The Journal of the American Osteopathic Association

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Resident Duty Hour Restrictions

To the Editor:

As chief residents of a previous dually accredited program and current Accreditation Council for Graduate Medical Education–accredited program with osteopathic recognition, we have seen how duty hour restrictions affect residents. We appreciate Berry and McClain's update on the transition to the single accreditation system and synopsis of the iCOMPARE (Individualized Comparative Effectiveness of Models Optimizing Patient Safety and Resident Education) trial and FIRST (Flexibility in Duty Hour Requirements for Surgical Trainees) trial.¹ We second the idea of investigating individualized duty hour policies to promote resident well-being, specifically after reviewing iCOMPARE data.

The iCOMPARE trial shows evidence of intern well-being negatively correlating with flexible duty hour restrictions in categories such as job satisfaction, career choice satisfaction, work-life balance, and overall well-being. Flexible

duty hour restrictions also correlated to higher measures of burnout.² This trend, on top of the study's perceived "burned out" control group, suggests that individualized duty hours policies may benefit from options with reductions in duty hours. Interestingly, Piotrowski et al³ reported that among 748 medical students who had an understanding of extended residency length and decreased annual salary, more than half of the students preferred a 60-hour work week compared with an 80-hour work week. Additionally, students interested in primary care specialties and women were more likely to prefer reduced duty hour requirements.³ With iCOMPARE data showing pervasive burnout and current medical students' interest in reduced duty hour options, we hope that individualized duty hour policies are comprehensively and objectively vetted in the future.

The American Osteopathic Association's Trainee Duty Hours Policy recognizes the need for strict duty hour mandates to aid in preventing poor resident well-being.⁴ In congruence with this policy, our residency has implemented policies to protect resident well-being. Two

successful policies include weekly wellness breaks to promote fun collaboration between residents and faculty and protected time for each resident class. This protected time is in addition to traditional didactic sessions and ensures a personal collaborative network in each cohort. These strategies have been successful for the well-being of our residents, and we believe other residencies should consider adopting similar policies until individualized duty hours become a realistic option. (doi:10.7556/jaoa.2019.110)

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Response

We thank Drs Ochi and Stephan for their insightful letter regarding our article, "Resident Duty Hour Restrictions: The Implications Behind the New Data

Ahead of the Single Accreditation System.”¹ The elusive balance of patient safety, resident well-being, and resident education remain the cornerstones of discussions about medical trainee duty hours, especially as we approach the single-accreditation system.² Since our article was published, the pivotal iCOMPARE (Individualized Comparative Effectiveness of Models Optimizing Patient Safety and Resident Education) trial’s patient safety data have been published,³ with findings from an analysis of 30-day mortality rates and other patient safety markers between randomized standard (restricted) vs flexible duty-hour rules for internal medicine residents. Flexible adjustment of duty-hour schedules did not adversely affect the primary outcome of 30-day mortality nor demonstrate noninferiority to readmission or death at 7 or 30 days, prolonged length of hospital stay, or patient safety indicators.³ In the end, patient safety remains top priority throughout medical training, and the iCOMPARE data for internal medicine³ training go hand-in-hand with the patient safety data for surgical trainees from the FIRST⁴ (Flexibility in Duty Hour Requirements for Surgical Trainees) trial—no differences were found in patient safety based on the type of duty-hour trainee regulations.

Full data from the most robust trials comparing duty-hour regulations (FIRST⁴ and iCOMPARE⁵) suggest that trainee opinions of duty hours may vary based on the level of training and

individualized institution-specific goals and objectives. These trials are the criterion standard for analysis, as there may never be more robust trials, and trainee recording of duty hours will always hinder accurate assessments. Ochi and Stephan provide unique, institution-specific strategies for mitigating duty-hour regulations and optimizing trainee well-being, and we commend their individualized, proactive efforts. We agree with the authors that a call for decreased work hours overall is needed but that the emphasis should be on effective work hours that provide individual satisfaction and gratification in one’s work. We need to bring the physician back to the bedside to emphasize continued focus on patient-centered care. The Accreditation Council for Graduate Medical Education has spearheaded such investigative programs and provided funding for a growing number of innovative project campaigns.⁶

We suggest that the focus be placed on individual institutions going forward to find ways to prevent both workplace and personal burnout and enhance trainee satisfaction. Today’s trainees are not only graduating with increased debt,⁷⁻⁸ but they are graduating mentally and physically exhausted⁹ and, most importantly, are weighed down by tasks unrelated to patient care. Herein, we must encourage proactive development of programs and tactics for trainees to stimulate more effective ways of patient care and to minimize burnout. Graduating trainees can then carry such advancements to their

clinical practices and work communities. (doi:10.7556/jaoa.2019.111)

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