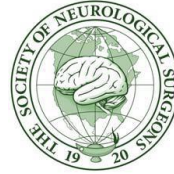




American
Association of
Neurological
Surgeons



CNS

December 19, 2016

Thomas J. Nasca, MD, MACP
Chief Executive Officer
Accreditation Council for Graduate Medical Education
401 North Michigan Avenue
Suite 2000
Chicago, IL 60611

Via email: cprrevision@acgme.org

SUBJECT: Common Program Requirements Review: Section VI, the Learning and Working Environment

Dear Dr. Nasca,

On behalf of the American Association of Neurological Surgeons (AANS), American Board of Neurological Surgery (ABNS), Congress of Neurological Surgeons (CNS) and Society of Neurological Surgeons (SNS), we appreciate the opportunity to comment on Section VI, the Learning and Working Environment, of the Common Program Requirements. Per your request, we have completed the Review and Comment Form, which accompanies this letter.

We commend the leaders of the Accreditation Council for Graduate Medical Education (ACGME) for the meticulous and thorough job they have done — and continue to do — to improve the learning and working environment for resident physicians. In developing the revised standards, the Common Program Requirements Phase 1 Task Force considered all available information, including relevant literature and written comments, received from the graduate medical education community and the public. In addition to their own exhaustive research and deliberations, the ACGME leadership convened a two-day congress in March 2016, to hear testimony from a wide array of organizations with expertise in resident education and resident and patient safety. We believe that the modest, though important, changes to the learning and working environment proposed by the ACGME reflect a thorough review of the issue and are a step in the right direction for enhancing resident training.

In 2003, the ACGME instituted the first national restrictions on duty hours for residents. What we have learned about resident duty hour restrictions since their inception concerns neurosurgeons, particularly those who are most interested and involved in neurosurgical training. In the last decade, studies and surveys have documented adverse effects from duty hour restrictions. Residents miss essential educational opportunities by reducing their hours of surgical experience, using midlevel practitioners for educationally valuable activities, reducing time in elective operations where surgical techniques are refined and cutting research and conference time. In addition, these rules compromise the continuity of care of neurologically unstable patients. Perhaps most important, current duty hour rules foster a shift-work mentality with its attendant loss of professionalism and the individual's commitment to the patient.

The present system forces our residents to choose between adherence to regulations requiring them to end their shift or the higher calling of personal commitment to patients who could still benefit from their care. If they choose the latter, they must lie or put their program at risk. A system that makes our residents feel they must lie about doing the right thing is a system in need of reform. The modest changes proposed to the Learning and Working Environment requirements are an important in the right direction.

An ever-increasing volume of data, including data from prospective randomized trials, demonstrates that the premise that we accepted in 2003 — that restricting duty hours would improve patient safety — is false. Not only have we not improved the safety of today's patients, but we are sacrificing the safety of future patients by diminishing resident training and making shift workers of those who should be learning to be consummate professionals.

Neurosurgery is a demanding technical specialty, but we do much more than perform procedures. We care for our patients in the clinic, the emergency room, the operating room, the recovery room, the intensive care unit and on the hospital wards. We are specialists in the care of patients with neurological disease, not technicians who have mastered a motor skill. We have always taken care of our patients whenever they need us, for as long as they need us. This is a founding principle of our specialty that we must not abandon. We vigorously resist training our residents to become shift workers instead of neurosurgeons.

Mastery of the knowledge and skills required to manage the long list of neurosurgical disorders requires many years of commitment and intensive experience. Neurosurgical learning episodes — from initial contact with the patients, through their evaluation, surgical treatment and immediate postoperative care — encompass many hours. To obtain the greatest educational value from these learning episodes, and to offer the safest care for neurosurgical patients, a resident must be present throughout this sequence of events. When these episodes cross the arbitrary shift boundaries set up by work hour restrictions — as is often the case — our residents are forced to decide between doing what is best for their patients and their education or following the rules that tell them that because their shift is over, they must punch the clock. This should stop.

Fatigue is a fact of a surgical career. It cannot be eliminated, but it can be managed. Maximizing patient safety and resident education requires attention to supervision and fatigue management, not designated shifts. Supervision will vary according to the level of training, with junior residents requiring more immediate supervision than senior residents who are assuming a greater degree of autonomy and responsibility for patient care. The last two years of resident training should serve as a transition to practice, during which residents develop the time management, clinical and operative skills to become an independent neurosurgical practitioner. Allowing a more flexible schedule, with or without the current 80-88 hour work-week system, will help residents internalize the importance of the continuity of care, take personal responsibility for their patients, avoid the moral dilemmas of the present system and enhance professionalism.

Our specific recommendations for oversight, graduated responsibility and work hours requirements for neurosurgical training are as follows:

- **PGY-1:** 80 hours per week, averaged over four weeks, one day in seven off-duty, averaged over four weeks and 10 hours off between duty shifts. In-house call — a 24-hour shift — may be followed by up to 10 hours to permit the resident to participate in the operating room, participate in didactic activities and maintain continuity of care. These changes would reclaim the PGY-1 year as the first year of resident training rather than the fifth year of medical school.
- **PGY-2 through 4:** 88 hours/week, averaged over four weeks, one day in seven off-duty, averaged over four weeks, 10 hours off between duty shifts. In-house call may be followed by up to 10 hours to permit the resident to participate in the operating room and didactic activities and maintain continuity of care. Residents may stay on duty or return to the hospital with fewer than 10 hours free of duty to provide continuity of care for severely ill, complex or unstable patients, for events of exceptional educational value or for humanistic attention to the needs of a patient or family.

- **PGY-5**: 88 hours/week, averaged over four weeks and one day in seven off-duty, averaged over four weeks — without other restrictions.
- **PGY-6 and 7**: One day in seven off-duty averaged over four weeks — without other restrictions.

We believe that these recommendations would make today's and tomorrow's patients safer, improve resident education and enhance professionalism.

Thank you for leadership on this issue and for considering our views. If you have any questions or need additional information, don't hesitate to contact us.

Sincerely,



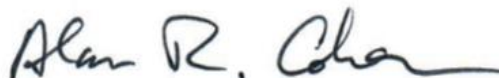
Frederick A. Boop, MD, President
American Association of Neurological Surgeons



Christopher I. Shaffrey, MD, Chairman
American Board of Neurological Surgery



Alan M. Scarrow, MD, President
Congress of Neurological Surgeons



Alan R. Cohen, MD, President
Society of Neurological Surgeons

Enclosure: Review and Comment Form

Staff Contact:

Katie O. Orrico, Director
AANS/CNS Washington Office
725 15th Street, NW, Suite 500
Washington, DC 20005
Direct Dial: 202-446-2024
Facsimile: 202-628-5264
Email: korrico@neurosurgery.org

ACGME Requirements Review and Comment Form

Title of Requirements	The Learning and Working Environment
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Organizations submitting comments should indicate whether the comments represent a consensus opinion of its membership or whether they are a compilation of individual comments.

Select [X] only one	
Organization (consensus opinion of membership)	<input type="checkbox"/>
Organization (compilation of individual comments)	<input type="checkbox"/>
Review Committee	<input type="checkbox"/>
Designated Institutional Official	<input type="checkbox"/>
Program Director in the Specialty	<input type="checkbox"/>
Resident/Fellow	<input type="checkbox"/>
Other (specify): Consensus statement of the American Association of Neurological Surgeons (AANS), the American Board of Neurological Surgery (ABNS), the Congress of Neurological Surgeons (CNS), the Society of Neurological Surgeons (SNS) and the AANS/CNS Washington Committee	<input checked="" type="checkbox"/>

Name	Robert E. Harbaugh, MD, FAANS, FACS, FAHA
Title	Past President of the AANS and SNS, Past Director of the ABNS, Past Chair of the AANS/CNS WC
Organization	AANS, ABNS, CNS, SNS, AANS/CNS Washington Committee

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization does not consent to the publication of any comments, please indicate such below.

We hereby consent to the publication of our comments
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The ACGME welcomes comments, including support, concerns, or other feedback, regarding the proposed requirements. For focused revisions, only submit comments on those requirements being revised. Comments must be submitted electronically and must reference the requirement(s) by both line number and requirement number. Add rows as necessary.

	Line Number(s)	Requirement Number	Comment(s)/Rationale
1	16-34	Preamble to Section VI	We agree with the title change and the principles enunciated in the preamble. In addition to mastering the technical aspects of neurological surgery, it is essential that that residents

	Line Number(s)	Requirement Number	Comment(s)/Rationale
			<p>internalize the importance of continuity of care, take personal responsibility for their patients and enhance professionalism. Maximizing patient safety and resident education requires attention to supervision and fatigue management, not designated shifts, and the preamble provides the context to balance these needs.</p>
2	37-175	VI.A.1.	<p>There is no question that resident education must be provided in an environment that emphasizes a culture of safety and quality improvement, and organized neurosurgery, therefore, supports the proposed changes in this section.</p> <p>While we agree that it is important to develop quality metrics by which residents and faculty members can be evaluated, we caution that these metrics must be meaningful and be developed by the individual specialties and should minimize additional administrative and reporting burdens.</p> <p>Because institutions and/or neurosurgery training programs may require additional time to develop patient safety and quality improvement activities and metrics, we recommend that the ACGME adopt a phased-in approach to these new requirements. We also recommend that these metrics build on programs that may already exist in the context of other initiatives, such as the Medicare Quality Payment Program and other patient safety and quality improvement programs, so institutions and neurosurgery residency programs do not have to reinvent the wheel.</p>
3	177-303	VI.A.2.	<p>We support the flexibility related to the supervision requirements. Supervision will vary according to the level of training, with junior residents requiring more immediate supervision than senior residents who are assuming a greater degree of autonomy and responsibility for patient care. The last two years of resident training should serve as a transition to practice, during which residents develop the time management, clinical and operative skills to become an independent neurosurgical practitioner.</p>

	Line Number(s)	Requirement Number	Comment(s)/Rationale
4	305-365	VI.B.	<p>We agree that a resident's time is not well spent fulfilling non-physician obligations that do not add to the overall educational experience and when such tasks are better provided by nursing, allied health professionals or clerical staff. Certainly, residents may be expected to occasionally perform such routine tasks as drawing blood, and the like, but given the compression of duty hours, their time must be maximized to develop the clinical and operative skills necessary to become an independent neurosurgical practitioner.</p> <p>We also agree that it is essential that residents and faculty take full responsibility for providing patient- and family-centered care, which includes reporting unsafe conditions and adverse events.</p>
5	367-434	VI.C.	<p>It is essential to enhance the well-being of residents and faculty alike. A recent study published in the <i>Journal of Neurosurgery</i> found the rate of burnout to be 62.9 percent among nonacademic neurosurgeons and 47.7 percent for academic neurosurgeons. Burnout can have major implications on a physician's personal health, career and relationship with patients.</p> <p>As put in a recent <i>AANS Neurosurgeon</i> article on the topic of neurosurgeon burnout, "We must take a lead in this effort by being active and vocal for ourselves, our colleagues and our patients and fight against the forces that erode our mental health and the quality of our work. We must reach out to colleagues that we perceive to be at risk. We must respectfully, but vociferously, inform the leadership at our institutions what reforms work for patient care and which ones get in the way. In the end, the only people we can expect to fight physician burnout are the physicians themselves. We owe it to ourselves and to our patients."</p>
6	436-459	VI.D.	<p>Organized neurosurgery concurs with the requirements regarding fatigue mitigation. Fatigue is a fact of a surgical career. It cannot be eliminated, but it can be managed. Maximizing patient safety and resident education requires attention to supervision and fatigue management, not designated shifts. There are many techniques for addressing fatigue, and we support the revisions to this section.</p>
7	461-507	VI.E.	<p>There is no question that neurological surgery is a</p>

	Line Number(s)	Requirement Number	Comment(s)/Rationale
			team sport, and as such, neurosurgery residency training programs must take appropriate steps to ensure continuity of care, particularly in the hand-off process, to ensure patient safety and quality of care. We, therefore, support the modest changes in this section.
8	509-702	VI.F.	<p>Our organizations are deeply concerned about ensuring the safety of today's patients, optimal supervision and education of our resident trainees, the health of our residents and continued access to well trained and responsible neurosurgeons in the future. We believe that duty hour restrictions must be more flexible and that they must vary according to the level of training.</p> <p>For PGY-1 through 5, organized neurosurgery supports the 80-hour work week, averaged over four weeks, with rotation-specific exceptions for up to 10 percent or a maximum of 88 hours. To allow for a more appropriate transition to independent practice, however, for more senior residents in PGY-6 and 7, we recommend one day in seven off-duty averaged over four weeks — without other restrictions.</p> <p>We fully support the recommendation to repeal the 16 hour limit for PGY-1 residents. We recommend a more flexible support that limits duty hours to 80 hours per week, averaged over four weeks, one day in seven off-duty, averaged over four weeks and 10 hours off between duty shifts. In-house call — a 24-hour shift — may be followed by up to 10 hours to permit the resident to participate in the operating room, participate in didactic activities and maintain continuity of care. Removing the 16-hour work limit would also be more consistent with other recommendations related to team-based care, professionalism, and continuity of care.</p>

General Comments:

We commend the leaders of the Accreditation Council for Graduate Medical Education (ACGME) for the meticulous and thorough job they have done — and continue to do — to improve the learning and working environment for resident physicians. In developing the revised standards, the Common Program Requirements Phase 1 Task Force considered all available information, including relevant literature and written comments, received from the graduate medical education community and the public. In addition to their own exhaustive research and deliberations, the ACGME leadership convened a two-day congress in March

2016, to hear testimony from a wide array of organizations with expertise in resident education and resident and patient safety. We believe that the modest, though important, changes to the learning and working environment proposed by the ACGME reflect a thorough review of the issue and are a step in the right direction for enhancing resident training.

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