



February 25, 2009

Thomas J. Nasca, MD, MACP
Chief Executive Officer
Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60611

Dear Dr. Nasca:

The Society of Critical Care Medicine, the American Thoracic Society, and the American College of Chest Physicians are communicating in unison to urge that the Accreditation Council for Graduate Medical Education (ACGME) not implement the Institute of Medicine's (IOM) recommendations to apply further, more sweeping duty-hour restrictions without consideration of a number of additional issues in the training of physicians and the delivery of care to patients, their families, and the public. Our multi-professional societies represent more than 75,000 practicing critical care clinicians in the United States, and our members are responsible for the care of many of the sickest patients in the US healthcare system. We are fully supportive of making graduate medical education a more humane and supportive environment. We believe, however, that it is essential to consider and address a number of extremely important consequences of these proposed changes before any alteration is enacted.

As professional societies representing both our members and the patients they serve, we believe additional restrictions on duty hours will have broad implications and unintended consequences for critical care subspecialty training programs. Our reservations are based on several important issues. The first involves the ability to appropriately train future specialist physicians, in particular, intensivists caring for critically ill patients. We believe any potential change must take into account an individual fellow's level of education. In our view, it is imperative that advanced subspecialty fellows be permitted to exercise the autonomy that advanced educational objectives require. Neither the ACGME nor the IOM have differentiated levels of training as applied to duty hours. There is no recognition that the educational objectives of an intern are quite different from a fellow in critical care medicine. Similarly, there is no recognition that the responsibilities and supervisory needs of an on-call intern are very different from a fellow in critical care medicine. This "one-size-fits-all" approach will have detrimental effects on the ability to train highly specialized physicians such as critical care specialists.

Second, the skills required of a critical care physician and, most importantly, when to apply these skills, are best acquired through continuity of care in a patient care setting. Further restrictions or fracture of duty hours may impact negatively on the competence of fellows in early recognition, resuscitation, stabilization, and ongoing care of the critically ill patient. Such restrictions will have an impact on continuity of care and training concerning the responsibilities of continuity of care. Shortened shift duration results in more frequent handoffs of patients, fragmentation rather than continuity of care, and lost time for didactic education. An appreciation of the totality and time course of both the pathologic process and the effects of intervention, especially in caring for those patients who are critically ill in which the evolution of illness is often rapid, is essential to provide optimal care for patients and training for physicians. Further restrictions of duty hours will increase the frequency at which residents and fellows must leave a critically ill patient whose condition may change frequently and jeopardize both the continuity of patient care and the training of physicians.

Third, our respective societies believe we must be able to ensure patient safety in order to provide high-quality training. It was concern about patient safety that initially pressed the ACGME to restrict resident duty hours to 80 per week with no more than 30 consecutive hours allowed. However, the ACGME did so without fully addressing unresolved issues that arose when the 1989 guideline for resident work hours was implemented (New York State regulations, Section 405.4). These included concerns not only about the negative impact that resident duty-hour restrictions might have on quality of resident education and continuity of care, as detailed above, but also regarding patient safety and adequate supervision of fellows. Further work-hour restrictions may place more responsibility for direct patient care on attending physicians and, ironically, reduce time available for supervision of fellows. Although existing data are inconclusive, there is some evidence to suggest that restrictions on resident duty hours have contributed to a decline in patient safety in the ICU.¹

Fourth, our societies are concerned that further duty-hour restrictions may impair training in professionalism, an ACGME core competency.² Professionalism is learned over time, and acquisition may be disrupted by additional duty-hour restrictions. Such restrictions send a message that house staff physicians are merely “shift workers” who become detached from their patients instead of trained professionals who are dedicated to their patients’ well-being. As fellows become shift workers and as attending physician documentation requirements become more stringent, the supervising physicians are increasingly becoming the point person for continuity in caring for patients and families. This has already substantially diminished the responsibilities and roles of senior subspecialty critical care fellows in team leadership, graduated responsibility for patient care, and interactions with patients and families. With this diminished responsibility comes a decrease in the training and experience that fosters professionalism.

Fifth, the ACGME requires that subspecialty training programs integrate scholarly activity to ensure fellows are knowledgeable and skilled in research and quality improvement. These are essential if our healthcare systems are to continue to improve over time. Unfortunately, further duty-hour restrictions imposed on all duties and at all levels of training will make it increasingly difficult to support the scholarly mission of subspecialty training. Moreover, given the necessary emphasis that work-hour restrictions will place on clinical training, knowledge and skills in research and quality improvement will go by the wayside as a casualty of reduced training time.

Without evidence demonstrating benefit for further limitations and without advanced planning to determine whether or not optimal resources, methods, and personnel are in place to ensure adequate training of new specialists and subspecialists, we believe it is ill-advised to impose additional duty-hour restrictions on the training of subspecialists.

We realize the ACGME is primarily concerned with the education of residents and fellows, but we also believe these restrictions could substantially and adversely affect patient care and outcomes, especially for critically ill patients. Our professional societies are working together to try to develop cost-effective solutions to caring for critically ill patients in the face of major work force shortages.³ Ironically, our graduating residents and fellows are now much less experienced in critical care than their counterparts from 10 years ago, further exacerbating this work-force problem. For all these reasons, the Society of Critical Care Medicine, the American Thoracic Society, and the American College of Chest Physicians urge the ACGME

¹ Chudgar SM, Cox CE, Que LG, Andolsek K, Knudsen NW, Clay AS. Current teaching and evaluation methods in critical care medicine: Has the Accreditation Council for Graduate Medical Education affected how we practice and teach in the intensive care unit? *Crit Care Med* 2009; 37:49-60. [Epub ahead of print] PMID: 19050627

² ACGME Common Program Requirement:: Educational Program, Curriculum components, ACGME Competencies: Interpersonal and Communication Skills, Approved by the ACGME Board February 13, 2007

³ Angus DC, Kelley MA, Schmitz RJ, et al. Current and projected workforce requirements for care of the critically ill and patients with pulmonary disease: can we meet the requirements of an aging population? *JAMA* 2000; 284:2762–2770

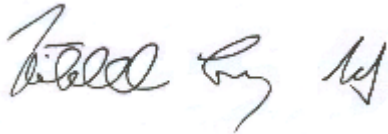
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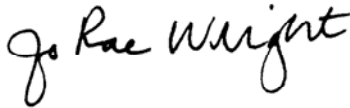
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not to implement the IOM's recommendations for additional duty-hour restrictions without further considerations of these additional issues of differences by level of training, continuity of care, patient safety and supervision of fellows, training in professionalism, and impact on training subspecialists in the methods of research and quality improvement.

Sincerely yours,

Handwritten signature of Mitchell Levy in black ink.

Mitchell Levy, MD, FCCM
President, Society of Critical Care Medicine

Handwritten signature of Jo Rae Wright in black ink.

Jo Rae Wright, PhD
President, American Thoracic Society

Handwritten signature of James A.L. Mathers, Jr. in black ink.

James A.L. Mathers, Jr., MD, FCCP
President, American College of Chest Physicians

cc: Patricia M. Surdyk, PhD, Executive Director, Institutional Review Committee, Accreditation Council for Graduate Medical Education
Kevin B. Weiss, MD, MPH, President and CEO, American Board of Medical Specialties
Dianne Wolman, Staff Officer, Institute of Medicine