ACGME Common Program Requirements
Section VI
Proposed Major Revisions

Note: The term "resident" in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms "resident" and "fellow" will be used respectively.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable. The Background and Intent text in the boxes below have been developed to provide greater detail regarding the intention behind specific requirements as well as guidance on how to implement the requirements in a way that supports excellence in residency education.

> 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.

VI.   ~~Resident Duty Hours in~~ The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- *Excellence in the safety and quality of care rendered to patients by residents today*

- *Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*

- *Excellence in professionalism through faculty modeling of:*

  - *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*

  - *the joy in curiosity, problem-solving, intellectual rigor, and discovery*

- *Commitment to the well-being of the residents, faculty members, students, and all members of the health care team*

> 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.

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 <u>director</u> must ~~be committed to~~
73		~~and responsible for promoting patient safety and~~
74		~~resident well-being~~ <u>design and maintain a program</u>
75		<u>that has a structure that promotes interprofessional</u>
76		<u>team-based care and a culture that provides safe</u>
77		<u>patient care</u> in a supportive educational
78		environment. ^(Core)
79		
80	VI.A.1.a).(2)	<u>Education on Patient Safety</u>
81		
82		<u>Programs must provide formal educational activities that</u>
83		<u>promote patient safety-related goals, tools, and</u>
84		<u>techniques. It is necessary for residents and faculty</u>
85		<u>members to consistently work in a well-coordinated</u>
86		<u>manner with other health care professionals using shared</u>
87		<u>methodologies to achieve institutional patient safety goals.</u>
88		<u>^(Core)</u>
89		

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

90		
91	VI.A.1.a).(3)	<u>Reporting, Investigation, and Follow-up of Adverse Events</u>
92		<u>and Near Misses</u>
93		
94		*<u>Reporting is a pivotal mechanism for improving patient</u>*
95		*<u>safety, and is essential for the success of any patient</u>*
96		*<u>safety program. Feedback and experiential learning are</u>*
97		*<u>essential to developing true competence in the ability to</u>*
98		*<u>identify causes and institute sustainable systems-based</u>*
99		*<u>changes to ameliorate patient safety vulnerabilities.</u>*
100		
101	VI.A.1.a).(3).(a)	<u>Residents, fellows, faculty members, and other</u>
102		<u>clinical staff members must know:</u>
103		
104	VI.A.1.a).(3).(a).(i)	<u>their responsibilities in reporting patient</u>
105		<u>safety events at the clinical site; and,</u> ^(Core)
106		
107	VI.A.1.a).(3).(a).(ii)	<u>how to report patient safety events at the</u>
108		<u>clinical site.</u> ^(Core)
109		
110	VI.A.1.a).(3).(b)	<u>Residents must participate as team members in</u>
111		<u>real and/or simulated interprofessional clinical site-</u>
112		<u>sponsored patient safety activities, such as root</u>
113		<u>cause analyses or other activities that include</u>
114		<u>analysis, as well as formulation and implementation</u>
115		<u>of actions.</u> ^(Core)
116		
117	VI.A.1.a).(3).(c)	~~VI.A.3.~~The program director must ensure that
118		residents <u>and faculty members</u> are integrated and
119		actively participate in <u>the implementation of</u>
120		interdisciplinary clinical quality improvement ~~and~~

121		~~patient safety programs.~~ at participating sites to
122		address issues identified by investigations. (Core)
123		
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.*
132		
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)
136		
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
142		
143	VI.A.1.b).(1)	Education in Quality Improvement
144		
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.*
149		
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)
154		
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.*
160		
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.*
171		

172	VI.A.1.b).(3).(a)	Residents must have the opportunity to participate
173		in interprofessional quality improvement activities,
174		including activities aimed at reducing health care
175		disparities. (Core)
176		
177	VI.A.2.	~~VI.D.~~Supervision and Accountability ~~of Residents~~
178		
179	*VI.A.2.a)*	*Although the attending physician is ultimately responsible for the*
180		*care of the patient, every physician shares in the responsibility*
181		*and accountability for their efforts in the provision of care.*
182		*Effective programs and Sponsoring Institutions define, widely*
183		*communicate, and monitor a structured chain of responsibility and*
184		*accountability as it relates to the supervision of all patient care.*
185		
186		*Supervision in the setting of graduate medical education provides*
187		*safe and effective care to patients; ensures each resident's*
188		*development of the skills, knowledge, and attitudes required to*
189		*enter the unsupervised practice of medicine; and establishes a*
190		*foundation for continued professional growth.*
191		
192	VI.A.2.a).(1)	~~VI.D.1.~~In the learning and working environment~~clinical~~
193		~~learning environment~~, each patient must have an
194		identifiable and appropriately-credentialed and privileged
195		attending physician (or licensed independent practitioner
196		as ~~approved~~ specified by the applicable Review
197		Committee) who is ~~ultimately~~ responsible and accountable
198		for the patient's care. (Core)
199		
200	VI.A.2.a).(1).(a)	~~VI.D.1.a)~~This information ~~should~~ must be available
201		to residents, faculty members, other members of
202		the health care team, and patients. (~~Detail~~ Core)
203		
204	VI.A.2.a).(1).(b)	~~VI.D.1.b)~~Residents and faculty members ~~should~~
205		must inform each patient of their respective roles in
206		that patient's care. (~~Detail~~ Core)
207		
208	*VI.A.2.b)*	~~VI.D.2.~~*Supervision may be exercised through a variety of*
209		*methods. ~~Some activities require the physical presence of the~~*
210		*~~supervising faculty member.~~ For many aspects of patient care, the*
211		*supervising physician may be a more advanced resident or fellow.*
212		*Other portions of care provided by the resident can be adequately*
213		*supervised by the immediate availability of the supervising faculty*
214		*member, fellow, or senior resident physician, either on site ~~in the~~*
215		*~~institution~~, or by means of telephonic and/or electronic modalities.*
216		*Some activities require the physical presence of the supervising*
217		*faculty member. In some circumstances, supervision may include*
218		*post-hoc review of resident-delivered care with feedback ~~as to the~~*
219		*~~appropriateness of that care~~.* (Detail)
220		
221	VI.A.2.b).(1)	~~VI.D.2.~~The program must demonstrate that the appropriate
222		level of supervision is in place for all residents ~~who care for~~

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)
227		
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)
247		
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)
254		
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)
263		
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. (~~Detail~~Core)
273		

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

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

290		
291 292 293 294 295 296 297 298 299	VI.A.2.e).(1).(a)	~~VI.D.5.a).(1) In particular~~Initially, PGY-1 residents ~~should~~must be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee ~~will~~may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.] (Core)
300 301 302 303 304	VI.A.2.f)	~~VI.D.6.~~Faculty supervision assignments ~~should~~must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (~~Detail~~Core)
305 306	VI.B.	~~VI.A.~~Professionalism~~, Personal Responsibility, and Patient Safety~~
307 308 309 310 311	VI.B.1.	~~VI.A.1.~~Programs and Sponsoring Institutions must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to ~~appear for duty~~be appropriately rested and fit to provide the ~~services~~care required by their patients. (Core)
312 313	VI.B.2.	~~VI.A.4.~~The learning objectives of the program must:
314 315 316 317	VI.B.2.a)	~~VI.A.4.a)~~be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)
318 319 320 321	VI.B.2.b)	~~VI.A.4.b) not~~ be ~~compromised by~~accomplished without excessive reliance on residents to fulfill non-physician ~~service~~ obligations; and, (Core)

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.

322
323   VI.B.2.c)   generally ensure manageable patient care responsibilities. (Core)
324
325   [As further specified by the Review Committee]
326

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.

327
328   VI.B.3.   ~~VI.A.5.~~The program director and Sponsoring Institution must ensure a
329   culture of professionalism that supports patient safety and personal
330   responsibility. (Core)
331
332   VI.B.4.   ~~VI.A.6.~~Residents and faculty members must demonstrate an
333   understanding and acceptance of their personal role in the:
334
335   VI.B.4.a)   ~~VI.A.6.b)~~provision of patient- and family-centered care; (Outcome)
336
337   VI.B.4.b)   ~~VI.A.6.a)~~assurance of the safety and welfare of patients entrusted
338   to their care, including the ability to report unsafe conditions and
339   adverse events; (Outcome)
340

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.

341
342   VI.B.4.c)   ~~VI.A.6.c)~~assurance of their fitness for ~~duty~~ work, including: (Outcome)
343

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.

344
345   VI.B.4.c).(1)   ~~VI.A.6.d)~~management of their time before, during, and after
346   clinical assignments; and, (Outcome)
347

348	VI.B.4.c).(2)	~~VI.A.6.e)~~recognition of impairment, including from illness,
349		fatigue, <u>and substance use,</u> in themselves, their peers<u>, and</u>
350		<u>other members of the health care team.</u> (Outcome)
351		
352	VI.B.4.d)	~~VI.A.6.f) attention~~ <u>commitment</u> 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~~ <u>clinical and</u>
358		<u>educational work</u> 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~~ <u>This includes the recognition</u> 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.	<u>Well-Being</u>
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.

378		
379	VI.C.1.	<u>This responsibility must include:</u>
380		
381	VI.C.1.a)	<u>efforts to enhance the meaning that the resident finds in the</u>
382		<u>experience of being a physician, including protecting time with</u>
383		<u>patients, minimization of non-physician obligations, provision of</u>
384		<u>administrative support, promotion of progressive autonomy and</u>
385		<u>flexibility, and enhancement of professional relationships;</u> (Core)

386
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.

397
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)
401

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:

<table>
<tr><td></td><td>o Patient Health Questionnaire (PHQ-9 or PHQ-2)</td></tr>
<tr><td></td><td>o Quick Inventory of Depressive Symptomatology (QIDS)</td></tr>
<tr><td></td><td>o Center for Epidemiologic Studies Depression Scale (CES-D)</td></tr>
<tr><td></td><td>o Beck Depression Inventory (BDI)</td></tr>
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413

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

420

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.

421

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

424

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

428

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.

429

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

435

436	VI.D.	~~VI.C.~~ Alertness Management/Fatigue Mitigation
437		
438	VI.D.1.	~~VI.C.1.~~ Programs must:
439		
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.

451		
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.

472
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 Institution~~s~~
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.

515
516   VI.F.1.   ~~VI.G.1.~~Maximum Hours of <u>Clinical and Educational </u>Work per Week
517
518   ~~Duty~~<u>Clinical and educational work</u> hours must be limited to 80 hours per
519   week, averaged over a four-week period, inclusive of all in-house ~~call~~
520   <u>clinical and educational</u> activities<u>, clinical work done from home,</u> and all
521   moonlighting. (Core)
522

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.

523		
524	VI.F.1.a)	~~VI.G.1.a) Duty~~Clinical and Educational Work Hour Exceptions
525		
526		A Review Committee may grant rotation-specific exceptions for up
527		to 10 percent or a maximum of 88 clinical and educational work
528		hours to individual programs based on a sound educational
529		rationale. (Detail)
530		
531	VI.F.1.a).(1)	~~VI.G.1.a).(1)~~In preparing a request for an exception, the
532		program director must follow the ~~duty~~ clinical and
533		educational work hour exception policy from the *ACGME*
534		*Manual of Policies and Procedures.* (~~Detail~~ Core)
535		
536	VI.F.1.a).(2)	~~VI.G.1.a).(2)~~Prior to submitting the request to the Review
537		Committee, the program director must obtain approval
538		from the Sponsoring Institution's GMEC and DIO. (~~Detail~~ Core)
539		

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.

540		
541	VI.F.2.	~~VI.G.2.~~Moonlighting
542		
543	VI.F.2.a)	~~VI.G.2.a)~~Moonlighting must not interfere with the ability of the
544		resident to achieve the goals and objectives of the educational
545		program, and must not interfere with the resident's fitness for work
546		nor compromise patient safety. (Core)
547		
548	VI.F.2.b)	~~VI.G.2.b)~~Time spent by residents in internal and external
549		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.

554		
555	VI.F.3.	VI.G.3.Mandatory Time Free of Duty Clinical Work and Education
556		
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)
561		
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."

567		
568	VI.F.4.	VI.G.4.Maximum Duty Clinical Work and Education Period Length
569		
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.

573		
574	VI.F.4.b)	~~VI.G.4.b) Duty periods of PGY-2 residents and above may be~~
575		~~scheduled to a maximum of 24 hours of continuous duty in the~~
576		~~hospital.~~ Clinical and educational work periods for residents must
577		not exceed 24 hours of continuous scheduled clinical
578		assignments. (Core)
579		
580	VI.F.4.b).(1)	~~VI.G.4.b).(1) Programs must encourage residents to use~~
581		~~alertness management strategies in the context of patient~~
582		~~care responsibilities. Strategic napping, especially after 16~~
583		~~hours of continuous duty and between the hours of 10:00~~
584		~~p.m. and 8:00 a.m., is strongly suggested.~~ (Detail)
585		
586	VI.F.4.b).(2)	~~VI.G.4.b).(2) It is essential for patient safety and resident~~
587		~~education that effective transitions in care occur. Residents~~
588		~~may be allowed to remain on-site in order to accomplish~~
589		~~these tasks; however, this period of time must be no longer~~
590		~~than an additional four hours.~~ Up to four hours of additional
591		time may be used for activities related to patient safety,
592		such as ensuring effective transitions of care, and/or
593		resident education. (Core)
594		
595	VI.F.4.b).(2).(a)	Additional patient care responsibilities must not be
596		assigned to a resident during this time. (Core)
597		

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.

598
599 VI.F.4.b).(3)   ~~VI.G.4.b).(3) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.~~ (Core)
600
601
602
603 VI.F.4.c)   ~~VI.G.4.b).(4)~~In unusual circumstances, <u>after handing off all patients to the team responsible for their continuing care,</u> residents, on their own initiative, may remain beyond their ~~scheduled~~ <u>24+ up to four-hour</u> period of ~~duty~~ <u>responsibilities</u> to continue to provide care to a single patient. Justifications for such extensions ~~of duty~~ are limited to reasons ~~of required~~ continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. <u>Another justification is to attend educational events on the resident's own initiative. These additional hours of care or education will be counted toward the 80-hour weekly limit.</u> (Detail)
604
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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.

616
617 VI.F.4.c).(1)   ~~VI.G.4.b).(4).(a) Under those circumstances, the resident must:~~
618
619
620 VI.F.4.c).(1).(a)   ~~VI.G.4.b).(4).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,~~ (Detail)
621
622
623
624 VI.F.4.c).(1).(b)   ~~VI.G.4.b).(4).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.~~ (Detail)
625
626
627
628
629 VI.F.4.c).(2)   ~~VI.G.4.b).(4).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.~~ (Detail)
630
631
632
633
634 VI.F.5.   ~~VI.G.5.~~Minimum Time Off between Scheduled ~~Duty~~ <u>Clinical Work and</u>

635	Education Periods
636	
637	VI.F.5.a) ~~VI.G.5.a) PGY-1 residents should have 10 hours, and must have~~
638	~~eight hours, free of duty between scheduled duty periods.~~ (Core)
639	

> 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.

640	
641	VI.F.5.b) ~~VI.G.5).(b) Intermediate-level residents [as defined by the Review~~
642	~~Committee] should have 10 hours free of duty, and must have~~
643	~~eight hours between scheduled duty periods. They~~ Residents
644	must have at least 14 hours free of ~~duty~~clinical work and
645	education after 24 hours of in-house ~~duty~~ call. (Core)
646	

> 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.

647	
648	VI.F.5.c) ~~VI.G.5.c) Residents in the final years of education [as defined by~~
649	~~the Review Committee] must be prepared to enter the~~
650	~~unsupervised practice of medicine and care for patients over~~
651	~~irregular or extended periods.~~ (Outcome)
652	
653	VI.F.5.c).(1) ~~VI.G.5.c).(1) This preparation must occur within the context~~
654	~~of the 80-hour, maximum duty period length, and one-day-~~
655	~~off-in-seven standards. While it is desirable that residents~~
656	~~in their final years of education have eight hours free of~~
657	~~duty between scheduled duty periods, there may be~~
658	~~circumstances [as defined by the Review Committee] when~~
659	~~these residents must stay on duty to care for their patients~~
660	~~or return to the hospital with fewer than eight hours free of~~
661	~~duty.~~ (Detail)
662	
663	VI.F.5.c).(1).(a) ~~VI.G.5.c).(1).(a) Circumstances of return-to-hospital~~
664	~~activities with fewer than eight hours away from the~~
665	~~hospital by residents in their final years of~~
666	~~education must be monitored by the program~~
667	~~director.~~ (Detail)
668	
669	VI.F.6. ~~VI.G.6.~~ Maximum Frequency of In-House Night Float
670	
671	~~Residents must not be scheduled for more than six consecutive nights of~~
672	~~night float.~~ (Core)Night float must occur within the context of the 80-hour,
673	and one-day-off-in-seven requirements. (Core)
674	
675	[The maximum number of consecutive weeks of night float, and maximum
676	number of months of night float per year may be further specified by the
677	Review Committee.]

678

> 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.

679
680   VI.F.7.   ~~VI.G.7.~~ Maximum In-House On-Call Frequency
681
682   ~~PGY-2~~ Residents ~~and above~~ must be scheduled for in-house call no more
683   frequently than every third night (when averaged over a four-week
684   period). (Core)
685
686   VI.F.8.   ~~VI.G.8.~~ At-Home Call
687
688   VI.F.8.a)   ~~VI.G.8.a)~~ Time spent in the hospital or at home performing clinical
689   responsibilities by residents on at-home call must count toward
690   the 80-hour maximum weekly ~~hour~~ limit. The frequency of at-home
691   call is not subject to the every-third-night limitation, but must
692   satisfy the requirement for one day in seven free of ~~duty~~ clinical
693   work and education, when averaged over four weeks. (Core)
694
695   VI.F.8.a).(1)   ~~VI.G.8.a).(1)~~ At-home call must not be so frequent or taxing
696   as to preclude rest or reasonable personal time for each
697   resident. (Core)
698
699   VI.F.8.b)   ~~VI.G.8.b)~~ Residents are permitted to return to the hospital while on
700   at-home call to care for new or established patients. Each episode
701   of this type of care, while it must be included in the 80-hour
702   maximum weekly limit, will not initiate a new "off-duty period." (Detail)
703

> 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.

704
705   ***
706   ***Core Requirements:** Statements that define structure, resource, or process elements essential to every
707   graduate medical educational program.
708   **Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving
709   compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance
710   with the Outcome Requirements may utilize alternative or innovative approaches to meet Core
711   Requirements.
712   **Outcome Requirements:** Statements that specify expected measurable or observable attributes
713   (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical
714   education.