

Task Force Committee Response - Alertness Management/Fatigue Mitigation

Alertness Management/Fatigue Mitigation

The program must:

educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps and back-up call schedules.

Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

*The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

Rationale and response to comments:

The Task Force noted that the preponderance of the comments to these requirements, from both individuals as well as organizations, was positive. The committee reviewed the language used to clarify that both alertness management as well as fatigue mitigation are required. Alertness management implies preventative measures that can be taken by the physician to minimize fatigue. Fatigue management strategies are measures that can be taken during periods of duty to manage fatigue and minimize its impact on performance in care of patients.

Naps and back-up call schedules were intended as clarification examples, not specific requirements.

It is beyond the responsibility of the Task Force to determine whether the ACGME will develop national “tools” for programs to use for education in fatigue mitigation and alertness management. The ACGME has, in the past, accepted the use of the SAFER Program as fulfilling these requirements.

The question of transportation back to the facility after taxi transportation home post call was discussed. The Task Force felt that additional requirements would be excessively prescriptive, could not anticipate all the circumstances in the wide range of clinical and geographic educational settings, and recognized that provision of transportation home after call was one of a series of options available to programs. Residents could be permitted to sleep in the hospital until rested sufficiently to drive home. In this case, adequacy of sleeping rooms would be closely evaluated. The primacy of resident safety, no matter the tactics employed, cannot be overstated.

Finally, a “FAQ” could be developed to clarify satisfactory program and institutional responses to these requirements. The Task Force believes that based on implementation date, the FAQ should be developed based on observations in the field of best practices. This would best be accomplished through the subcommittee on requirements of the Council of Review Committees.

Task Force Committee Response - At-Home Call

At-Home Call

Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for 1 day in 7 free of duty, when averaged over 4 weeks.

*At-home call must not be so frequent or taxing to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”

Rationale and response to comments:

The Task Force noted that the comments were divided, with some supporting the standards as written, some asking for specific modifications to elements of home call (both strengthening elements of the standards, as well as removing elements of the standards), and some requesting either clarification for a unique circumstance in a particular specialty. Finally, some desired a specific definition of, “at home call must not be so frequent or taxing” to preclude rest or reasonable personal time for each resident.”

The Task Force, in assessing these comments, noted the following:

1. This standard, prior to modification, is unchanged over the current standard
2. Home call provides the more senior resident or fellow with the opportunity to experience the actual practice of medicine as it is conducted in the United States. Physicians must be available to their patients, cross cover patients of other physicians, and respond to patients’ needs from home in the practice setting.
3. There is no evidence that home call is cited excessively, especially concerning the frequent or taxing clarification
4. The use of home call differs widely based on specialty, level of training, and the unique dimensions of the specific training program
5. There is general agreement that any time spent in hospital must count towards the 80 hour limit
6. The structure of home call is that it is often not rotational on a daily basis, but may be organized around some other metric, such as weeks. Hence, the 3rd night call requirement should not apply, but the Task Force felt it necessary to reinforce that 1 day free in 7 when averaged over 4 weeks free of all duties applies in the home call situation
7. If nuances of home call require more specific oversight or guidance, individual review committees may make standards more stringent in the setting of home call

Task Force on Quality Care and Professionalism Response to Public Comments

Task Force Committee Response - Clinical Responsibilities

Clinical Responsibilities

The clinical responsibilities for each resident must be based on the PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

[Optimal Clinical Workload must be further examined by each Review Committee]

Rationale and response to comments:

Many of the comments to this requirement were general in nature, and not relevant to this specific standard.

The Task Force determined that the specifics of case load limits must be evaluated, and possibly be prescribed, by each review committee. At the present time, across all specialties, the Task Force did not accept the premise that limits on case loads could be rationally defined, nor were they required in every specialty. Indeed, in some specialties, assurance of adequacy of experience is the major concern (for instance, in Obstetrics and Gynecology). In others, excessive service is a concern (for instance, Internal Medicine, where case limits by level of training already exist).

This standard is an enabling standard, requiring each review committee to address the limits of the clinical responsibilities, especially in the PGY-1 year, that should be present in each discipline. While it does not require each review committee to set limits on resident case loads, it sets the expectation that each review committee examine and justify their position on the issue.

Task Force Committee Response - Duty Hour Exception

Duty Hour Exception

No Change was recommended for this program requirement

Rationale and response to comments:

The Task Force noted that there were supports and opposition to the 10% duty hour exception. Others asked for examples of educational rationale for duty hour exception to the 80 hour rule.

In discussing this topic, the committee took into account the following factors:

1. Extensive testimony to the duty hours Task Force in the National Duty Hours Congress (6/2009) that the exception, currently confined to a single specialty, was being monitored appropriately
2. Extensive testimony to the duty hours Task Force in the National Duty Hours Congress (6/2009) that the exception recognized the unique educational needs of that specialty
3. Extensive testimony to the duty hours Task Force in the National Duty Hours Congress (6/2009) that the ACGME must recognize differences in patient care delivery, and requirements of effective residency training, across the specialties (i.e., "One size does not fit all")
4. That the experience of the past 5 years indicates that the exception has not been abused, and has been of value in Neurosurgical residency training.

Task Force Committee Response - Mandatory Time Free of Duty

Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

Rationale and response to comments:

Comments on this standard varied from supportive of 1 day in 7 free of duty averaged over 4 weeks, through 1 day in every 7 free of duty, to the IOM recommendation of 1 day every 7, with one weekend free per month of duty. The Task Force determined that the program and residents should have the flexibility to average time free from duty over 4 weeks, and chose to maintain the standard as it was proposed, which is unchanged over the current (2003) standard. ACGME experience is that this standard is not violated with any significant frequency (resident survey data).

Task Force Committee Response - Maximum Hours of Work per Week

Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

The Task Force recommends this standard, unchanged.

Rationale and response to comments:

The comments ranged from explicit support from individuals, membership organizations, and review committees through individuals who differed with the standard in both directions. That is, some indicated that 80 hours of duty was excessive, and others that 80 hours of duty was inadequate preparation for independent practice. The Task Force judged that the current standard had resulted in a documented salutary reduction in the numbers of hours worked, improved satisfaction of residents, a small increase in sleep time of residents, and had not resulted in adverse outcomes for patients in large national studies. Furthermore, evidence exists that residents identify 76-82 hours as ideal from an experiential learning perspective (Baldwin, et al). The Task Force also noted that the IOM Committee supported the standard as written.

The Task Force specifically considered limiting resident time to 80 hour limits per week without averaging. The Task Force rejected this due to the excessive reduction in flexibility in scheduling that such a requirement would provide, in the absence of a compelling salutary trade off associated with not averaging.

Task Force Committee Response - Maximum Frequency of In-House Night Float

Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float. (The *maximum number of consecutive weeks of night float, and maximum number of months of night float per year* may be further specified by the Review Committee.)

Rationale and response to comments:

The Task Force reviewed the comments, that sorted into either shorter limits on night float duration of consecutive days (4) or longer (7). The former position was justified on the basis of non-shift of the circadian rhythm with a 4 day cycle, and the latter (7) permits adjustment in circadian rhythm, and permits ease of scheduling of nighttime coverage.

The Task Force judged that the standard remain as written (6 consecutive nights of night float maximum) for the following reason. The Task Force felt strongly that residents rotating on night float, especially for more than one week, must have 1 full day in 7 free of duty each 7 days, in order to prevent or remediate potential accumulated sleep deficit. The committee recognizes that it may present scheduling challenges in programs currently utilizing 7 day night float cycles, but believes that it is essential that no resident be asked to work a week of night duty without one full day free of duty.

The Task Force also felt strongly that each Review Committee examine the number of consecutive weeks of night float permitted, and the maximum number of months of night float per year permissible in their specialty.

Task Force Committee Response - Maximum In-House On-Call Frequency

Maximum In-House On-Call Frequency

*PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a 4 week period).

Rationale and response to comments:

The Task Force reviewed the comments, which were supportive of call schedules that occur no more frequently than every third night. However, the vast majority of the comments supported the existing (2003) standard, that permits residents and program directors to “average” every third night, when averaged over 4 weeks. This is due to the inflexibility that the inability to average induces, and results in the unintended consequences of inability to schedule full weekends off each month, especially in small programs where excess capacity to support resident call schedules does not exist.

After extensive discussion, the Task Force elected to return to the existing (2003) standard of the scheduling of in-house call no more frequently than every-third-night, when averaged over 4 weeks. The committee reminds the community that aggressive scheduling of very intense (alternate night call) for long stretches (1-2 weeks) followed by 2 weeks without call are considered unacceptable, and will be cited by review committees.

Task Force Committee Response

Maximum Duty Period Length

Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident must:

appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Rationale and response to comments:

The vast majority of comments received by the ACGME were in reference to this group of standards, and in particular the 16 hours of consecutive duty for PGY-1 residents. While the majority of comments concerning the 16 hours of consecutive duty for PGY-1 residents were negative, a minority of respondents, including many of the major medical organizations, were supportive of this change. The majority of the comments concerning the PGY-2 and above standards, and the flexibility for these house officers to remain with an acutely ill patient beyond the usual time limits were well-received and supported by most who commented. The exception to this statement is the subset of those who supported the 16 hour limits for PGY-1 residents, but felt that the 16 hour limit should be applied to all residents.

The Task Force re-considered the 16 hours for PGY-1 residents, and the standards for PGY-2's and above (including flexibility) and strongly reaffirmed these standards for the following reasons:

1. There are data from four, single-site, small studies in medical and general surgical PGY-1 residents that residents on a 16 hour versus a traditional schedule make fewer errors.
2. There are ACGME data that demonstrate that PGY-1 residents work the most hours of any cohort of residents
3. There is physiologic data that demonstrates a dip in performance of psychomotor vigilance tasks between 16 and 24 hours that is statistically significant. This data is of questionable

Task Force Committee Response

- clinical significance, especially in the context of medical decision making and the current medical model. This decline is likely to be substantially worse for some residents than for others, given the variability in severity of affect among study participants.
4. The Task Force believes that sleep physiologic observations are only one factor in the design of educational standards, rather than the organizing principles which should drive our residency educational paradigm.
 5. There was a consensus on the Task Force that the clinical care environment has become much more complex, and requires that novice residents be more clearly and directly supervised to promote both patient safety and resident learning, and that supervision is likely the more important factor in preventing errors.
 6. The training paradigm adopted by the Task Force is predicated on better preparation and supervision of the learning of the PGY-1, and progressive liberalization of the duty hour standards as the resident demonstrates the competency to be delegated greater degrees of conditional independence in the care of patients
 7. These standards occur in the context of an expansion of the dimensions of expectations for residents and faculty concerning alertness management, fatigue mitigation, professionalism, enhanced specificity of supervision, and an explicit declaration that residents must be prepared to enter the unsupervised practice of medicine at the end of residency.

The Task Force clarifies that the additional four hours is sufficient for transitions in care to be provided. As one resident noted in the comments, their program did not schedule the additional six hours after a 24 hour call for handovers, they scheduled 30 hour shifts. The Task Force is making clear that the four hours after 24 hours of consecutive duty is to be used for transitions in care. Furthermore, the Task Force reiterated that the additional four hours for transitions in care did **not** apply to PGY-1 residents. Similarly, the ability to remain beyond time to care for a single patient does **not** apply to PGY-1 residents. Were that to be permitted, a resident would potentially work 20-22 hours, and immediately begin their next 16 hour period of duty.

The Task Force notes that PGY-1 residents may be scheduled for up to 80 hours per week, averaged over four weeks. Their contact time with patients should not be diminished. Similarly, their time “away” from their patients is less than on their post call day in the current situation of 24+6 call. If designed properly, continuity, especially from the patients’ perspective, can be enhanced.

These standards do not preclude the PGY-1 from working at night, and gaining experience that will prepare them for the nighttime hospital environment and the problems encountered. They will be more alert during their first experiences with nighttime care of patients.

The Task Force noted with gratitude the letter from the American College of Surgeons, beginning the process of establishing specific competencies that residents would be expected to master prior to being granted the “right” to work for 24 consecutive hours. They propose a competency based promotion model prior to the completion of the PGY-1 year. The Task Force applauds this as a model to work towards, but in the absence of clearly established expectations, a standardized method to measure achievement, and faculty development programs to assure effective evaluation, this model awaits study and operationalization. The Task Force does, however, believe that this model should be considered in the next revision of the resident duty hours standards as a part of the move towards outcomes based resident education. The Task Force also suggests that this might well serve as a pilot proposal for study.

Task Force Committee Response

Finally, the Task Force considered this section of the duty hour standards as part of the broader context of creating an educational model that takes advanced beginners and molds them into experts at graduation.

Task Force Committee Response - Minimum Time Off between Scheduled Duty Periods

Minimum Time Off between Scheduled Duty Periods

PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

Residents in the final years of education (as defined by the RC) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This must occur within the context of the 80-hr, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have 8 hrs free of duty between scheduled duty periods, there may be circumstances (as defined by the RC) when these residents must stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of duty. Such circumstances must be monitored by the PD.

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

Rationale and response to comments:

The Task Force reviewed the extensive number of comments provided. The majority of individuals and organizations supported the attempts at enhanced flexibility and progressive liberalization of duty hour standards that permit the resident, as they mature in knowledge and experience, to approach those circumstances that will be encountered in the unsupervised practice of their particular specialty, while still in the supervised practice environment of residency training. It permits the testing of ability to function in more prolonged care settings, while placing the needs of their individual patients first.

There were few comments requesting increasing inflexibility or prolonging the periods off duty in these standards. The language of “should” versus “must” in many of the commentaries indicates a lack of understanding of the meaning in ACGME standards of these terms. The intention of the “should be 10 hours, and must be 8 hours” is the indication that, in the majority of settings, the resident should have 10 hours free of duty between duty periods. Under certain circumstances, to be clearly identified and justified during reviews by the respective Review Committee, residents may be permitted to provide care where less than 10 hours are scheduled free of duty, but they must have 8 hours free of duty. Similarly, during rotations where PGY-1 residents are scheduled for 16 hours of duty, they must have 8 hours free of duty. If they are scheduled for fewer hours (for instance, 12 hours of scheduled duty, with 2 hours for transitions in care – 14 hours total) the resident would have 10 hours free of duty.

Finally, the committee chose to modify the description of the expectations for time between scheduled duty periods to define the circumstances and expectations for senior residents. Each Review Committee will define “senior residents” and the circumstances under which those residents are permitted to have fewer than 8 hours between scheduled duty periods. It is the intent of the Task Force that this be clearly defined in each specialty, and that it largely target resident physicians who are providing needed care for

Task Force on Quality Care and Professionalism Response to Public Comments

their patients in a continuity fashion similar to that encountered in the actual practice of that specialty. While most clearly applicable in the senior surgical resident who has performed a procedure on a patient, it is also applicable to senior residents and fellows in other disciplines.

Task Force Committee Response - Moonlighting

Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

PGY-1 residents are not permitted to moonlight.

Rationale and response to comments:

The Task Force reviewed the comments, and concluded that the original language would remain unchanged. Concerns over the debt level of residents remains a disturbing issue. It is not, however, a reason for creating a loophole to hours of clinical work limits.

The Task Force responds to the concerns over scope of regulation by the definition of moonlighting in the ACGME Glossary.

Task Force Committee Response - Professionalism, Personal Responsibility, and Patient Safety

Professionalism, Personal Responsibility, and Patient Safety

Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

The program must be committed to and be responsible for promoting patient safety and resident well-being in a supportive educational environment.

The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

The learning objectives of the program must:

be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

*The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

assurance of the safety and welfare of patients entrusted to their care;

provision of patient- and family-centered care;

assurance of their fitness for duty;

Task Force Committee Response - Professionalism, Personal Responsibility, and Patient Safety

management of their time before, during, and after clinical assignments;
recognition of impairment, including illness and fatigue, in themselves and in their peers;
attention to lifelong learning;
the monitoring of their patient care performance improvement indicators; and,
honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

All residents and faculty members must demonstrate responsiveness to patient needs that supersede self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

Rationale and response to comments:

The vast majority of the comments concerning these standards was supportive. Concerns over the ability to monitor and substantiate components of the responsibilities of residents and faculty actions. The Task Force modified the expectation through the addition of "an understanding and acceptance of their personal role in the following." The Task Force chose not to modify any other components of the standards in this section of the requirements.

Task Force Committee Response - Supervision of Residents

Supervision of Residents

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each RRC) who is ultimately responsible for that patient's care.

This information should be available to residents, faculty members, and patients.

Residents and faculty members should inform patients of their respective roles in each patient's care.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

The program must demonstrate that the appropriate level of supervision is in place for all patients cared for by all residents.

Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

Direct Supervision – The supervising physician is physically present with the resident and patient.

Indirect Supervision:

Task Force Committee Response - Supervision of Residents

with direct supervision immediately available – The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

with direct supervision available – The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

Each resident is responsible for knowing the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

In particular, during the PGY-1, residents should be supervised either directly, or indirectly with direct supervision immediately available. Each RRC must describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Rationale and response to comments:

The Task Force chose to modify certain of the standards in the supervision standards based on comments.

The first modification entailed reordering of standards in order to more clearly frame the supervision standards in the context of the learning environment.

The addition of "fellow" in the description of members of the physician care team who are considered eligible to supervise more junior residents.

The replacement of the "confines" of the site of patient care with "the hospital or site" of patient care clarifies both that the standard refers to the facility where patient care is being delivered, rather than required on the unit (for example, within the confines of the intensive care unit) where patient care is

Task Force Committee Response - Supervision of Residents

delivered.

The definition of indirect supervision with direct supervision available was further clarified to include communication “by means of telephonic and/or electronic modalities” based on comment.

The specific requirements for supervision of PGY-1 residents was further clarified, empowering individual Review Committees with the responsibility to establish the competencies to be demonstrated for the PGY-1 to progress to Indirect Supervision with Direct Supervision Available.

The Task Force discussed the range of comments alleging that specified supervisory expectations for PGY-1 residents will create physicians who lack the ability to make independent decisions. The Task Force reaffirmed its positions:

1. First year residents must be supervised appropriately as they acquire basic knowledge and skills specific to the specialty.
2. Supervision does not equate with the absence of independent decision making
3. These supervision standards set out the concepts of graded authority and conditional independence that are the foundation of delegation of authority to more senior residents and fellows.

Task Force Committee Response - Teamwork

Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

Each RRC must define the elements that must be present in each specialty.

Rationale and response to comments:

The Task Force noted that most comments that were specific to this standard were supportive. The Task Force judged that the suggestions regarding the proper terminology for the desired team experiences was “interprofessional” to assure the desired experiences working in teams with other members of the health professions was clear.

The Task Force further determined that each specialty would define the expectations for minimum experiences in interprofessional teams, and the nature and scope of the required interprofessional team experience.

Finally, the Task Force rejected the concept that limitations of consecutive time for PGY-1 residents of 16 hours precludes functioning in interprofessional teams. The members of those interprofessional teams do not work 24 consecutive hours. PGY-1 total hours of work per week (when averaged over 4 weeks) remains up to 80 hours (not reduced). The Task Force judged that there was ample time for interprofessional team experience, not only during the PGY-1 year, but throughout the remaining years of residency.

Task Force Committee Response - Transitions of Care

Transitions of Care

Programs must design clinical assignments to minimize the number of transitions in patient care.

Institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

Programs must ensure that residents are competent in communicating with team members in the hand-over process.

Institutions must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

The Task Force made no changes to these proposed standards

Rationale and response to comments:

The Task Force notes the concern of many that limits on PGY-I handovers would “dramatically” increase the number of handovers. The Task Force, in modeling the comparison of q 3rd night schedules with daily schedules for PGY-1 residents of a maximum of 16 hours, finds a potential increase in transitions of care of 2-4 per week. Further, during rotations where PGY-1 residents are working during daylight hours, their contact time with faculty, supervising residents, and awake patients is increased. Finally, the episodes of consecutive hours away from patients decreases from a current maximum of 18 hours on the weekday post call, to 8-10 hours in a 14-16 hour daytime rotation.

The standard requiring programs to create schedules that, within the context of the other duty hour standards, minimize the numbers of transitions is not internally inconsistent. Physicians and all other caregivers must provide transitions in care. Schedules can be produced that are inconsistent with the goal of minimizing these transitions. This standard sets the expectation that the program director examine and schedule resident duty schedules to minimize the numbers of transitions in care, within the context of the other duty hour standards.

Finally, the Task Force notes that transitions in care must be improved. As a member of the IOM Committee who testified to the Task Force stated (paraphrased) the fact that we are less than ideally effective in assuring effective transitions in care is not an excuse to design clinical care delivery in a manner that fosters fatigue. No matter what the duty hour limitations are at a given point in time, and even in the setting of the absence of duty hour limitations (for faculty, for instance), we have transitions in care. Those transitions must be improved.