditation Council for Graduate Medical Education, and PGY postgraduate year.
† Program adherence was defined by residency program directors regarding which policies were followed at their institution during the trial period (100% response rate).
‡ Residency programs assigned to the flexible-policy group were allowed to waive four ACGME duty-hour requirements concerning maximum shift length and minimum time off between shifts.
§ These ACGME duty-hour requirements remained the same in both study groups.
2016 Position Statements on Duty Hours and the Learning and Working Environment

At the end of December 2015, the ACGME formally requested position statements from its member organizations, constituent organizations, and others who have standing in the discussion on current ACGME resident duty hour requirements and standards governing key aspects of the learning and working environment, including impact analyses, recommendations, and supporting evidence. In his January 7, 2016 Letter to the Community, ACGME CEO Thomas J. Nasca, MD, MACP summarized this request in context of the phased review and revision process established for the Common Program Requirements. The statements received by the ACGME in response to this request are listed below.

Accreditation Council for Continuing Medical Education
Alliance of Independent Academic Medical Centers
Alliance for Academic Internal Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Emergency Medicine
American Academy of Family Physicians
American Academy of Neurology
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Pediatrics
American Association for Thoracic Surgery
American Association of Neurological Surgeons; American Board of Neurological Surgery;
Congress of Neurological Surgeons; and Society of Neurological Surgeons
Thomas J. Nasca, MD  
CEO, Accreditation Council for Graduate Medical Education  
515 N. State St, Suite 2000  
Chicago, IL 60654

Dear Dr. Nasca:

We are responding to your request for a formal position paper from the American Board of Surgery (ABS) in regard to the ACGME review of the accreditation requirements for resident duty hours and key dimensions of the learning and working environment. You specifically requested responses to the following points:

1. ABS position on the current ACGME resident duty hour requirements
2. ABS recommendations regarding dimensions of resident duty hours requirements
3. ABS recommendations regarding standards governing key aspects of the learning and working environment.

The opinions expressed herein were derived from four sources:

(A) The American Board of Surgery is composed of 36 directors who are actively practicing surgeons plus one public member who is a health policy analyst at George Washington University. Three of the practicing surgeons are at-large members who are chosen because of their practice in a rural non-academic environment. Slightly more than half are general surgeons, and the remainder are specialists in vascular surgery, pediatric surgery, surgical critical care, gastrointestinal surgery, and other general surgical subspecialties. These individuals typically have 2-3 decades of experience as surgical educators; most have been program directors, and the majority are currently division chiefs, department chairs, or medical school deans. These individuals have extensive direct contact with surgical residents on a daily basis, and are responsible for the operation of surgical residencies in all types of institutions. Their aggregate experiences are reflected in the discussions and decisions made by the ABS in regard to the requirements for certification in surgery and its subspecialties.
Resident Duty Hours
It is the ABS position that the three basic requirements:
(A) Duty hours limited to 80 hours per week,
(B) one day free of duty every week, and
(C) in-house call no more often than every third night
    (all of the above averaged over 4 weeks)
are appropriate and should be maintained for most surgical residents.
However, we feel the specific requirements regarding shift lengths and time off are overly rigid, are inappropriate in the context of the professional clinical responsibilities which are necessary for the care of critically ill hospitalized patients, and have contributed significantly to a reduction in the clinical experience of residents and the opportunities for a greater degree of independence and autonomy, particularly in the senior years of residency.
The specific requirements we feel are detrimental are:
(A) 16-hour Rule and 8-10 hour rest
(B) 24-hour shift limit and mandated rest between shifts
(C) Night-float limits to 6
### Violations

<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>Rule</th>
<th>Description</th>
<th>Comments</th>
<th>Duty Type</th>
<th>Log Date</th>
<th>Rotation</th>
</tr>
</thead>
</table>
| Beaulieu, Peter Andrew | PRG 3  | ACGME Short Break | Only 8 Hrs Off Between Jul 14 2015 8:00AM And Jul 14 2015 4:00PM. Should Have 10 Hrs. | Mary Fountain - (8/12/2015 1:27 PM)  
No violation. Resident had 8 hours off. | Rotation-BWH | 7/14/2015 4:00 PM | SURG:SCC:SICU-BWH |
SUMMARY

• Duty hours are here to stay
• FIRST Trial extension
• Violations: headaches for PD & programs
• Shift mentality should be discouraged
• Aim of training programs is to turn out responsible surgeons with good judgment