

1 **ACGME Common Program Requirements**
2 **Section VI**
3 **Proposed Major Revisions**
4

5 Note: The term “resident” in this document refers to both specialty residents and subspecialty
6 fellows. Once the Common Program Requirements are inserted into each set of specialty and
7 subspecialty requirements, the terms “resident” and “fellow” will be used respectively.
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9 Where applicable, text in italics describes the underlying philosophy of the requirements in that
10 section. These philosophic statements are not program requirements and are therefore not
11 citable. The Background and Intent text in the boxes below have been developed to provide
12 greater detail regarding the intention behind specific requirements as well as guidance on how
13 to implement the requirements in a way that supports excellence in residency education.
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Background and Intent: In developing the revised standards, the Common Program Requirements Phase 1 Task Force considered all available information, including relevant literature, written comments received from the graduate medical education community and the public, and testimony provided during the ACGME Congress on the Resident Learning and Working Environment. Deliberations of the Task Force were guided by the need to develop standards that: (1) emphasize that graduate medical education programs are designed to provide professional education rather than vocational training; (2) are based on the best available evidence; and (3) support the philosophy outlined below.

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16 VI. ~~Resident Duty Hours in~~ The Learning and Working Environment
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18 Residency education must occur in the context of a learning and working environment
19 that emphasizes the following principles:
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- 21 • Excellence in the safety and quality of care rendered to patients by residents today
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- 23 • Excellence in the safety and quality of care rendered to patients by today’s residents
24 in their future practice
25
- 26 • Excellence in professionalism through faculty modeling of:
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 - 28 ○ the effacement of self-interest in a humanistic environment that supports the
29 professional development of physicians
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 - 31 ○ the joy in curiosity, problem-solving, intellectual rigor, and discovery
32
- 33 • Commitment to the well-being of the residents, faculty members, students, and all
34 members of the health care team
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Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support

the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to safely provide care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

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VI.A. Patient Safety, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for ensuring patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within coordinated health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. To this end, the safety system is perceived as fair and effective in bringing about needed improvements. An effective organization has formal mechanisms to assess attitudes toward safety and improvement in order to identify areas requiring intervention.

VI.A.1.a).(1).(a) The program, its leadership, faculty, residents, and fellows must actively participate in these patient safety systems and culture. ^{(Core)*}

72 VI.A.1.a).(1).(b) VI.A.2.The program director must be committed to
73 and responsible for promoting patient safety and
74 resident well-being design and maintain a program
75 that has a structure that promotes interprofessional
76 team-based care and a culture that provides safe
77 patient care in a supportive educational
78 environment. (Core)

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80 VI.A.1.a).(2) Education on Patient Safety

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82 Programs must provide formal educational activities that
83 promote patient safety-related goals, tools, and
84 techniques. It is necessary for residents and faculty
85 members to consistently work in a well-coordinated
86 manner with other health care professionals using shared
87 methodologies to achieve institutional patient safety goals.
88 (Core)

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Background and Intent: Optimal patient safety occurs in the setting of a coordinated
interprofessional learning and working environment.

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91 VI.A.1.a).(3) Reporting, Investigation, and Follow-up of Adverse Events
92 and Near Misses

93
94 Reporting is a pivotal mechanism for improving patient
95 safety, and is essential for the success of any patient
96 safety program. Feedback and experiential learning are
97 essential to developing true competence in the ability to
98 identify causes and institute sustainable systems-based
99 changes to ameliorate patient safety vulnerabilities.

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101 VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other
102 clinical staff members must know:

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104 VI.A.1.a).(3).(a).(i) their responsibilities in reporting patient
105 safety events at the clinical site; and, (Core)

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107 VI.A.1.a).(3).(a).(ii) how to report patient safety events at the
108 clinical site. (Core)

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110 VI.A.1.a).(3).(b) Residents must participate as team members in
111 real and/or simulated interprofessional clinical site-
112 sponsored patient safety activities, such as root
113 cause analyses or other activities that include
114 analysis, as well as formulation and implementation
115 of actions. (Core)

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117 VI.A.1.a).(3).(c) VI.A.3.The program director must ensure that
118 residents and faculty members are integrated and
119 actively participate in the implementation of
120 interdisciplinary clinical quality improvement and

121 patient safety programs at participating sites to
122 address issues identified by investigations. ^(Core)
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124 VI.A.1.a).(4) Resident Education and Experience in Disclosure of
125 Adverse Events

126
127 Patient-centered care requires patients, and when
128 appropriate families, to be apprised of clinical situations
129 that affect them, including adverse events. This is an
130 important skill for faculty physicians to model, and for
131 residents to develop and apply.
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133 VI.A.1.a).(4).(a) All residents must receive training in how to
134 disclose patient safety events to patients and
135 families. ^(Core)
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137 VI.A.1.a).(4).(b) Residents should have the opportunity to
138 participate in the disclosure of patient safety
139 events. ^(Detail)
140

141 VI.A.1.b) Quality Improvement

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143 VI.A.1.b).(1) Education in Quality Improvement

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145 A cohesive model of health care includes quality-related
146 goals, tools, and techniques that are necessary in order for
147 health care professionals to achieve quality improvement
148 goals.
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150 VI.A.1.b).(1).(a) Residents and faculty members must receive
151 training and experience in quality improvement
152 processes, including an understanding of health
153 care disparities. ^(Core)
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155 VI.A.1.b).(2) Quality Metrics

156
157 Access to data is essential to prioritizing activities for care
158 improvement and evaluating success of improvement
159 efforts.
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161 VI.A.1.b).(2).(a) Residents and faculty members should receive
162 specialty-specific data on quality metrics and
163 benchmarks related to their patient populations.
164 ^(Detail)
165

166 VI.A.1.b).(3) Engagement in Quality Improvement Activities

167
168 Experiential learning is essential to developing the ability to
169 identify and institute sustainable systems-based changes
170 to improve patient care.
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172	VI.A.1.b).(3).(a)	<u>Residents must have the opportunity to participate in interprofessional quality improvement activities, including activities aimed at reducing health care disparities.</u> (Core)
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177	VI.A.2.	VI.D.Supervision and Accountability of Residents
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179	VI.A.2.a)	<u>Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs and Sponsoring Institutions define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.</u>
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186		<u>Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.</u>
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192	VI.A.2.a).(1)	VI.D.1. In the <u>learning and working environment</u> clinical learning environment , each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved <u>specified</u> by the applicable Review Committee) who is ultimately responsible <u>and accountable</u> for the patient's care. (Core)
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200	VI.A.2.a).(1).(a)	VI.D.1.a) This information should <u>must</u> be available to residents, faculty members, <u>other members of the health care team</u> , and patients. (Detail-Core)
201		
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204	VI.A.2.a).(1).(b)	VI.D.1.b) Residents and faculty members should <u>must</u> inform each patient of their respective roles in that patient's care. (Detail-Core)
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208	VI.A.2.b)	VI.D.2. <u>Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site in the institution, or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.</u> (Detail)
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221	VI.A.2.b).(1)	VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for
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223 patients based on each resident's level of training and
224 ability, as well as patient complexity and acuity.
225 Supervision may be exercised through a variety of
226 methods, appropriate to the situation. ^(Core)
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228 [The Review Committee may specify which activities
229 require different levels of supervision.]
230

231 VI.A.2.c) ~~VI.D.3.~~Levels of Supervision

232
233 To ensure oversight of resident supervision and graded authority
234 and responsibility, the program must use the following
235 classification of supervision: ^(Core)
236

237 VI.A.2.c).(1) ~~VI.D.3.a)~~Direct Supervision – the supervising physician is
238 physically present with the resident and patient. ^(Core)
239

240 VI.A.2.c).(2) ~~VI.D.3.b)~~Indirect Supervision:

241
242 VI.A.2.c).(2).(a) ~~VI.D.3.b).(1)~~with Direct Supervision immediately
243 available – the supervising physician is physically
244 within the hospital or other site of patient care, and
245 is immediately available to provide Direct
246 Supervision. ^(Core)
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248 VI.A.2.c).(2).(b) ~~VI.D.3.b).(2)~~with Direct Supervision available – the
249 supervising physician is not physically present
250 within the hospital or other site of patient care, but
251 is immediately available by means of telephonic
252 and/or electronic modalities, and is available to
253 provide Direct Supervision. ^(Core)
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255 VI.A.2.c).(3) ~~VI.D.3.c)~~Oversight – the supervising physician is available
256 to provide review of procedures/encounters with feedback
257 provided after care is delivered. ^(Core)
258

259 VI.A.2.d) ~~VI.D.4.~~The privilege of progressive authority and responsibility,
260 conditional independence, and a supervisory role in patient care
261 delegated to each resident must be assigned by the program
262 director and faculty members. ^(Core)
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264 VI.A.2.d).(1) ~~VI.D.4.a)~~The program director must evaluate each
265 resident's abilities based on specific criteria, guided by the
266 Milestones. ~~When available, evaluation should be guided~~
267 ~~by specific national standards-based criteria.~~ ^(Core)
268

269 VI.A.2.d).(2) ~~VI.D.4.b)~~Faculty members functioning as supervising
270 physicians should delegate portions of care to residents,
271 based on the needs of the patient and the skills of each
272 resident. ^(DetailCore)
273

274 VI.A.2.d).(3) VI.D.4.e)Senior residents or fellows should serve in a
 275 supervisory role to junior residents in recognition of their
 276 progress toward independence, based on the needs of
 277 each patient and the skills of the individual resident or
 278 fellow. ^(Detail)
 279
 280 VI.A.2.e) VI.D.5.Programs must set guidelines for circumstances and
 281 events in which residents must communicate with ~~appropriate the~~
 282 supervising faculty member(s), ~~such as the transfer of a patient to~~
 283 ~~an intensive care unit, or end-of-life decisions.~~ ^(Core)
 284
 285 VI.A.2.e).(1) VI.D.5.a)Each resident must know the limits of their scope
 286 of authority, and the circumstances under which the
 287 resident is permitted to act with conditional independence.
 288 ^(Outcome)
 289

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

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 291 VI.A.2.e).(1).(a) VI.D.5.a).(1) In particular ~~Initially~~, PGY-1 residents
 292 ~~should~~ must be supervised either directly or
 293 indirectly with direct supervision immediately
 294 available. [Each Review Committee ~~will~~ may
 295 describe the conditions and the achieved
 296 competencies under which PGY-1 residents
 297 progress to be supervised indirectly, with direct
 298 supervision available.] ^(Core)
 299
 300 VI.A.2.f) VI.D.6.Faculty supervision assignments ~~should~~ must be of
 301 sufficient duration to assess the knowledge and skills of each
 302 resident and to delegate to the resident the appropriate level of
 303 patient care authority and responsibility. ^(Detail-Core)
 304

305 VI.B. VI.A. Professionalism, Personal Responsibility, and Patient Safety

307 VI.B.1. VI.A.1.Programs and Sponsoring Institutions must educate residents and
 308 faculty members concerning the professional responsibilities of
 309 physicians, including their obligation to appear for duty ~~be~~ appropriately
 310 rested and fit to provide the ~~services~~ care required by their patients. ^(Core)
 311

312 VI.B.2. VI.A.4.The learning objectives of the program must:

314 VI.B.2.a) VI.A.4.a)~~be~~ accomplished through an appropriate blend of
 315 supervised patient care responsibilities, clinical teaching, and
 316 didactic educational events; ^(Core)
 317

318 VI.B.2.b) VI.A.4.b) ~~not be compromised by~~ accomplished without excessive
 319 reliance on residents to fulfill non-physician ~~service~~ obligations;
 320 and, ^(Core)
 321

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital, routine blood drawing for laboratory tests, routine monitoring of patients when off the ward, and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

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VI.B.2.c) generally ensure manageable patient care responsibilities. (Core)

[As further specified by the Review Committee]

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

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VI.B.3. ~~VI.A.5.~~The program director and Sponsoring Institution must ensure a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. ~~VI.A.6.~~Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the:

VI.B.4.a) ~~VI.A.6.b.)~~provision of patient- and family-centered care; (Outcome)

VI.B.4.b) ~~VI.A.6.a.)~~assurance of the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

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VI.B.4.c) ~~VI.A.6.c.)~~assurance of their fitness for duty work, including; (Outcome)

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for duty adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

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VI.B.4.c).(1) ~~VI.A.6.d.)~~management of their time before, during, and after clinical assignments; and, (Outcome)

- 348 VI.B.4.c).(2) VI.A.6.e)recognition of impairment, including from illness,
 349 fatigue, and substance use, in themselves, their peers, and
 350 other members of the health care team. (Outcome)
 351
 352 VI.B.4.d) VI.A.6.f) attention commitment to lifelong learning; (Outcome)
 353
 354 VI.B.4.e) VI.A.6.g)the monitoring of their patient care performance
 355 improvement indicators; and, (Outcome)
 356
 357 VI.B.4.f) VI.A.6.h) ~~honest and~~ accurate reporting of ~~duty~~ clinical and
 358 educational work hours, patient outcomes, and clinical experience
 359 data. (Outcome)
 360
 361 VI.B.5. VI.A.7.All residents and faculty members must demonstrate
 362 responsiveness to patient needs that supersedes self-interest. ~~They must~~
 363 ~~recognize~~ This includes the recognition that under certain circumstances,
 364 the best interests of the patient may be served by transitioning that
 365 patient's care to another qualified and rested provider. (Outcome)
 366
 367 VI.C. Well-Being
 368
 369 *In the current health care environment, residents and faculty members are at*
 370 *increased risk for burnout and depression. Psychological, emotional, and*
 371 *physical well-being are critical in the development of the competent, caring, and*
 372 *resilient physician. Self-care is an important component of professionalism; it is*
 373 *also a skill that must be learned and nurtured in the context of other aspects of*
 374 *residency training. Programs and Sponsoring Institutions have the same*
 375 *responsibility to address well-being as they do to ensure other aspects of*
 376 *resident competence.*
 377

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

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 379 VI.C.1. This responsibility must include:
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 381 VI.C.1.a) efforts to enhance the meaning that the resident finds in the
 382 experience of being a physician, including protecting time with
 383 patients, minimization of non-physician obligations, provision of
 384 administrative support, promotion of progressive autonomy and
 385 flexibility, and enhancement of professional relationships; (Core)

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387 VI.C.1.b) attention to scheduling, work intensity, and work compression that
388 impacts resident well-being; ^(Core)

389
390 VI.C.1.c) evaluating safety data and addressing the safety of residents and
391 faculty members in the learning and working environment; ^(Core)
392

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, patient violence, vehicle collisions, and emotional well-being after adverse events.

393
394 VI.C.1.d) policies and programs that encourage optimal resident and faculty
395 member well-being; and, ^(Core)
396

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

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398 VI.C.1.d).(1) Residents must be given the opportunity to attend medical,
399 mental health, and dental care appointments, including
400 those scheduled during their working hours. ^(Core)
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Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

402
403 VI.C.1.e) attention to resident and faculty member burnout, depression, and
404 substance abuse. The program and Sponsoring Institution must
405 educate faculty members and residents in identification of the
406 symptoms of burnout, depression, and substance abuse, including
407 means to assist those who experience these conditions.
408 Residents and faculty members must also be educated to
409 recognize those symptoms in themselves and how to seek
410 appropriate care. The program and Sponsoring Institution must:
411 ^(Core)
412

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials include, but are not limited to:

- ACGME Physician Well-being web page (<http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being>)
- Compassion Satisfaction/Fatigue Self-Test
- General Health Questionnaire (GHQ) 13
- Substance abuse: National Institute for Drug Abuse (NIDA: <https://www.drugabuse.gov/>)
- Burnout and Depression:

- Patient Health Questionnaire (PHQ-9 or PHQ-2)
- Quick Inventory of Depressive Symptomatology (QIDS)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Beck Depression Inventory (BDI)

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VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; ^(Core)

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when a fellow resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

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VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, ^(Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health counseling and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

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VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have a policy and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. ^(Core)

- 436 VI.D. ~~VI.C. Alertness Management/Fatigue Mitigation~~
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- 438 VI.D.1. ~~VI.C.1. Programs must:~~
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- 440 VI.D.1.a) ~~VI.C.1.a)~~ educate all faculty members and residents to recognize
441 the signs of fatigue and sleep deprivation; ^(Core)
- 442
- 443 VI.D.1.b) ~~VI.C.1.b)~~ educate all faculty members and residents in alertness
444 management and fatigue mitigation processes; and, ^(Core)
- 445
- 446 VI.D.1.c) ~~VI.C.1.c)~~ ~~adopt~~ encourage residents to use fatigue mitigation
447 processes to manage the potential negative effects of fatigue on
448 patient care and learning, ~~such as naps or back-up call schedules.~~
- 449 ^(Detail)
- 450

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

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- 452 VI.D.2. ~~VI.C.2.~~ Each program must ~~have a process to ensure~~ continuity of patient
453 care, consistent with the program's policy and procedures referenced in
454 VI.C.2. in the event that a resident may be unable to perform their patient
455 care responsibilities ~~duties~~ due to excessive fatigue. ^(Core)
- 456
- 457 VI.D.3. ~~VI.C.3.~~ The Sponsoring Institution must provide adequate sleep facilities
458 and/or safe transportation options for residents who may be too fatigued
459 to safely return home. ^(Core)
- 460
- 461 VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care
- 462
- 463 VI.E.1. ~~VI.E.~~ Clinical Responsibilities
- 464
- 465 The clinical responsibilities for each resident must be based on PGY,
466 patient safety, resident education-ability, severity and complexity of
467 patient illness/condition, and available support services. ^(Core)
- 468
- 469 [Optimal clinical workload ~~will~~ may be further specified by each Review
470 Committee.]
- 471

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

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473 VI.E.2. VI.F. Teamwork
474
475 Residents must care for patients in an environment that maximizes
476 effective communication. This must include the opportunity to work as a
477 member of effective interprofessional teams that are appropriate to the
478 delivery of care in the specialty. ^(Core)
479
480 [Each Review Committee will define the elements that must be present in
481 each specialty.]
482
483 VI.E.3. VI.B. Transitions of Care
484
485 VI.E.3.a) VI.B.1. Programs must design clinical assignments to ~~minimize the~~
486 ~~number of~~ optimize transitions in patient care, including their
487 safety, frequency, and structure. ^(Core)
488
489 VI.E.3.b) VI.B.2. ~~Programs, in partnership with their Sponsoring Institutions~~
490 ~~and programs,~~ must ensure and monitor effective, structured
491 hand-over processes to facilitate both continuity of care and
492 patient safety. ^(Core)
493
494 VI.E.3.c) VI.B.3. Programs must ensure that residents are competent in
495 communicating with team members in the hand-over process.
496 ^(Outcome)
497
498 VI.E.3.d) VI.B.4. ~~The sponsoring institution~~ Programs and clinical sites must
499 ensure the availability of ~~maintain and communicate~~ schedules
500 ~~that inform all members of the health care team of~~ attending
501 physicians and residents currently responsible for ~~each patient's~~
502 care. ^(Detail-Core)
503
504 VI.E.3.e) Each program must ensure continuity of patient care, consistent
505 with the program's policy and procedures referenced in VI.C.2, in
506 the event that a resident may be unable to perform their patient
507 care responsibilities due to excessive fatigue or illness. ^(Core)
508
509 VI.F. VI.G. ~~Resident Duty Hours~~ Clinical Experience and Education
510
511 Programs and Sponsoring Institutions must design an effective program structure
512 that is configured to provide residents with educational and clinical experience
513 opportunities, as well as reasonable opportunities for rest and personal activities.
514

Background and Intent: In the new requirements, the terms “clinical experience and education,” “Clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.

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VI.F.1. ~~VI.G.1.~~ Maximum Hours of Clinical and Educational Work per Week

~~Duty~~ Clinical and educational work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call ~~and clinical and educational~~ activities, clinical work done from home, and all moonlighting. ^(Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling

While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. Such programs may need to consider adjusting schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work period when developing schedules to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for adverse accreditation action.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on-site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirements provide flexibility for residents to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be

counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

PGY-1 and PGY-2 Residents

PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident's assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

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- VI.F.1.a) ~~VI.G.1.a) Duty~~ Clinical and Educational Work Hour Exceptions
- A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. ^(Detail)
- VI.F.1.a).(1) ~~VI.G.1.a).(1)~~ In preparing a request for an exception, the program director must follow the duty-clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. ^(Detail-Core)
- VI.F.1.a).(2) ~~VI.G.1.a).(2)~~ Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. ^(Detail-Core)

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

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- VI.F.2. ~~VI.G.2.~~ Moonlighting
- VI.F.2.a) ~~VI.G.2.a)~~ Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. ^(Core)
- VI.F.2.b) ~~VI.G.2.b)~~ Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must

550 be counted toward the 80-hour maximum weekly limit. (Core)
551
552 VI.F.2.c) ~~VI.G.2.c)~~ PGY-1 residents are not permitted to moonlight. (Core)
553

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs.

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555 VI.F.3. ~~VI.G.3.~~ Mandatory Time Free of Duty-Clinical Work and Education

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557 VI.F.3.a) The program must design an effective program structure that is
558 configured to provide residents with educational opportunities, as
559 well as reasonable opportunities for rest and personal well-being.
560 (Core)

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562 VI.F.3.b) ~~VI.G.3.~~ Residents must be scheduled for a minimum of one day in
563 seven free of ~~duty-clinical work and education~~ every week (when
564 averaged over four weeks). At-home call cannot be assigned on
565 these free days. (Core)
566

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes educational and personal goals. Programs are strongly discouraged from scheduling residents for 24 straight days of work followed by four days off, as this is likely to result in resident fatigue and may have a negative impact on resident well-being. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

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568 VI.F.4. ~~VI.G.4.~~ Maximum Duty-Clinical Work and Education Period Length

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570 VI.F.4.a) ~~VI.G.4.a)~~ Duty periods of PGY-1 residents must not exceed 16
571 hours in duration. (Core)
572

Background and Intent: The Task Force examined the question of "consecutive time on-task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a “shift” mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.B. of these requirements.

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VI.F.4.b)

~~VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)~~

VI.F.4.b).(1)

~~VI.G.4.b).(1) Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)~~

VI.F.4.b).(2)

~~VI.G.4.b).(2) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. Up to four hours of additional time may be used for activities related to patient safety, such as ensuring effective transitions of care, and/or resident education. (Core)~~

VI.F.4.b).(2).(a)

Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

Background and Intent: The additional time referenced in VI.F.4.b).(2) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided.

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599 VI.F.4.b).(3) ~~VI.G.4.b).(3) Residents must not be assigned additional~~
600 ~~clinical responsibilities after 24 hours of continuous in-~~
601 ~~house duty.~~^(Core)
602
603 VI.F.4.c) ~~VI.G.4.b).(4)~~In unusual circumstances, after handing off all
604 patients to the team responsible for their continuing care,
605 residents, on their own initiative, may remain beyond their
606 ~~scheduled 24+ up to four-hour period of duty responsibilities~~ to
607 continue to provide care to a single patient. Justifications for such
608 extensions of ~~duty~~ are limited to reasons of ~~required~~ continuity for
609 a severely ill or unstable patient, academic importance of the
610 events transpiring, or humanistic attention to the needs of a
611 patient or family. Another justification is to attend educational
612 events on the resident's own initiative. These additional hours of
613 care or education will be counted toward the 80-hour weekly limit.
614 (Detail)
615

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the 24+ up to four-hour limit in the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily; residents must not be required to stay. Programs allowing residents to remain beyond the 24+ up to four-hour limit must ensure that the decision to remain is initiated by the resident and that residents are not coerced.

This additional time must be counted toward the 80-hour maximum weekly limit.

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617 VI.F.4.c).(1) ~~VI.G.4.b).(4).(a) Under those circumstances, the resident~~
618 ~~must:~~
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620 VI.F.4.c).(1).(a) ~~VI.G.4.b).(4).(a).(i) appropriately hand over the care~~
621 ~~of all other patients to the team responsible for their~~
622 ~~continuing care; and,~~^(Detail)
623
624 VI.F.4.c).(1).(b) ~~VI.G.4.b).(4).(a).(ii) document the reasons for~~
625 ~~remaining to care for the patient in question and~~
626 ~~submit that documentation in every circumstance to~~
627 ~~the program director.~~^(Detail)
628
629 VI.F.4.c).(2) ~~VI.G.4.b).(4).(b) The program director must review each~~
630 ~~submission of additional service, and track both individual~~
631 ~~resident and program-wide episodes of additional duty.~~
632 (Detail)
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634 VI.F.5. ~~VI.G.5.~~Minimum Time Off between Scheduled Duty Clinical Work and

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Education Periods

VI.F.5.a) ~~VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.~~ ^(Core)

Background and Intent: The requirements regarding time off between clinical and educational work periods have been eliminated in support of providing programs with increased flexibility in scheduling. It is emphasized that programs are expected to comply with the 80-hour weekly limit, averaged over four weeks.

VI.F.5.b) ~~VI.G.5).(b) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They~~ Residents must have at least 14 hours free of ~~duty~~ clinical work and education after 24 hours of in-house ~~duty call.~~ ^(Core)

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

VI.F.5.c) ~~VI.G.5.c) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.~~ ^(Outcome)

VI.F.5.c).(1) ~~VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.~~ ^(Detail)

VI.F.5.c).(1).(a) ~~VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.~~ ^(Detail)

VI.F.6. ~~VI.G.6. Maximum Frequency of In-House Night Float~~

~~Residents must not be scheduled for more than six consecutive nights of night float.~~ ^(Core) Night float must occur within the context of the 80-hour, and one-day-off-in-seven requirements. ^(Core)

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

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Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

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VI.F.7. ~~VI.G.7.~~Maximum In-House On-Call Frequency

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~~PGY-2 Residents and above~~ must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). ^(Core)

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686 VI.F.8.

~~VI.G.8.~~At-Home Call

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688 VI.F.8.a)

~~VI.G.8.a.)~~Time spent in the hospital or at home performing clinical responsibilities by residents on at-home call must count toward the 80-hour maximum weekly ~~hour~~ limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of duty clinical work and education, when averaged over four weeks. ^(Core)

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695 VI.F.8.a).(1)

~~VI.G.8.a).(1)~~At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. ^(Core)

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699 VI.F.8.b)

~~VI.G.8.b.)~~Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour maximum weekly limit, will not initiate a new “off-duty period.” ^(Detail)

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Background and Intent: This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day’s case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

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***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

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Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

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Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

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