ACGME Program Requirements for Graduate Medical Education in Ophthalmology

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

A. Definition and Scope of the Specialty

Residency training programs in ophthalmology should provide a stable, well-coordinated, and progressive educational experience in the entire spectrum of ophthalmic diseases and ocular surgery. Residents in ophthalmology should develop diagnostic, therapeutic, and manual skills, as well as sound judgment in the application of such skills. Each resident must have major technical and patient care responsibilities in order to provide an adequate base for a comprehensive ophthalmic practice. That base must include: optics, visual physiology, and corrections of refractive errors; retina, vitreous, and uvea; neuro-ophthalmology; pediatric ophthalmology and strabismus; external disease and cornea; glaucoma, cataract, and anterior segment; oculoplastic surgery and orbital diseases; and ophthalmic pathology.

B. Duration and Scope of Education

1. The length of training in ophthalmology must be at least 36 calendar months, including appropriate short periods for vacation, special assignments, or exceptional individual circumstances approved by the program director.

2. Any program that extends the length of training beyond 36 calendar months must present an educational rationale that is consonant with the program requirements and the objectives for residency training. Approval for an extended curriculum must be obtained prior to implementation and at each subsequent review. Prior to entry in the program, each resident must be notified in writing of the required curriculum length.

3. The length of time of residency training for a particular resident may be extended by the program director if that resident needs additional training. If the extension is six months or less, the program director must notify the residency Review Committee of the extension, and must describe the proposed curriculum for that resident and the measures taken to minimize any impact on other residents. Any changes in rotation schedules should be included in the notification. Express permission must be obtained in advance from the Review Committee if the extension is greater than six months. (See Section II. A. 4.r. below)

I. Institutions

A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

1. The majority of the required clinical and didactic educational experiences must occur and be coordinated by the program director at this institution.

B. Participating Sites

1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

c) specify the duration and content of the educational experience; and,

d) state the policies and procedures that will govern resident education during the assignment.

e) outline the educational goals and objectives to be attained by the resident during the assignment.

2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

3. The participating site should provide resources not otherwise available to the program.

4. Assignments at participating sites must be of sufficient length to ensure a quality educational experience, and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the specialties' needs, all participating sites must demonstrate the ability to promote the program goals, and educational and peer activities. Exceptions must be justified and approved in advance.

5. If the distance between participating sites and the sponsoring institution is great enough to prevent residents' regular attendance at the didactic and clinical conferences, or if the rotation otherwise precludes attendance, the program director must demonstrate that each resident has a formal educational experience that fulfills the program requirements.

6. There should be formal teaching case presentations at each participating site to assure optimal utilization of patients for teaching purposes. Alternatively, cases should be brought from participating sites to the sponsoring institution for presentation if formal teaching case presentations are held only there.

7. Rotations to foreign countries shall not be used to meet minimum educational standards.

II. Program Personnel and Resources

A. Program Director

1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

a) The program director should be a member of the medical staff of the sponsoring or integrated institution. The institution must ensure that the program director is given sufficient authority, financial support, and facilities by the governing body of the sponsoring institution to permit him or her to organize and supervise the following activities of the training program: resident selection and evaluation, resident instruction, patient management, research, and initiation of recommendations for staff recruitment.

b) The program director should have a term of at least three years.

2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

3. Qualifications of the program director must include:

a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

b) current certification in the specialty by the American Board of Ophthalmology**, or specialty qualifications that are acceptable to the Review Committee; and,**

c) current medical licensure and appropriate medical staff appointment.

4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

b) approve a local director at each participating site who is accountable for resident education;

c) approve the selection of program faculty as appropriate;

d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

e) monitor resident supervision at all participating sites;

f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

g) provide each resident with documented semiannual evaluation of performance with feedback;

h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

i) provide verification of residency education for all residents, including those who leave the program prior to completion;

j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

(1) distribute these policies and procedures to the residents and faculty;

(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

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205 **(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
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209 **k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
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213 **l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
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218 **m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
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222 **n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
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226 **(1) all applications for ACGME accreditation of new programs;**
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229 **(2) changes in resident complement;**
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231 **(3) major changes in program structure or length of training;**
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234 **(4) progress reports requested by the Review Committee;**
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236 **(5) responses to all proposed adverse actions;**
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238 **(6) requests for increases or any change to resident duty hours;**
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241 **(7) voluntary withdrawals of ACGME-accredited programs;**
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244 **(8) requests for appeal of an adverse action;**
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246 **(9) appeal presentations to a Board of Appeal or the ACGME; and,**
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249 **(10) proposals to ACGME for approval of innovative educational approaches.**
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252 **o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
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256 **(1) program citations, and/or**
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258 **(2) request for changes in the program that would have**
259 **significant impact, including financial, on the program**
260 **or institution.**
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262 p) ensure that all residents have equivalent educational experiences;
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264 q) seek approval from the Review Committee for a required rotation
265 of six months or more to any site other than the primary teaching
266 site;
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268 r) seek approval from the Review Committee for any change in
269 resident complement, either the total number or the number at any
270 level. If the change in resident complement results from an
271 extension of a single resident's training, and is not greater than six
272 months, only prior notification of the Review Committee is
273 required;
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275 s) prepare explicit written descriptions of the lines of responsibility for
276 the care of patient, and make these clear to all members of
277 teaching teams. Residents must be provided with rapid, reliable
278 systems for communication with and appropriate involvement of
279 supervisory physicians in a manner appropriate for quality patient
280 care and educational programs;
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282 t) ensure that residents are educated in basic and clinical sciences
283 through a structured and regularly-scheduled series of
284 conferences and lectures, including but not limited to those topics
285 included in Definition and Scope of Specialty, above. This series
286 should include a minimum of 360 hours during the 36 month
287 training program, at least 200 hours of which are intramural. In
288 addition, a minimum of six hours per month should be devoted to
289 case presentation conferences (e.g., Grand Rounds, Continuous
290 Quality Improvement) attended by several faculty and a majority of
291 residents. The program director or designee is responsible for
292 documenting residents' attendance at conferences;
293
294 u) ensure the residents are entering their operative cases into the
295 resident case log system; and,
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297 v) verify the surgical experiences of each resident, including the
298 number of cases in each category where the resident has served
299 as the primary surgeon or the assistant surgeon. This
300 documentation must be provided to the Review Committee on its
301 program information forms; individual resident logs must be
302 available at the time of the site visit.
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B. Faculty

1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

2. The physician faculty must have current certification in the specialty by the American Board of Ophthalmology**, or possess qualifications acceptable to the Review Committee.**

a) The faculty must have subspecialty expertise across a broad range of ophthalmic disciplines, including those described in Introduction Section A. of these program requirements. Such expertise will usually be acquired by subspecialty fellowship training.

3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

(1) peer-reviewed funding;

(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

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(4) participation in national committees or educational organizations.

c) Faculty should encourage and support residents in scholarly activities.

C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

1. Clinic

   The outpatient area of each participating site must have a minimum of one fully-equipped examining lane for each resident in the clinic. There must be access to current diagnostic equipment. This should encompass equipment designed for ophthalmic photography (including fluorescein angiography), perimetry, ultrasonography, keratometry, and retinal electrophysiology, as well as other appropriate equipment.

2. Operating Room Facilities

   The surgical facilities for ophthalmology resident training at each participating site must include at least one operating room fully-equipped for ophthalmic surgery, including an operating microscope.

3. Inpatient Facilities

   There must be inpatient facilities with access to sufficient space and beds for good patient care. An eye examination room with a slit lamp should be easily accessible.

4. Residents must have access to a surgical skills development facility (e.g., a wet lab, materials or simulators) and instruction within the program.

5. The volume and variety of clinical ophthalmological problems in children and adults must be sufficient to afford each resident a graduated and supervised experience with the entire spectrum of ophthalmic diseases, so that the resident may develop diagnostic, therapeutic, and manual skills and judgment as to their appropriate use.

E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

1. All applicants entering ophthalmology training programs must have taken a post-graduate clinical year (PGY-1) in a program accredited by either the ACGME or the Royal College of Physicians and Surgeons of Canada. The PGY-1 year must include training in which the resident has primary responsibility for patient care in fields such as internal medicine, neurology, pediatrics, surgery, family medicine, or emergency medicine. At minimum, six months of this year must be a broad experience in direct patient care.

B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

1. A critical mass or minimum number of residents is essential to provide an opportunity for meaningful interaction throughout the training period. Each program must be structured to have at least two residents in each year of training.

C. Resident Transfers

1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed

454 **residents' education. The program director must report the presence of**
455 **other learners to the DIO and GMEC in accordance with sponsoring**
456 **institution guidelines.**
457
458 **IV. Educational Program**
459
460 **A. The curriculum must contain the following educational components:**
461
462 **1. Overall educational goals for the program, which the program must**
463 **distribute to residents and faculty annually;**
464
465 **2. Competency-based goals and objectives for each assignment at**
466 **each educational level, which the program must distribute to**
467 **residents and faculty annually, in either written or electronic form.**
468 **These should be reviewed by the resident at the start of each**
469 **rotation;**
470
471 **3. Regularly scheduled didactic sessions;**
472
473 **4. Delineation of resident responsibilities for patient care, progressive**
474 **responsibility for patient management, and supervision of residents**
475 **over the continuum of the program; and,**
476
477 **5. ACGME Competencies**
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479 **The program must integrate the following ACGME competencies**
480 **into the curriculum:**
481
482 **a) Patient Care**
483
484 **Residents must be able to provide patient care that is**
485 **compassionate, appropriate, and effective for the treatment of**
486 **health problems and the promotion of health. Residents:**
487
488 (1) will understand, in particular, the c*are of the surgical*
489 ***patient,*** to have the medical and technical knowledge, as
490 well as the skills, necessary to care for the surgical patient.
491 Included here is the understanding of the preoperative
492 ophthalmic and general medical evaluation and
493 assessment of indications for surgery and surgical risks
494 and benefits, informed consent, intraoperative skills, local
495 and general anesthetic considerations, acute and longer-
496 term postoperative care, and management of systemic and
497 ocular complications that may be associated with surgery
498 and anesthesia;
499
500 (2) should be responsible for the care of an adequate number
501 of outpatients who represent a broad range of ophthalmic
502 diseases. There must be appropriate faculty supervision of
503 the residents in all outpatient clinic visits. Appropriate
504 faculty supervision occurs when the faculty provides direct

505 supervision (resident primarily sees the patient, faculty
506 sees patient with resident, and collaborative effort
507 determines management), or when the faculty is on site
508 and readily available to see any patient upon request of
509 the resident;
510
511 (3) should participate in a minimum of 3,000 outpatient visits in
512 which the resident performs a substantial portion of the
513 examination;
514
515 (4) should have access to a simulated operative setting (e.g.,
516 wet lab) to allow them to develop proficiency in basic
517 surgical techniques;
518
519 (5) must perform and assist at a sufficient number of surgeries
520 to become skilled as comprehensive ophthalmic surgeons.
521 While the total number of operative procedures to be
522 performed is not specified, the Review Committee will
523 consider a minimum number of key procedures as
524 acceptable. (The minimum numbers are listed on the
525 ACGME website); and,
526
527 (6) must have graduated technical and patient care
528 responsibilities in the surgery (including laser surgery) of
529 cataract, strabismus, cornea, glaucoma, retina/vitreous,
530 oculoplastic, and trauma to provide an adequate base for a
531 comprehensive ophthalmic practice.
532
533 **b) Medical Knowledge**
534
535 **Residents must demonstrate knowledge of established and**
536 **evolving biomedical, clinical, epidemiological and social-**
537 **behavioral sciences, as well as the application of this**
538 **knowledge to patient care. Residents:**
539
540 (1) should have a minimum of 36 hours of experience in gross
541 and microscopic examination of pathological specimens,
542 including the residents' review of pathological specimens
543 of their patients with a pathologist who has demonstrated
544 expertise in ophthalmic pathology. The experience with
545 such a pathologist may take place intramurally or
546 extramurally at a laboratory considered by the Review
547 Committee to be capable of providing such training, and
548
549 (2) should have documented experiences in practice
550 management, ethics, advocacy, visual rehabilitation, and
551 socio-economics.
552
553 **c) Practice-based Learning and Improvement**
554
555 **Residents must demonstrate the ability to investigate and**

556 **evaluate their care of patients, to appraise and assimilate**
557 **scientific evidence, and to continuously improve patient care**
558 **based on constant self-evaluation and life-long learning.**
559 **Residents are expected to develop skills and habits to be able**
560 **to meet the following goals:**
561
562 **(1) identify strengths, deficiencies, and limits in one's**
563 **knowledge and expertise;**
564
565 **(2) set learning and improvement goals;**
566
567 **(3) identify and perform appropriate learning activities;**
568
569 **(4) systematically analyze practice using quality**
570 **improvement methods, and implement changes with**
571 **the goal of practice improvement;**
572
573 **(5) incorporate formative evaluation feedback into daily**
574 **practice;**
575
576 **(6) locate, appraise, and assimilate evidence from**
577 **scientific studies related to their patients' health**
578 **problems;**
579
580 **(7) use information technology to optimize learning; and,**
581
582 **(8) participate in the education of patients, families,**
583 **students, residents and other health professionals.**
584
585 **d) Interpersonal and Communication Skills**
586
587 **Residents must demonstrate interpersonal and**
588 **communication skills that result in the effective exchange of**
589 **information and collaboration with patients, their families,**
590 **and health professionals. Residents are expected to:**
591
592 **(1) communicate effectively with patients, families, and**
593 **the public, as appropriate, across a broad range of**
594 **socioeconomic and cultural backgrounds;**
595
596 **(2) communicate effectively with physicians, other health**
597 **professionals, and health related agencies;**
598
599 **(3) work effectively as a member or leader of a health care**
600 **team or other professional group;**
601
602 **(4) act in a consultative role to other physicians and**
603 **health professionals; and,**
604
605 **(5) maintain comprehensive, timely, and legible medical**
606 **records, if applicable.**

(6) receive experience in providing inpatient and outpatient consultation during the course of three years of education.

e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

(1) compassion, integrity, and respect for others;

(2) responsiveness to patient needs that supersedes self-interest;

(3) respect for patient privacy and autonomy;

(4) accountability to patients, society and the profession; and,

(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

(2) coordinate patient care within the health care system relevant to their clinical specialty;

(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

(4) advocate for quality patient care and optimal patient care systems;

(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

(6) participate in identifying system errors and

658 **implementing potential systems solutions.**
659
660 **B. Residents' Scholarly Activities**
661
662 **1. The curriculum must advance residents' knowledge of the basic**
663 **principles of research, including how research is conducted,**
664 **evaluated, explained to patients, and applied to patient care.**
665
666 **2. Residents should participate in scholarly activity.**
667
668 **3. The sponsoring institution and program should allocate adequate**
669 **educational resources to facilitate resident involvement in scholarly**
670 **activities.**
671
672 **V. Evaluation**
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674 **A. Resident Evaluation**
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676 **1. Formative Evaluation**
677
678 **a) The faculty must evaluate resident performance in a timely**
679 **manner during each rotation or similar educational**
680 **assignment, and document this evaluation at completion of**
681 **the assignment.**
682
683 **b) The program must:**
684
685 **(1) provide objective assessments of competence in**
686 **patient care, medical knowledge, practice-based**
687 **learning and improvement, interpersonal and**
688 **communication skills, professionalism, and systems-**
689 **based practice;**
690
691 **(2) use multiple evaluators (e.g., faculty, peers, patients,**
692 **self, and other professional staff);**
693
694 **(3) document progressive resident performance**
695 **improvement appropriate to educational level; and,**
696
697 **(4) provide each resident with documented semiannual**
698 **evaluation of performance with feedback.**
699
700 **c) The evaluations of resident performance must be accessible**
701 **for review by the resident, in accordance with institutional**
702 **policy.**
703
704 d) Assessment will include the care of the surgical patient.
705
706 e) Assessment should include an annually required objective test as
707 a component of evaluating the resident's cognitive ability. While
708 each program may utilize its own test instruments, the Ophthalmic

Knowledge Assessment Program (OKAP) examination is an example. However, results of the OKAP examination should not be used as the only criterion of resident performance. An analysis of the results of these tests should guide the faculty in assessing the strengths and weaknesses of individual residents and of the program.

2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

a) document the resident's performance during the final period of education, and

b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

B. Faculty Evaluation

1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

3. This evaluation must include at least annual written confidential evaluations by the residents.

C. Program Evaluation and Improvement

1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

a) resident performance;

b) faculty development;

c) graduate performance, including performance of program graduates on the certification examination; and,

d) program quality. Specifically:

(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

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761 **(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
764
765 **2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**
770
771 3. The Review Committee for Ophthalmology will evaluate the overall effectiveness of the program director as an administrator and educator.
773
774 4. Performance of program graduates on the certification examination over the most recent five year period will be used as one measure of evaluating the program's effectiveness. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Ophthalmology (ABO) regarding the resident performance on the certifying examination. The program will be considered deficient if
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782 a) the pass rate on both the written and oral examination of the first time American Board of Ophthalmology examinees from the program is less than 60% averaged over the past five years, or
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786 b) less than 80% of those eligible to take the examination over the past five years and actually take the examination.
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789 **VI. Resident Duty Hours in the Learning and Working Environment**
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791 **A. Principles**
792
793 **1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.**
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797 **2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
799
800 **3. Didactic and clinical education must have priority in the allotment of residents' time and energy.**
802
803 **4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**
805
806 **B. Supervision of Residents**
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808 **The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.**
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811 1. There should be direct faculty supervision of each resident in at least
812 1,000 outpatient visits. Direct faculty supervision occurs when faculty
813 members also examine the patient with the resident and discuss the
814 management of the patient with the resident before the patient leaves the
815 clinic.
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817 2. For emergency care, faculty must be readily available to see any patient
818 upon request by the resident.
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820 **C. Fatigue**
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822 **Faculty and residents must be educated to recognize the signs of fatigue**
823 **and sleep deprivation and must adopt and apply policies to prevent and**
824 **counteract its potential negative effects on patient care and learning.**
825
826 **D. Duty Hours (the terms in this section are defined in the ACGME Glossary**
827 **and apply to all programs)**
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829 **Duty hours are defined as all clinical and academic activities related to the**
830 **program; i.e., patient care (both inpatient and outpatient), administrative**
831 **duties relative to patient care, the provision for transfer of patient care,**
832 **time spent in-house during call activities, and scheduled activities, such as**
833 **conferences. Duty hours do *not* include reading and preparation time**
834 **spent away from the duty site.**
835
836 **1. Duty hours must be limited to 80 hours per week, averaged over a**
837 **four-week period, inclusive of all in-house call activities.**
838
839 **2. Residents must be provided with one day in seven free from all**
840 **educational and clinical responsibilities, averaged over a four-week**
841 **period, inclusive of call.**
842
843 **3. Adequate time for rest and personal activities must be provided.**
844 **This should consist of a 10-hour time period provided between all**
845 **daily duty periods and after in-house call.**
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847 **E. On-call Activities**
848
849 **1. In-house call must occur no more frequently than every third night,**
850 **averaged over a four-week period.**
851
852 **2. Continuous on-site duty, including in-house call, must not exceed 24**
853 **consecutive hours. Residents may remain on duty for up to six**
854 **additional hours to participate in didactic activities, transfer care of**
855 **patients, conduct outpatient clinics, and maintain continuity of**
856 **medical and surgical care.**
857
858 **3. No new patients may be accepted after 24 hours of continuous duty.**
859
860 a) A new patient is defined as any patient for whom the resident has
861 not previously provided care.

862
863 **4. At-home call (or pager call)**
864
865 **a) The frequency of at-home call is not subject to the every-**
866 **third-night, or 24+6 limitation. However at-home call must not**
867 **be so frequent as to preclude rest and reasonable personal**
868 **time for each resident.**
869
870 **b) Residents taking at-home call must be provided with one day**
871 **in seven completely free from all educational and clinical**
872 **responsibilities, averaged over a four-week period.**
873
874 **c) When residents are called into the hospital from home, the**
875 **hours residents spend in-house are counted toward the 80-**
876 **hour limit.**
877
878 **F. Moonlighting**
879
880 **1. Moonlighting must not interfere with the ability of the resident to**
881 **achieve the goals and objectives of the educational program.**
882
883 **2. Internal moonlighting must be considered part of the 80-hour weekly**
884 **limit on duty hours.**
885
886 **G. Duty Hours Exceptions**
887
888 **A Review Committee may grant exceptions for up to 10% or a maximum of**
889 **88 hours to individual programs based on a sound educational rationale.**
890
891 **1. In preparing a request for an exception the program director must**
892 **follow the duty hour exception policy from the ACGME Manual on**
893 **Policies and Procedures.**
894
895 **2. Prior to submitting the request to the Review Committee, the**
896 **program director must obtain approval of the institution's GMEC and**
897 **DIO.**
898
899 **VII. Experimentation and Innovation**
900
901 **Requests for experimentation or innovative projects that may deviate from the**
902 **institutional, common and/or specialty specific program requirements must be**
903 **approved in advance by the Review Committee. In preparing requests, the**
904 **program director must follow Procedures for Approving Proposals for**
905 **Experimentation or Innovative Projects located in the ACGME Manual on Policies**
906 **and Procedures. Once a Review Committee approves a project, the sponsoring**
907 **institution and program are jointly responsible for the quality of education offered**
908 **to residents for the duration of such a project.**
909
910 ***
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