Your Questions Answered

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Senior Vice President, Surgical Accreditation
ACGME

Thoracic Surgery Directors Association
Baltimore, MD
14 May 2016
Disclosures

In recovery:
  21 years as a Program Director

Fiduciary:
  Full-time ACGME

Financial:
  Of course not. This is education!
Topics

• Duty Hours
• Milestones
• Resident Supervision
Topics

• Duty Hours
• Milestones
• Resident Supervision
Duty Hours in TS

• ACGME established 1981

• Duty hours in Special Requirements for Residency Training in Thoracic Surgery 1981-1989:
1990: First “Duty Hours” in TS

Special Requirements for Residency Training in Thoracic Surgery
In: 1990-1991 Directory of Graduate Medical Education Programs.
Chicago, IL: American Medical Association; 1990. p. 130

c. It is the responsibility of the program director to ensure assignment of reasonable in-hospital duty hours so that residents are not required regularly to perform excessively prolonged periods of duty.
1993: Duty Hours in TS

It is desirable that residents’ work schedules be designed so that on average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of routine responsibilities and be on call in the hospital no more often than every third night. Since training in thoracic surgery is at senior levels, the ratio of hours worked and on-call time varies considerably and necessitates flexibility.

Special Requirements for Residency Training in Thoracic Surgery
In: 1993-1994 Graduate Medical Education Directory.
Chicago, IL: American Medical Association; 1993. p. 149
2. Duty Hours
   a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
   b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
   c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
   d. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.
Common PRs 2004

a. In-house call must occur no more frequently than every third night, averaged over a four-week period.

b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.
Every third or fourth night during in-patient rotations is recommended. Residents must not be required regularly to perform excessively difficult or prolonged duties. When averaged over four weeks, residents should spend no more than eighty hours per week in hospital duties. Residents at all levels should, on average, have the opportunity to spend at least one day out of seven free of hospital duties and should be on call no more often than every third night. There should be adequate opportunity to
Internal Medicine 1998: “Must”

i. When averaged over any 4-week rotation or assignment, residents must not spend more than 80 hours per week in patient care duties.

j. Residents must not be assigned on-call in-house duty more often than every third night.

k. When averaged over any 4-week rotation or assignment, residents must have at least 1 day out of 7 free of patient care duties.
# Common PRs 2011

<table>
<thead>
<tr>
<th>PR</th>
<th>PGY 1</th>
<th>Int.</th>
<th>Final</th>
<th>PR</th>
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<td>80 hrs/week (averaged)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>VI.G.1.</td>
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<td>One day off in seven (averaged)</td>
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<td>Maximum continuous duty 16 hrs</td>
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<td></td>
<td>VI.G.4.a)</td>
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<td>Maximum continuous duty 24 hrs</td>
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<td>VI.G.4.b)</td>
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<td>Additional 4 hrs for transitions</td>
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<td>√</td>
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<td>Time off between duty: Should have 10; Must have 8</td>
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<td>Time off between duty: Should have 10; Must have 8</td>
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<td>Must have 14 hrs off after 24 hrs in-house duty</td>
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<td>VI.G.5.b)</td>
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<tr>
<td>Should have 8 hrs off after 24 hrs in-house duty</td>
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<td>√</td>
<td>VI.G.5.c).(1)</td>
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<tr>
<td>Maximum in-house call q 3 (averaged)</td>
<td></td>
<td>√</td>
<td>√</td>
<td>VI.G.7.</td>
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Effective July 1, 2013
ACGME Approach to DH

• Sep 2001: Work Group on Resident Duty Hours and the Learning Environment
  • 2003 ACGME Duty Hour Requirements
  ▪ Commitment to review in five years

• Feb 2009: Task Force on Quality Care and Professionalism
  ▪ Five year review delayed by 2008 IOM Report
  • 2011 ACGME Duty Hour Requirements
ACGME Approach to DH

ACGME Board of Directors Actions:

• Sep 2013  iCOMPARE (waiver & funding)
• Feb 2014  FIRST (waiver & funding)
• Sep 2015  Task Force for CPR revision
Duty Hours Studies

- FIRST trial in General Surgery
- iCOMPARE trial in Medicine
- Supported by ACGME
  - Specific PRs waived for participating programs
  - Financial support
- Not conducted by ACGME
FIRST Trial (Surgery)

- PRs maintained for programs in study arm:
  - Duty hours limited to 80/week (averaged)
  - One day off / week over 4 weeks (averaged)
  - In-house call ≤ 3 / week (averaged)
FIRST Trial (Surgery)

- PRs waived for programs in study arm:
  - PGY-1 duty periods limited to 16 hours
  - PGY-2 and above residents limited to 24 hours duty plus 4 for transition of care
  - Must have 14 hrs off after 24 hrs in-house duty
  - Must have ≥ 8-10 hrs off after regular shift
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.
January 7, 2016

Dear Members of the Graduate Medical Education Community,

I trust that this letter finds you well and looking forward to another year of opportunity to serve, and to prepare the next generation of physicians to serve the American Public. At the ACGME, we are continuing the process of remolding the accreditation of graduate medical education sponsors and programs into one of continuous improvement and aspiration to excellence. When we began this journey, we were faced with many challenges, and while the nature of those challenges may have changed, challenges continue to present opportunities to improve and evolve.

The next step in this evolution is for us to review the framework of the ACGME’s requirements. In this regard, a major effort will commence this month. The ACGME will embark on a full review of its Common Program Requirements in two phases over the next 18 months. The ACGME Board of Directors has commissioned a Common Program Requirements Phase 1 Task Force to concentrate on collecting information and producing recommended updates to Section VI, Resident Duty Hours in the
Task Forces

- CPR Phase 1 Task Force: Section VI.
- CPR Phase 2 Task Force: Sections I. – V.
CPR Phase 1 Task Force

• CPR Phase 1 Task Force on Section VI: “Duty Hours and the Learning Environment”
  A. Professionalism, Personal Responsibility, Patient Safety
  B. Transitions of Care
  C. Alertness Management / Fatigue Mitigation
  D. Resident Supervision
  E. Clinical Responsibilities
  F. Team Work
  G. Duty Hours

7 January 2016 Letter to Community
CPR Phase 1 Task Force

Composition:
• 8 members ACGME BoD
• 9 members RC chairs
• 3 RC residents
CPR Phase 1 Task Force

Surgical representation:
- General Surgery: 3 faculty; 1 resident
- Neurosurgery: 1 faculty; 1 resident
- OB-Gyn: 2 faculty
- Thoracic Surgery: 1 faculty
CPR Phase 1 Task Force

Timeline:

- Sep 2015 approved by ACGME BoD
- Dec 2015 Request for Organizational Positions
- 600+ page review of duty hour literature
- January 23-24 1st Task Force meeting
- March 16-17 “National Congress”
- Any proposed changes in CPRs
  - 45-day public comment period
  - Acted upon by ACGME BoD June & Sept 2016

7 January 2016 Letter to Community
CPR Phase 2 Task Force

Common Program Requirements

I. Institutions
II. Program Personnel and Resources
III. Resident Appointments
IV. Educational Program
V. Evaluation
Topics

• Duty Hours
• Milestones
• Resident Supervision
TS Milestones

Thoracic Surgery Milestones

Chair: Walter Merrill, MD

Working Group
Andrea J. Carpenter, MD, PhD
Laura Edgar, EdD, CAE
James Fann, MD
Robert Higgins, MD
Richard Lee, MD
Tom C. Nguyen, MD
Carolyn Reed, MD*
Peggy Simpson, EdD
Ara Vaporiyan, MD, FACS, MHPE
Thomas Varghese, MD, FACS
Edward Verrier, MD
Cameron Wright, MD
Stephen Yang, MD

Advisory Group
William Baumgartner, MD
Timothy Brigham, MDiv, PhD
John Calhoon, MD
David Fullerton, MD
John Potts, MD
Douglas Wood, MD
## TS Milestones

### # of Sub-Competencies per Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total # Sub-comp</th>
<th>PC</th>
<th>MK</th>
<th>SBP</th>
<th>PBLI</th>
<th>PROF</th>
<th>ICS</th>
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<td>Internal Medicine</td>
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<tr>
<td>Thoracic Surgery</td>
<td>25</td>
<td>8</td>
<td>9</td>
<td>3</td>
<td>2</td>
<td>2</td>
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TS Milestones

- TS is a “Phase 2” specialty
- Entered NAS in 2014-2015 (Milestones and CLER part of NAS)
- One year of data analyzed
- TS complicated by multiple paradigms
TS Milestones

• Milestone data from (June 2015):

  • Internal Medicine (n = 24,352)
  • Emergency Medicine (n = 5,950)
  • Neurosurgery (n = 1,305)
  • Orthopedic surgery (n = 3,597)
  • Thoracic Surgery (2-yr) (n = 123)
  • Thoracic Surgery (3-yr) (n = 96)
  • Thoracic Surgery (6-yr) (n = 117)
Level 4 Attainment Rates:

• While *not a requirement* for graduation, the goal of each residency program is to enable attainment of Level 4 Milestone performance targets by graduation for all residents in the program.
TS Milestones

Residents Attaining Level 4 or Higher for each Patient Care Sub-Competencies: 2-yr programs

(June 2015)
TS Milestones

Residents Attaining Level 4 or Higher for each Patient Care Sub-Competencies: 3-yr programs

(June 2015)
TS Milestones

Residents Attaining Level 4 or Higher for each Patient Care Sub-Competencies: 6-yr programs

(June 2015)
Box and Whisker Plots
Patient Care Sub-Competencies 2-yr programs

(June 2015)
Box and Whisker Plots
Patient Care Sub-Competencies 3-yr programs

(June 2015)
Box and Whisker Plots
Patient Care Sub-Competencies 6-yr programs

(June 2015)
Level 4 or Higher Attainment in ALL sub-competencies of a given competency 2-yr programs

(June 2015)
TS Milestones

Level 4 or Higher Attainment in ALL sub-competencies of a given competency 3-yr programs

(June 2015)

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TS Milestones

Level 4 or Higher Attainment in ALL sub-competencies of a given competency 6-yr programs

(June 2015)
## TS Milestones

% of Senior-Most Residents Attaining Level 4 or Higher ALL sub-competencies of a given competency

<table>
<thead>
<tr>
<th>Specialty</th>
<th>PC</th>
<th>MK</th>
<th>SBP</th>
<th>PBLI</th>
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<td>48</td>
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<td>63</td>
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<td>Thoracic Surgery 3yr (n=30)</td>
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<td>53</td>
<td>70</td>
<td>67</td>
<td>67</td>
<td>77</td>
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<tr>
<td>Thoracic Surgery i-6 (n=9)</td>
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<td>56</td>
<td>78</td>
<td>89</td>
<td>100</td>
<td>100</td>
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NB: these data are collapsed across sub-competencies.

(June 2015)
Milestones Team

- **Milestone Development and Revision**
  - Laura Edgar EdD (Executive Director)
  - Megan Bluth BS
  - Sydney Roberts BS

- **Research and Evaluation**
  - Stan Hamstra PhD (VP for Milestones R&E)
  - Kenji Yamazaki PhD (statistician)
  - Lisa Conforti MPH
  - Nicholas Yaghmour MPP
  - Eric Holmboe, MD (SVP for Milestones R&E)
TS Milestones

- Milestones **NOT** used in accreditation
- Tool for:
  - Resident self-directed learning
  - Resident feedback
  - Program evaluation
- *May* be used to improve national curriculum
TS Milestones

• No change in TS Milestones currently planned
• No target date for TS Milestones 2.0
• Milestones Summit I: December 2015
• Milestones Summit II: December 2016
• Summits aimed at:
  • Lessons learned
  • Streamlining language of 4 “soft” competencies
Topics

• Duty Hours

• Milestones

• Resident Supervision
Background

• *Admittedly* influenced by general surgery

• But, surveys of residents, residency graduates, practicing physicians and hospital administrators (and other data) indicate that residency does not prepare individuals well for independent practice.
Why Aren’t Residents Prepared?

• Lack of preparation of medical students
• Duty hour limitations
• Residency is hospital based
• Changing surgical diseases and conditions
• Changing surgical techniques
• Curriculum lagging behind
• Teaching methodologies lagging behind
• Lack of faculty development
The Major Factor

One factor more important than all of those:

• Lack of *appropriate* resident supervision
Appropriate Supervision

- Residents do **not** run amok in our programs
- Residents are **heavily** supervised
- *Most* residents not **appropriately** supervised
Appropriate Supervision

- PGY-1: Direct Supervision
- PGY-F: Indirect Supervision or Oversight
- *Any* resident competent at a task should perform that task with Indirect Supervision
Appropriate Supervision

• The number of programs where there is appropriate supervision is *vanishingly* small
How Did We Get Here?

- Loss of autonomy insidious and multifactorial
How Did We Get Here?

- IL-372
- Patient Safety Movement
- CMS “never events”
- Burgeoning subspecialty training
- Growth in the number of faculty
- Faculty stretched
- Quality metrics
Result

• After x years of residency, too many lack:
  • the technical ability
  • the judgment
  • and/or the confidence

• To pass board exams, and

• To independently practice the specialty
Solutions

• No magic bullet

• I suggest several steps
Solutions

- Supervision policies that promote autonomy
- Lengthen resident rotations
- Require senior residents to TA juniors
- *Fewer* teaching faculty
- Enhanced faculty development
  - Educational topics
  - Medicare billing rules
  - ACGME supervision requirements
- Demand honest feedback & evaluation
- Evaluate teaching faculty
- Pay faculty members for teaching

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Commitment

• There must be a commitment to properly train the next generation of surgeons by:
  • Faculty
  • Program Director
  • Chair
  • Hospital
  • Medical school
  • Public
Need to Educate

• The House of Surgery must educate
  • Deans of medical schools
  • CEOs of hospitals

• **Need** for appropriate resident supervision

• *May* slightly decrease RVU production

• *May* slightly affect quality metrics

• Ultimately good return on investment
Need to Educate

• The House of Surgery must educate Public
• Need for *appropriate* resident supervision
• Not throwing patient safety out the window
• Striking a balance of safety today vs tomorrow
Summary

With these things we can:

• Have the best surgical training in the world
• Provide the best surgical care in the world
• Preserve the profession of general surgery
Topics

• Duty Hours
• Milestones
• Resident Supervision
"We’d now like to open the floor to shorter speeches disguised as questions."