

## Frequently Asked Questions about the ACGME Common Duty Hour Standards Effective July 1, 2011

**Question:** *How should the averaging of the duty hour standards (e.g., 80-hour weekly limit, one-day-off-in-seven, and call every third night) be handled? For example, what should be done if a resident takes a vacation week?*

**Answer:** Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period; or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident takes vacation or other leave, the ACGME requires that vacation or leave days be taken out of the numerator and the denominator for calculating duty hours, call frequency or days off (i.e., if a resident is on vacation for one week, the hours for that rotation should be averaged over the remaining three weeks). The standards do not permit a “rolling” average, because this may mask compliance problems by averaging across high and low duty hour rotations. The rotation with the greatest hours and frequency of call must comply with the common duty hour standards.

Program directors should check with the specific Review Committee to determine if further guidelines or requirements apply to this regulation. For example, the Program Requirements for Internal Medicine do not permit averaging of the interval between in-house call. It is useful to remember that the ACGME expects that duty hours during the rotation with the greatest hours and frequency of call comply with the common standards.

**VI.A.4.b): Professionalism, Personal Responsibility, and Patient Safety**  
**“The learning objectives of the program must...not be compromised by excessive reliance on residents to fulfill non-physician service obligations.”**

**Question:** *What is meant by “non-physician service obligations”?*

**Answer:** Non-physician service obligations are those duties which in most institutions are performed by technologists, aides, transporters, nurses, or other categories of health care workers. Examples 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 awaiting or undergoing procedures, etc.

**VI.A.5.: Professionalism, Personal Responsibility, and Patient Safety**

**Question:** *How will compliance with the new standards be determined?*

**Answer:** These requirements will be assessed by the Site Visitor’s report of resident and faculty interviews, and the anonymous resident survey. Additional data will come from faculty participation in maintenance of certification and involvement in CME and scholarly activity. The program director is expected to constantly work with faculty members and residents to establish a milieu of professional behavior and personal responsibility, and a high regard for patient safety in the department.

The program director cannot be accountable for faculty and resident activity during time off. However the program director must be sensitive to signs of lack of professionalism as indicated by lack of fitness for duty (as defined in the ACGME glossary).

## **VI.B.: Transitions of Care**

**Question:** *Please define the ACGME's expectations regarding transitions of care. How should programs and institutions monitor effective transitions of care and minimize the number of such transitions?*

**Answer:** Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming teams/individuals responsible for that specific patient or group of patients. Programs and institutions are expected to have a documented process in place for ensuring the effectiveness of transitions. This can be accomplished in many different ways. For example, the program or institution can review and document on a regular basis a sample of a transition, to include review of a sample patient's chart and interview of the incoming responsible individual and/or team to ensure key elements in the patient care continuum for that patient have been transmitted and are clearly understood. Pertinent elements evaluated should include exam findings, laboratory data, any clinical changes, family contacts, and any change in responsible attending physician. Scheduling of on-call shifts should be optimized to ensure a minimum number of transitions, and there should be documentation of the process involved in arriving at the final schedule. The specifics of these schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident education.

## **VI.C.3.: Alertness Management**

**Question:** *Please clarify the definition of adequate sleep facilities. Do call rooms meet this need?*

**Answer:** "Adequate sleep facilities" are defined as an environment in which residents may sleep or rest for periods of time, ranging from minutes to hours. While traditional call rooms may meet this need, other technologies/areas may be useful as well. This is an area of rapid development, and thus this definition is necessarily broad.

## **VI.D.: Supervision of Residents**

**Question:** *Who can be a supervising physician?*

**Answer:** A physician, a member of the medical staff, or a more senior resident designated by the program director can supervise a junior resident. Such designation must be based on demonstrated competency in medical expertise and supervisory capability.

In rare instances, a Review Committee may allow non-physician, licensed, independent practitioners designated by the program director to supervise residents.

**Question:** *What is meant by "progressive authority and responsibility, conditional independence, and a supervisory role in patient care" for residents?*

**Answer:** Residents enter residency programs as novices and are expected to graduate as accomplished physicians capable of functioning competently and without supervision. Depending on the specialty, this transition may take from three to seven or more years. The development and adoption of specialty-specific “milestones” (objective curricular criteria to be mastered during a given year of residency) that will govern residents’ advancement from one year of education to the next will provide one tool for guiding the authority and responsibility granted to residents. These milestones will help program directors and faculty members determine the levels of responsibility assigned to each individual resident. Until those are in place, documented criteria for such assignments need to be included in the make-up of the program. Great care must be taken in determining the level of involvement each resident will have in direct patient care so as to ensure patient safety. Another level of advancement lies in the granting of supervisory authority to resident over a more junior resident. This will require not only documentation of a medical knowledge and procedural competency skill sets, but also a documented ability to effectively teach and oversee the work of others. At any level of assignment, the initial few days or weeks should be carefully monitored to ensure that the individual resident is capable of functioning in his/her assigned role. If not, then remediation will be necessary before the assignment can continue.

#### **VI.G.1.: Maximum Hours of Work Per Week**

**Question:** *What is included in the definition of duty hours under the standard “duty hours must be limited to 80 hours per week.”?*

**Answer:** Duty hours are defined as all clinical and academic activities related to the residency program. This includes clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care. For call from home, only the hours spent in the hospital after being called in to provide care count toward the 80-hour weekly limit.

Hours spent on activities that are required by the accreditation standards, such as membership on a hospital committee, or that are accepted practice in residency programs, such as residents’ participation in interviewing residency candidates, must be included in the count of duty hours. It is not acceptable to expect residents to participate in these activities on their own hours; nor should residents be prohibited from taking part in them.

Duty hours do not include reading, studying, and academic preparation time, such as time spent away from the patient care unit preparing for presentations or journal club .

**Question:** *Which tasks that can be completed at home (completion of medical records and office tasks; orders submitted and lab tests reviewed; verbal orders that can be signed at home; preparing conferences; and time spent on research) would count toward the 80 hours?*

**Answer:** Any tasks related to performance of duties, even if performed at home, count toward the 80 hours.

#### **VI.G.1.a): Duty Hour Exceptions**

**“A Review Committee may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale.”**

**Question:** *Can duty hours for surgical chief residents be extended to 88 hours per week?*

**Answer:** Programs interested in extending the duty hours for their chief residents can use the “88-hour exception” to request an increase up to 10% in duty hours on a program-by-program basis, with endorsement of the sponsoring institution’s graduate medical education committee (GMEC) and the approval of the Review Committee. Requests for an exception must be based on a sound educational justification. Some Review Committees categorically do not permit programs to use the 10% exception.

**Question:** *What is meant by “sound educational justification” for a request to increase the weekly limit on duty hours by up to 10 percent?*

**Answer:** The ACGME’s position is that an increase in duty hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve residents’ educational experience. This requires that all hours in the extended work week contribute to resident education. An example is that a surgical program needs to demonstrate that residents do not attain the required case experiences in some categories, unless resident hours are extended beyond the weekly limit, and that all reasonable efforts to limit activities that do not contribute to enhancing their surgical skills have already been made.

Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and for a subgroup of the residents/fellows in the program (e.g., the chief resident year) or for individual rotations or experiences.

### **VI.G.3.: Mandatory Time Free of Duty**

**“Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.”**

**Question:** *The common duty hour standards state that residents must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period. How should programs interpret this standard if the “day off” occurs after a resident’s on-call day?*

**Answer:** The common duty hour standards call for a 24-hour day off. Many Review Committees have recommended that this day off should ideally be a “calendar day,” e.g., the resident wakes up in his or her home and has a whole day available. Review Committees have also noted that it is not permissible to have the day off regularly or frequently scheduled on a resident’s post-call day, but understand that in smaller programs it may occasionally be necessary to have the day off fall on the post-call day. Note that in this case, a resident would need to leave the hospital post-call early enough to allow for 24 hours off of duty. For example, if the resident is expected to return to the hospital at 7:00 a.m. the following day, he/she would need to leave the hospital at 7:00 a.m. on the on-call session day. Because call from home does not require a rest period, the day after a pager call may be used as a day off.

**Question:** *If a program only has a few residents and the residents prefer to be on call for two days during one weekend so that they can have another weekend completely free of duties, does this comply with the duty hour standards?*

**Answer:** In some programs residents take call for an entire weekend (Friday and Sunday for instance), to allow them to take the next weekend off. This practice is acceptable so long as total duty hours, one-day-off-in-seven, and frequency of call are within the limits specified by the relevant requirements. For example, this would *not* be permissible in Internal Medicine,

because the Program Requirements for Internal Medicine do not permit averaging of in-house call assignments.

Note that for in-house call, residents must be accorded adequate rest time (usually 10 hours) between the two weekend duty periods. There are no exceptions to this rule. Thus, in-house call on two consecutive nights (e.g., Friday and Saturday) must include adequate rest (usually 10 hours) between the two duty shifts.

#### **VI.G.4.: Maximum Duty Hour Period Length**

**Question:** *Are first-year residents allowed to remain on-site for an additional four hours after their sixteen hour shifts for didactics, patient follow-up, and care transition?*

**Answer:** PGY-1 residents may not remain on-site after their 16-hour shifts. Periods of duty for first-year residents must not exceed 16 hours in duration.

**Question:** *Please clearly define “duty hour period”. Does it only include scheduled work hours or hours directly working with patients, or does it include hours doing any patient-related activities?*

**Answer:** Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

#### **VI.G.4.b): Maximum Duty Period Length**

**Question:** *How should naps for residents be scheduled? What if a resident chooses not to nap?*

**Answer:** Strategic napping is strongly suggested in the Program Requirements, especially between the hours of 10:00 p.m. and 8:00 a.m. Naps should not be scheduled, but rather should occur based upon patient needs and resident fatigue.

#### **VI.G.4.b).(2):**

**Question:** *What activities are permitted during the four hours allowed for transitions?*

**Answer:** Residents who have completed a 24-hour duty period may spend up to an additional four hours to ensure an appropriate, effective, and safe transition of care.

Residents must not be permitted to participate in the care of new patients in any patient care setting during this four-hour period.

Residents must not be assigned to outpatient clinics, including continuity clinics, during this four-hour period.

Residents must not be assigned to participate in a new procedure, such as an elective scheduled surgery, during this four-hour period.

Residents who have satisfactorily completed the transition of care may, at their discretion, attend an educational conference that occurs during the four hours.

**Question:** *Can a resident attend continuity clinic during the four hours after a 24-hour period of continuous duty?*

**Answer:** Residents must not be assigned any additional clinical responsibilities after a 24-hour period of continuous in-house duty, which includes attending continuity clinic. The additional four-hour period following a 24-hour shift is to ensure that effective transitions in care occur.

**Question:** *How is the 24-hour limit on in-house call duty applied?*

**Answer:** The activity that drives the 24-hour limit is “continuous duty”. If a resident spends 12 hours in the hospital caring for patients, performing surgery, or attending conferences, followed by 12 hours on-call, he/she has spent 24 hours of “continuous duty” time, and is limited to up to four additional hours during which their activities are limited to participation in didactic activities, transfer of patient care, and maintaining continuity of medical and surgical care.

**Question:** *What is the ACGME’s interpretation of the use of the added period of up to four hours at the end of a 24-hour duty and on-call shift?*

**Answer:** The goal of the added hours at the end of the on-call period is to promote didactic learning and continuity of care. Clarifying language for activities that are permitted during the up-to-four-hour period after the end of the 24-hour continuous duty period for each specialty can be found by clicking on the Duty Hour menu item from the homepage of the ACGME website.

#### **VI.G.5.: Minimum Time Off Between Scheduled Duty Periods**

**Question:** *Please explain the rule regarding time off between scheduled duty periods. What is meant by “should be 10 hours, must be eight hours”?*

**Answer:** “Should” is used when a requirement is so important that an appropriate educational justification must be offered for its absence. It is important to remember that when an abbreviated rest period is offered either regularly or under special circumstances, the program director and faculty must monitor residents for signs of sleep deprivation.

A typical resident work schedule specifies the number and length of nights on call, but does not always outline the length of each work day. Scheduled or expected duty periods should be separated by 10 hours.

There are however, inevitable and unpredictable circumstances in which resident duty periods will be prolonged. In these instances, residents must still have a minimum of eight hours free of duty before the next scheduled duty period begins. This standard applies to PGY-1 and intermediate-level residents (as defined by the individual Review Committees).

**Question:** *Under what circumstances would eight hours between shifts be acceptable?*

**Answer:** Scheduled or expected duty hour periods should be separated by 10 hours. If there are inevitable and unpredictable circumstances that occur in which a resident’s duty hours are prolonged, they must still have a minimum of eight hours free from duty before the next scheduled duty period begins.

#### **VI.G.7.: Maximum In-House On-Call Frequency**

**“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).”**

**Question:** *What is the definition of “on-call duty”?*

**Answer:** On-call duty is defined as a continuous duty period between the evening hours of the prior day and the next morning, generally scheduled in conjunction with a day of patient care duties prior to the call period. Call may be taken in-house or from home, but home call is appropriate only if the service intensity and frequency of being called is low. Scheduled duty shifts (generally eight, 10 or 12 hours in length), such as those worked in the ICU, on emergency medicine rotations, or on “night float”, are exempt from the requirement that call be scheduled no more frequently than every third night.

**Question:** *How many times in a row can a resident take call every other night?*

**Answer:** The objectives for allowing the averaging of in-house call (in all specialties except internal medicine) is to offer flexibility in scheduling, not to permit call every other night for any length of time, even if done in the interest of creating longer periods of free time on weekends or later in the month.

Residents can be assigned to a maximum of four call nights in any seven-day period. This can only be done one week per month. Residents must not take night call for two consecutive nights.

**Question:** *Is it permissible for a resident to be on call every other night for two weeks straight and then be off for two weeks?*

**Answer:** No.

#### **VI.G.8.: At-Home Call**

**“The frequency of at-home call is not subject to the every-third-night limitation...”**

**Question:** *Which standards apply to time in the hospital after being called in from home call?*

**Answer:** For call taken from home (pager call), the time the resident spends in the hospital after being called in is counted toward the weekly duty hour limit. The only other numeric duty hour standard that applies is that one-day-in-seven that must be free of all patient care responsibilities, which includes at-home call. The ACGME also requires that programs monitor the intensity and workload resulting from at-home call, through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.

**Question:** *Does the minimum of eight hours between shifts apply to at-home call?*

**Answer:** Although it must count toward the 80-hour weekly maximum, when residents assigned to at-home call return to the hospital to care for patients a new off-duty period is not initiated, and therefore is not subject to the requirement of eight hours between shifts. However, the frequency and duration of time returning to the hospital must not preclude rest or reasonable personal time for residents.

**Question:** *Can PGY-1 residents take at-home call, and if so what are the work-hour restrictions for this?*

**Answer:** PGY-1 residents are limited to a 16-hour shift and are not allowed to take at-home call.

#### **VI.G.8.a).(1): At-Home Call**

**Standard:** At-Home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

**Clarification:** The Review Committees recognize that at-home call may, on occasion, be demanding. This may include frequent phone consultations or a return to the hospital to provide emergency care or consultation. However, if at-home call predictably prevents a resident from obtaining adequate rest, or if it is associated with extensive returns to provide hospital service, the Review Committee may cite the program under this standard.

#### **Duty Hours Limits and Research and Other Non-Patient Care Activities**

**Question:** *How do the ACGME common duty hour standards apply to research activities?*

**Answer:** The ACGME duty hour standards pertain to all *required* hours in the residency program (the only exceptions are reading and self-learning, and time on call from home during which the resident is not required to be in the hospital). Research of up to six months scheduled during one or more of the accredited years of the program is required in many specialties and may also contain a clinical element. When research is a formal part of the residency and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent duty hour standards.

There are only two situations when the ACGME duty hour standards do not apply to research. One is when programs offer an additional research year that is not part of the accredited years. In this case the ACGME standards do not apply to that year. The other case is when residents conduct research on their own time, which makes these hours identical to other personal pursuits. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident when he or she participates in patient care.

**Question:** *How are the standards applied to rotations that combine research and clinical activities?*

**Answer:** Some programs have added clinical activities to “pure” research rotations, such as having research residents covering “night float”. This combination of research and clinical assignments could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments. This suggests limits on clinical assignments during research rotations, both to ensure safe patient care, resident learning, and resident well-being, and to promote the goals of the research rotation.

**Question:** *If a journal club is held in the evening for two hours, outside of the hospital, and is not held during the regularly scheduled duty hours, and attendance is strongly encouraged but not mandatory, would those hours count toward the 80-hour weekly total?*



**Answer:** If attendance is “strongly encouraged,” the hours should be included because duty hours apply to all required hours in the program, and it is difficult to distinguish between “strongly encouraged” and required. Another way to look at it is that such a journal club, if held weekly, would add two hours to the residents’ weekly time. A program in which two added hours result in a problem with compliance with the duty hour standards likely has a duty hour problem.

**Question:** *If some of a program’s residents attend a conference that requires travel, how should the hours for duty hour compliance?*

**Answer:** If attendance at the conference is required by the program, or the resident is a representative for the program (e.g., he/she is presenting a paper or poster), the hours should be recorded just as they would for an “on-site” conference hosted by the program or its sponsoring institution. This means that the hours during which the resident is actively attending the conference should be recorded as duty hours. Travel time and non-conference hours while away do not meet the definition of “duty hours” in the ACGME standards.

### **Institutional Monitoring and Oversight of Duty Hours**

**Question:** *The ACGME states that it rigorously monitors duty hours in accredited programs, and that the sponsoring institution has the oversight for duty hour. Does this mean that our sponsoring institution must do electronic, “real-time” monitoring of duty hours in all accredited programs?*

**Answer:** The ACGME requires that programs and their sponsoring institutions monitor resident duty hours to ensure they comply with the standards, but does not specify how monitoring and tracking of duty hours should be handled. The only ACGME requirement related to monitoring is that all programs complete the six-question duty hour survey on the ACGME’s Accreditation Data System (ADS) and that this information be reviewed and endorsed by each program’s designated institutional official (DIO).

A number of approaches exist for monitoring resident hours, from resident self-reporting to swipe cards and other electronic measures. All of these have some advantages and some drawbacks, with none clearly being superior in every way and in all settings. The ACGME does not mandate a specific monitoring approach, since the ideal approach should be tailored to the program and the sponsoring institution, and the approach best suited for neurological surgery will be different from the one most appropriate for preventive medicine, dermatology, or pediatrics, etc. Programs and institutions may benefit from hearing what has worked in settings similar to theirs.

**Question:** *If the results of a program’s completed ACGME Resident Survey show that a number of residents exceeded several of the duty hour limits, what will the ACGME do?*

**Answer:** The survey has several objectives, but its most important functions are to serve as a focusing tool for the ACGME site visit. If such a program is scheduled for a site visit soon, the site visitor will ask detailed questions about duty hour compliance to verify and clarify the information from the resident survey through on-site interviews and review of documents such as rotation and on-call schedules. This may highlight that residents misunderstood the question, or it may reveal problems with duty hour compliance. If such a program is not scheduled for a site visit in the near future, resident survey results that suggest non-compliance with the duty hours may result in the Review Committee’s following up to request data on duty hours and, if indicated, a corrective action plan. The Review Committees recognize that in many programs a

few residents occasionally work beyond the limits, and limit follow-up to programs where the data suggest a potential program-level compliance problem.

**Best Practice:** Programs should note that the results of the ACGME Resident Survey are available to them and their sponsoring institutions in ADS. Programs can use this information to determine if compliance problems suggested by the data are confirmed by the residents, and to pinpoint compliance problems and address them before their next ACGME site visit.

### **Other Frequently Asked Questions**

**Question:** *Can we “relax” the duty hour standards over holidays or during other times when the hospital is “short-staffed,” during periods when some residents are ill or on leave, or when there is an unusually large patient census or demand for care?*

**Answer:** The ACGME expects that duty hours in any given four-week period comply with all applicable standards. This includes months with holidays, during which institutions may have fewer staff members on duty. During the holiday period, residents not on vacation may be scheduled more frequently, but the scheduling for the rotation (generally four weeks of a month) must comply with the common and Review Committee-specific duty hour standards. Further, the schedule during the holidays themselves may not violate common duty hour standards (such as the requirement for adequate rest between duty periods), or Review Committee-specific standards.