

## Frequently-Asked Questions about the ACGME Common Duty Hour Standards

(Updated February 2010)

This set of responses to frequently asked questions (FAQs) about the common duty hour standards was most recently updated in February 2010, and is organized by standard for easy reference. It reflects the growing experience of the ACGME in promoting compliance with the standards. The standards and the FAQ below, address situations where activities are scheduled or occur with some frequency in residency and fellowship programs. The FAQ may not be able to offer guidance in cases of rare patient care and other circumstances and the professional judgment of program directors and DIOs should be applied in those situations.

In addition to these ACGME Common Duty Hour Requirements, individual Residency Review Committees (RRCs) may enforce more restrictive limits, as warranted by patient safety, resident education and resident well-being considerations in their discipline. Programs should address specialty-specific questions to the RRC staff team.

We welcome your comments on this FAQ. Please send them via e-mail to [iphilibert@acgme.org](mailto:iphilibert@acgme.org), or call Ingrid Philibert, PhD, MBA, at 312/755-5003.

### **“Duty hours must be limited to 80 hours 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.”*

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 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 participating 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 preparing for presentations or journal club, that is spent away from the patient care unit.

### **“Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities.”**

*Question: The common duty hour standards state that residents must be provided with 1 day in 7 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 the resident’s on-call day?*

**Answer:** The common duty hour standards call for a 24-hour day off. Many RRCs 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. RRCs also have 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 duty. E.g., if the resident is expected to return to the hospital at 7 am the following day, the on-call session day he/she would need to leave at 7 am. Because call from home does not require a rest period, the day after a pager call may be used as a day off.

**Question:** *Our program only has a few residents and residents prefer to be on call for two days during one weekend, so they can have another weekend completely free of duties. Does this practice 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 are within the limits specified by the relevant program requirements. Thus, it would not be permissible in Internal Medicine, because the Internal Medicine program requirement do not permit averaging of the requirement that call must be no more frequent than every 3<sup>rd</sup> day.

Note that for in-house call, residents must be accorded adequate rest (generally 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 (generally 10 hours) between the two duty shifts.

**“Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.”**

**Question:** *The required 10-hour rest period continues to be problematic for my program. How does the ACGME interpret this common duty hour standard?*

**Answer:** The language of this requirement states, “Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period...” “Should” is used when a requirement is so important that an appropriate educational justification must be offered for its absence. An interpretation of what constitutes “appropriate justification” cannot be made a priori, but allowing added time for important didactic lectures or cases with particular educational value are examples most RRCs would consider appropriate. 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.

**“In-house call must occur no more frequently than every third night, 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 8, 10 or 12 hours in length), such as those worked in the ICU, on Emergency Medicine rotations or “night float” are exempt from the requirement that call be scheduled no more frequently than every third night.

**“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 must be free of all patient care responsibilities, which includes home call. The ACGME also requires that programs monitor the intensity and workload resulting from home call, through periodic assessment of the frequency of being called into the hospital and the length and intensity of the in-house activities.

**“Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in the Program Requirements.”**

*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 6 additional hours during which their activities are limited to participation in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in the Program Requirements.”

*Question: What is the ACGME’s interpretation of the use of the added period of up to six 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, including ambulatory and surgical continuity. Some RRCs have exempted longitudinal care experiences and experiences that promote peri-operative or care continuity. Clarifying language for activities that are permitted during the up to six hours after the end of the 24-hour period for each core specialty can be found on the ACGME’s Website (“RRC-specific duty hour language”).

#### **Averaging of Selected Standards over a 4-Week Period**

*Question: How should the averaging of the duty hour standards (80-hour weekly limit, one day off in 7, and call every third night) is handled? For example, what should be done if a resident takes a vacation week?*

**Answer:** A recurrent question concerns the averaging period that applies to the 80-hour weekly limit, and the requirements that one day in seven be free from all program duties and that in-house call be no more frequent than every third night. Averaging must occur by rotation, either a four-week or a one-month period, or the period of the rotation if it is shorter than four weeks. Where rotations are less than four weeks in length, averaging must be done over these shorter assignments. This avoids heavy and light assignments being combined in achieve compliance.

If a resident takes vacation or other leave, 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 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.

The program requirements for Internal Medicine do not permit averaging of the interval between in-house call. It is useful to remember that ACGME expects that duty hours during the rotation with the greatest hours and frequency of call comply with the common standards.

***Question: Can residents take in-house call every other night for some part of the month, if they get extra time off later in the months?***

ACGME advises against scheduling in-house call every other night for any extended periods, because it can be demanding on the residents. 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 every other night call 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.

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

***Question: We would like to extend duty hours for our surgical chief residents to 88 hours per week. Can we do this?***

**Answer:** Program interested in extending the duty hours for their chief resident 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 RC. Some RCs categorically do not permit programs to use the 10% exception, and that requests for an exception must be based on a sound educational justification.

***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 increase in duty hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve the residents’ educational experience. This requires that all hours in the extended workweek 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 8 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.

### **Duty Hour Limits and Resident Moonlighting and other Clinical Activities**

***Question: Why does the ACGME distinguish between “in-house moonlighting,” which is counted under the weekly duty hour limit, and external moonlighting, which is not included?***

**Answer:** The ACGME has two reasons for counting in-house moonlighting toward the weekly duty hours. First, it applies the same standard to all hours residents spend in teaching institutions, whether they are part of the required educational program or are spent moonlighting in-house. Second, it prevents institutions from inappropriately using in-house moonlighting to replace clinical service activities residents covered previously as part of the educational program.

The ACGME's purview extends to teaching programs and sponsoring institutions, but not resident activities outside of their educational program. In contrast, individual programs and sponsoring institutions may prohibit or limit resident moonlight, so long as they notify residents and applicants of this restriction.

***Question: Our residents engage in “in-house moonlighting.” Which ACGME duty hour standards apply?***

**Answer:** For internal moonlighting, the combined hours of residency education and internal moonlighting must comply be at 80 or fewer hours, averaged over four weeks. None of the other numeric standards (e.g., 10 hours rest period, 1 in 7 free of all programs responsibilities) apply. However, the expectation is that the residents' total hours spent in-house will not exceed what is advisable from a patient safety and resident learning perspective.

**Question:** *Some of our residents volunteer in a free clinic sponsored by our institution. It is not a required element of our program and residents do not receive pay for this activity. We are not sure whether this constitutes 'in-house moonlighting,' since the activity is voluntary and they are not being compensated.*

**Answer:** Under the ACGME's definition, all clinical activities sponsored by the institution at which the resident trains are either part of the required educational program or 'in-house moonlighting.' If volunteer activities are done in lieu of other, regular program activities, they should be considered an elective. In that case, they are subject to all standards governing clinical activities that are part of the program.

If these volunteer activities are performed in addition to the hours in the program, they should be considered 'in-house moonlighting,' despite the fact that residents do not receive compensation.

### **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 6 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?*

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. RCs 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:** *A journal club is held in the evening for 2 hours, outside the hospital. It is not held during the regularly scheduled duty hours, and attendance is strongly encouraged but not mandatory. Do these hours count toward the 80-hour weekly total?*

**Answer:** If attendance "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, and a program where two added hours result in a problem with compliance with the duty hour standards likely has a duty hour problem.

**Question:** *Some of our residents are going to a conference on the West Coast that requires travel. How should we count these hours for duty hour compliance?*

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 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 programs and their sponsoring institutions to monitor resident duty hours to ensure that they comply with the standards, but it does not specify how monitoring and tracking of duty hours should be handled. The only requirement related to ACGME monitoring is that all programs complete the six-question duty hour survey on the ACGME’s Accreditation Database (ADS) and that this information be reviewed and endorsed by the 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. 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. Programs and institutions may benefit from hearing what has worked in settings similar to theirs.

**Question:** *Our program completed the ACGME Resident Survey last fall. The data showed that a number of residents exceeded several of the duty hour limits. What will the ACGME do?*

**Answer:** The ACGME resident survey has several objectives, but its most important functions are to serve as a focusing tool for the ACGME site visit. If your program will be site visited soon, the site surveyor will ask detailed questions about duty hour compliance to verify and clarify the information in the Resident Survey through on-site interviews and review of documents such as rotation and on-call schedules. This can highlight that residents misunderstood the question or it can reveal problems with duty hour compliance. If your 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 RCs following up with your program to request data on duty hours and, if indicated, a corrective action plan. The RCs 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 institution through the Accreditation Data System. Program can use this information to determine if compliance problems suggested by the data are

confirmed by the residents. Program can then use this data to pinpoint compliance problems and to address them before their next ACGME site visit.

### **Other Frequently Asked Questions**

***Question: Now that the common duty hour standards have gone into effect, will the RCs continue to enforce their own more restrictive standards?***

**Answer:** Yes. The common duty hour standards establish a minimum for all specialties where no standards existed prior to July 2003. Specialties with more restrictive standards will continue to enforce those. This includes Emergency Medicine, which limits duty hours to 72 per week, and Internal Medicine, which does not permit averaging of the requirement that call be scheduled no more frequently than every three days.

***Question: What determines the duty hour limits for residents who rotate in another accredited program?***

The duty hour limits of the program in which the resident rotates apply to all residents, both those in the programs and rotators from another specialty. The common examples are that family medicine and TY residents in an emergency department rotation must comply with EM hours, but that EM residents who rotate in Otolaryngology or another specialty are held to those specialties' longer hours. This also applies when a program has an exception, but it helps to remember that the standard defines the *maximum allowable* hours, not required hours or hours for all residents, suggesting it is always possible to work fewer hours than the limit.

The exception is that when RCs have a specific requirement for particular assignments, the program through which the resident is rotating needs to comply. The example is that the RC for Internal Medicine has a standard that "during emergency medicine assignments, continuous duty must not exceed 12 hours." This precludes added assignments to conferences and journal clubs that would take a rotating IM resident beyond 12 hours while on an emergency department rotation, though the Emergency Medicine program requirements would permit that.

***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 4 weeks of a month) must comply with the common and RC specific duty hour standards, and the schedule during the holidays themselves may not violate common duty hour standards, such as the requirement for adequate rest between duty periods, or RC specific standards, such as the Internal Medicine requirement that averaging of the frequency of in-house call is not permitted.