

2010 ACGME Residency Common Program Requirements

The Accreditation Council for Graduate Medical Education (ACGME) mandated restrictions on the number of hours housestaff may work in 2003. Based on a literature review of sleep patterns, as well as available data on medical errors, the Institute of Medicine (IOM) put forth a report in 2008 with recommendations for additional changes to be made in resident education. More recently, the ACGME issued new common program requirements addressing patient and resident safety focusing on the following elements:

Educational Program

Each program must have a defined curriculum with competency-based goals and objectives for each rotation / assignment at each educational level and delineation of progressive responsibilities for patient care, management and supervision clearly identified. The learning objectives must be accomplished through supervised patient care, clinical teaching, and didactic sessions and not be compromised excessive, non-physician service obligations.

Duty Hours

Duty hours must be limited to 80 hours per week, averaged over a 4 week period and include all in-house call as well as internal and external moonlighting. Exceptions may be made up to 88 hours per week. PGY-1 residents are not permitted to moonlight. Residents must be scheduled for a minimum of one day free of duty every week, averaged over 4 weeks. The maximum duty period length for PGY-1 residents is 16 hours in duration. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours in house. Strategic napping is strongly suggested. Residents at the PGY-2 level and above may remain on site for an additional 4 hours for education or transfer of care but not be assigned additional clinical duties. Residents must have 8 hours free of duty between scheduled periods, though 10 hours is strongly suggested. They must have 14 hours free after a 24 hour in-house duty period. Residents must not be scheduled for more than 6 nights of consecutive night float duty or no more frequently than every-third-night in-house call over a 4 week period. At-home call is counted toward the 80-hour week restriction if residents are called back into the hospital.

Evaluation

Each program must provide residents with multiple evaluator, semi-annual feedback addressing progressive resident performance as well as a summative evaluation upon completion of the program. At least annually, the program must allow for confidential evaluation of faculty and curriculum by the residents.

Supervision

Resident supervision comes in many forms to ensure graded authority and responsibility while maintaining patient safety. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. Supervision should be adequate to provide the resident with feedback.

Patient Safety

Programs must design clinical assignments to limit the number of transfers of care from one team to the next and facilitate structured, effective hand-off processes for continuity of care and patient safety, including a schedule informing team members of the responsible resident and attending physician.

Resident Well-Being

Residents and faculty must be educated in alertness management as well as recognizing and addressing the signs of sleep deprivation and fatigue, including back-up call schedules or protected sleep time. Each program must offer safe transportation or call rooms to ensure resident safety.

Duty Hours Limits	2003 ACGME Limits (1)	2010 ACGME Limits (3)	2008 IOM Recs (2)	AMA Policy (3)
Maximum hours of work per week	80 hours averaged over 4 weeks	No change	No change	Supports current ACGME policy
Maximum shift length	30 hours, with 24 hours for admitting new patients and then 6 hours to complete work, transfer care and education	PGY-1: 16 hours PGY2+: 28 hours; 24 hrs for new admissions; 4 hrs to complete work, transfers and education; strategic napping strongly suggested	30 hours with 16 hours for admitting new patients, then 5 hour protected sleep, then remaining time for completing work and education. Alternative: 16 hours with no protected sleep	Supports original ACGME policy but recommends additional study
Maximum in-hospital on call frequency	Every 3 rd night, on average	Every 3 rd night, on average	Every 3 rd night, no averaging	Supports current ACGME policy
Minimum time off between scheduled shifts	10 hours	8 hours mandatory (10 suggested) 14 hours after 24h shift	10 hours after shift 12 hours after night 14 hours after 30 hours	
Maximum frequency of in-hospital night shifts	Not addressed	Maximum 6 consecutive nights on night float	4 night max 48 hours off after 3 or 4 night on	
Moonlighting	Internal moonlighting counted in 80 hours	All moonlighting counted in 80 hours PGY-1 Not allowed to moonlight	All moonlighting counted in 80 hours All other restrictions applying to moonlighting	
Limit on hours for exceptions	88 hours for select programs with educational rationale	No change	No change	Supports current ACGME policy

Resident Duty Hours: A Review of the Institute of Medicine Recommendations, Current ACGME Guidelines and AMA Policy

In December 2008, the Institute of Medicine released a report addressing current ACGME resident duty hour regulations and their impact on patient and resident safety. Based on a review of the sleep literature as well as data available on medical errors, the IOM issued their recommendations for additional changes to be made in resident schedules. In response to the IOM report, the ACGME convened a meeting in March to discuss the IOM recommendations and to evaluate the impact of these changes on training in the different specialties. The March meeting brought forth diverse opinions on the feasibility and desirability of additional restrictions on resident work hours. In response, the ACGME formed a task force charged with developing a response to the IOM report, incorporating the diverse needs of the different specialties. To guide the work of the task force, the ACGME has asked the different specialties and medical organizations to provide their recommendations. In April, the AMA submitted a letter which outlines current AMA policy as well as AMA recommendations for future action (attached).

In addition to the duty hour recommendations, the IOM also addressed the following issues:

Resident Education and Supervision: The IOM Committee expressed concern that the reduction in hours worked by residents had resulted in an increase in resident workload, leaving less time for learning. They also raised concerns about the amount of supervision that residents were receiving. To address these concerns, they recommended the following:

RRCs set specialty specific guidelines for the number of patients residents can treat during a shift taking into consideration the level of training and the characteristics of the patient
Training programs need to provide closer supervision for residents to include in-house supervision for all PGY1 trainees.

Patient safety and error detection: The IOM Committee recommended that additional protections be developed to improve the culture of safety.

Train residents in error detection, correction, reporting and monitoring
Improve the process/procedures used to transfer care of patients

Recommendations of the RFS Committee on Medical Education:

1. The AMA support current duty hour requirements as set forth in the Common Program Requirements, Accreditation Council for Graduate Medical Education, Section VI.
2. The AMA support additional study of the issues raised with respect to duty hours in the IOM report and consider further modifications of the current duty hours requirements based on the results of this inquiry.
3. The AMA oppose the involvement of outside organizations, including CMS and JAHCO, in the monitoring of duty hours.
4. The AMA support the development of specialty specific guidelines for the provision of supervision of trainees.
5. The AMA support the development of procedures to be used in transferring patient care, as set forth in the Report on Transfer of Patient Care, presented at the A-09 meeting.

References:

1. Common Program Requirements, Accreditation Council for Graduate Medical Education, Section VI.
2. Resident Duty Hours: Enhancing Sleep, Supervision and Safety, Report of the Institute of Medicine, December 2008, www.nap.edu

Relevant AMA Policy:

H-310.957 Resident Working Conditions Reform Update

(1) Our AMA supports the following new language pertaining to resident work hours and environment for the "General Requirements" of the "Essentials of Accredited Residencies in Graduate Medical Education": Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients. (a) Special requirements relating to duty hours and on-call schedules shall be based on an educational rationale and patient need, including continuity of care. (b) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged. (c) Resident duty hours and on-call schedules must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the General and Special Requirements that apply to each program. Detailed structuring of resident service is an integral part of the approval process and therefore close adherence to the General and Special Requirements is essential to program accreditation. (2) Our AMA supports the following proposed revision of the "Special Requirements" for surgery: It is desirable that residents' work schedule be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of seven free of routine responsibilities and be on-call in the hospital no more often than every third night. The ratio of hours worked and on-call time will vary, particularly at the senior levels, and therefore necessitates flexibility. (BOT Rep. YY, I-91; Reaffirmed: Sunset Report, I-01)

H-310.927 Resident Physician Working Conditions

(1) Our AMA adopts the following definitions for resident physician education: (a) "Total duty hours" represents those scheduled hours of activity associated with a residency program and include: (i) scheduled time providing direct patient care or supervised patient care that contributes to the ability of the resident physician to meet educational goals and objectives; (ii) scheduled time to participate in formal educational activities, (iii) scheduled time providing administrative and patient care services of limited or no educational value, and (iv) time needed to transfer the care of patients; and (b) "Organized educational activities" are of two types: (i) "Formal educational activities" include scheduled educational programs such as conferences, seminars, and grand rounds and (ii) "Patient care educational activities" include individualized instruction with a more senior resident or attending physician and teaching rounds with an attending physician. (2) Resident physician total duty hours must not exceed 80 hours per week, averaged over a two-week period and that our AMA work with GME accrediting bodies to determine if an increase of 5% may be appropriate for some training programs. (3) Workdays that exceed 12 hours are defined as on-call. (4) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for up to 30 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. (5) On-call shall be no more frequent than every third night and there be at least one consecutive 24-hour duty-free period every seven days both averaged over a two-week period. (6) **On-call from home shall be counted in the calculation of total duty hours and on-call frequency if the resident physician can routinely expect to get less than eight hours of sleep.** (7) There should be a duty-free interval of at least 10 hours prior to returning to duty. (8) Limits on total duty hours must not adversely impact resident physician participation in the organized educational activities of the residency program. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians for at least eight hours per week averaged over a two-week period. (9) Scheduled time providing patient care services of limited or no educational value be minimized (10) **Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work.** (CME Rep. 9, A-02)

H-310.979 Resident Physician Working Hours and Supervision

(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate

medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care. (b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents. (c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements. (d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident. (e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards. (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services." (h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records. (i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities." (j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government. (CME Rep. C, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-08)

H-310.963 Residency/Fellowship Working Hours and Supervision

It is the policy of the AMA (1) to continue to work with the Accreditation Council for Graduate Medical Education to implement AMA policy for residency work hours reform; and (2) to use existing policy as a guideline in working with state medical societies to obtain modification, if needed, of pending and future legislation on total residency work hours, conditions and supervision. (Sub. Res. 191, I-90; Reaffirmed: Sunset Report, I-00)

H-310.928 Resident/Fellow Work and Learning Environment

Our AMA may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions. (Res. 310, I-01; Reaffirmed: Res. 322, A-03)

D-310.964 Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety

Our AMA: 1. Reaffirms support of the current Accreditation Council for Graduate Medical Education duty hour standards. 2. Continues to monitor the enforcement and impact of the ACGME duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and will monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back at the 2010 Annual Meeting of the AMA House of Delegates. 3. Will, as part of its Initiative to Transform Medical Education strategic focus, utilize relevant evidence on patient safety and sleep to develop a learning environment model that optimizes balance between resident education, patient care, quality and safety, and report back at the 2010 Annual Meeting. 4. Will review, evaluate, and publicize the work of the ACGME Committee on Innovation, in particular its pilot projects related to duty hours, and will encourage participation by ACGME Residency Review Committees and residency programs in these and other efforts towards innovation and improvement in graduate medical education and patient safety. 5. Will ask the ACGME to consider offering programs/institutions additional incentives, such as longer accreditation cycles or reduced accreditation fees, to ensure programmatic and institutional compliance with duty hour limits. 6. Encourages publication of studies about the effects of duty hour standards, extended work shifts, hand offs and continuity of care procedures, and sleep deprivation and fatigue on patient safety, medical error, resident well-being, and resident learning outcomes, and will disseminate study results to GME designated institutional officials (DIOs), program directors, resident/fellow physicians, attending faculty, and others. 7. Will communicate to all GME DIOs, program directors, resident/fellow physicians, and attending faculty about the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and

ethics. 8. Will use the GME e-Letter, AMA Resident and Fellow Section publications, and other communications vehicles to raise awareness among residents (particularly first-year residents) of the ACGME and its role in monitoring and enforcing duty hours. 9. Council on Medical Education will closely monitor the progress of the Institute of Medicine (IOM) committee studying resident duty hours and patient safety and to respond, and/or assist the AMA Washington Office in responding, to any legislative or regulatory initiatives that arise from the IOM or other bodies. 10. Urges the ACGME and AOA to decrease the barriers to reporting duty violations and resident intimidation. (CME Rep. 5, A-08)

D-310.973 Enforcement of ACGME Duty Hour Standards

Our AMA will: (1) Continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards, as they relate to the larger issues of optimal patient care and learning environment for residents, with a report back at the 2008 Annual Meeting of the AMA House of Delegates. (2) Encourage and disseminate the results of studies that link compliance with duty hours standards to patient care quality and medical errors, as well as to resident learning and professionalism. (3) Work with other interested groups to regularly inform GME designated institutional officials (DIOs), program directors, resident physicians, and attending faculty about the adverse effects of sleep deprivation and fatigue on patient safety and resident well-being. **(4) Work with the ACGME to improve the reporting mechanisms for duty hour violations in order to better protect resident confidentiality and improve the learning environment.** (CME Rep. 4, A-06)

D-310.996 Compliance with Resident Work Hour Requirements

(1) ACGME will be asked to collect and report annually the number and variety of violations of duty-hour requirements identified by each Residency Review Committee (2) Our AMA will study the impact of prolonged work hours, **including moonlighting**, on resident physician performance and well-being. (CME Rep. 5, I-99)

D-310.987 Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety

Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians. (Res. 314, A-03)

E-8.088 Resident Physician Involvement in Patient Care

Residents and fellows have dual roles as trainees and caregivers. First and foremost, they are physicians and therefore should always regard the interests of patients as paramount. To facilitate both patient care and educational goals, physicians involved in the training of residents and fellows should ensure that the health care delivery environment is respectful of the learning process as well as the patient's welfare and dignity. (1) In accordance with graduate medical education standards such as those promulgated by the Accreditation Council for Graduate Medical Education (ACGME), training must be structured to provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise. (2) Residents' and fellows' interactions with patients must be based on honesty. Accordingly, residents and fellows should clearly identify themselves as members of a team that is supervised by the attending physician. (3) If a patient refuses care from a resident or fellow, the attending physician should be notified. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from that patient's care or, if appropriate, transfer the patient's care to another physician or non-teaching service, or to another health care facility. (4) Residents and fellows should participate fully in established mechanisms for error reporting and analysis in their training programs and hospital systems. They should cooperate with attending physicians in the communication of errors to patients. (See Opinion E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm.") (5) Residents and fellows are obligated, as are all physicians, to monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. (See Opinion E-9.035, "Physician Health and Wellness.") Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting") might be potentially harmful to themselves and patients. Other activities that interfere with adequate rest during off-hours might be similarly harmful. (6) Residency and fellowship programs must offer means to resolve educational or patient care conflicts that can arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully. When necessary, higher administrative authorities or the relevant Residency Review Committee (RRC) should be involved, as articulated in ACGME guidelines. (I, II, V, VIII) Issued November 2005 based on the report "Resident Physician Involvement in Patient Care," adopted June 2005.

Additional Resources: The ACGME response to the IOM report can be found at www.acgme.org. Additional information on the transfer of patient care can be found in the Committee on Medical Education Report presented at A-09.