

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

On July 1, 2003, the ACGME's new common duty hour standards became effective for all accredited residency programs. The goal is to set a minimum standard; individual RRCs may set more restrictive standards, as warranted by patient safety, resident education and resident well-being considerations in their discipline.

In the spring of 2003, the ACGME published the first set of responses to frequently asked questions (FAQs) about the common duty hour standards. The answers below some updated responses in areas where the ACGME and the Residency Review Committees (RRCs) have refined the standards, as well as clarifications related to implementation and monitoring of the standards. The responses still represent a general answer based on the common standards, and programs should address specialty-specific question to their RRC team.

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 on-call period. Call may be taken in-house or from home. Call from home is appropriate if the service intensity and frequency of being called is low.

On-call duty excludes regular duty shifts worked during night hours, as is done in Emergency Medicine. It also excludes night float assignment used in many programs to replace on-call shifts to reduce the continuous waking hours and strenuous nature of some in-house call.

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 for patient care transfer, educational debriefing and didactic activities.

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.

Question: *Is it permissible for resident to take call from home for extended periods, such as a month?*

Answer: The requirement that one day in seven must be free of patient care responsibilities would prohibit residents from being assigned home call for an entire month. Assignment of a partial month (more than six days but less than 24 days) is possible. Programs considering this option need to check with their RRC, since the application of this standard varies among RRCs.

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. One would expect that the combined hours spent on self-directed research and program-required activities meet the test for a reasonably rested and alert resident when he or she participates in patient care.

Recently, some programs have view the research rotations as an opportunity to add clinical activities, such as research residents covering “night float.” This creates an emerging “gray area” in which research and clinical assignments overlap, which could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. RRCs 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:** The ACGME’s definition of duty hours does not explicitly mention participation on hospital committees, time spent interviewing residency candidates and similar activities? Are these activities included in the count of duty hours?*

Answer: Yes, hours spent on activities that are required by the accreditation standards, such as membership on 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. Programs should note that these activities do not consume significant hours when averaged over a given period, and their benefits to the residency program are substantial.

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

Answer: Yes, with attendance “strongly encouraged,” these 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:** 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. The first is to apply 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. The second reason is to prevent institutions from inappropriately using in-house moonlighting to replace clinical service activities residents covered previously as part of the educational program.

The second reason is that the ACGME's purview extends to teaching programs and sponsoring institutions, but not resident activities outside of their educational program. Many perceive the ACGME does not have the right to curtail moonlighting or place all moonlighting hours under a weekly duty hour limit. In contrast, individual programs and institutions may prohibit or limit resident moonlight, and may do so formally via the resident contract.

Question: *What is the current ACGME 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. At its June 2003 meeting, the ACGME approved refined RRC-specific language for appropriate activities for the period of up to six hours after the end of the 24-hour period of continuous duty. They include RRC specific language detailing acceptable activities, and provide specialty-specific definitions of what constitutes a “new patient.” A summary document showing the language for each accredited core specialty can be found on the ACGME’s Website under the duty hour pull-down menu, under “RRC-specific duty hour language.”

Questions have arisen on how the “no new patients” requirement applies to ambulatory clinic experiences, especially clinics where both new and return patients are seen. The requirement that no “new patients” be seen after the 24-hour continuous duty period does not allow post-call residents to take part in clinical experiences where all patients presumably are “new patients,” such as the Emergency Department (ED) and a new patient clinic. In specialties with longitudinal care experiences and those that permit post-call residents to participate in ambulatory clinics, programs are encouraged to contact their RRC to learn whether residents may provide care for new patients scheduled among the return patients in these clinics.

Question: *How should duty hours be calculated when a resident takes a vacation week?*

Answer: Vacation days should always be taken out of the numerator and the denominator for calculating averaged duty hours, or on-call frequency. E.g., if a resident is on vacation for one week, the hours and the on-call frequency for that rotation should be averaged over the remaining weeks.

Question: *We have heard that the duty hour standards can be “relaxed” over the Christmas holidays or other times when the hospital is “short-staffed.”*

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 overall scheduling pattern for the month must comply with the common and RRC 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 RRC specific standards, such as the Internal Medicine requirement that averaging of the frequency of in-house call is not permitted.

Question: *The ACGME has states that it will rigorously monitor duty hours in accredited programs, and that the sponsoring institution has the oversight for duty hour. We have that this requires the sponsoring institution to do electronic, “real-time” monitoring of duty hours in all accredited programs. Is this true?*

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

Web Accreditation Database (WebADS) and that this information be reviewed and endorsed by the Designated Institutional Official (DIO).

The ACGME is aware that 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: *Now that the common duty hour standards have gone into effect, will the RRCs 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: *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: It is common in smaller surgical residency programs to have residents on duty one weekend (Friday and Sunday for instance), so they can be off the next weekend. As long as the call schedule and total duty hours average out within parameters specified by the relevant program requirements, this type of every other weekend schedule is acceptable. 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) is not permitted, unless the residents are given a rest period of about 10 hours between the two duty shifts.

Question: *The ACGME common duty hour standards state that residents must be provided with 1 day in 7 free from all educational and clinical 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: This question is complex because it requires the simultaneous interpretation of several ACGME standards, and because there are differences in the interpretation of this standard by the individual RRCs. Where 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. Others have noted that it is not permissible to have the day off routinely scheduled on a resident’s post-call day.

Having the day off always be a non post-call day can create scheduling problems in smaller programs, but the argument for keeping the post-call day and the day off separate comes from Doris Stoll, PhD, Executive Director of several surgical RRCs. Dr. Stoll notes that time left in the day after an in-house call is not a day off. This is because the requirement for a rest period after in-house call to rest and sleep, suggesting that this rest period is not a part of the 24-hour day off. Because call from home (pager call) does not require a rest period, the day after a pager call may be considered 24 hours off.

Other RRCs have not been as explicit, but would likely not consider it appropriate to have the residents' day regularly scheduled on their post-call day.

Question: *The requirement 10-hour rest period continues to be problematic for many programs. 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 provided between all daily duty periods and after in-house call." Adequate rest is a "**must**" requirement, while the requirement for a 10-hour period is a "**should**." "**Should**" is interpreted as "a term used to designate requirements that are so important that their absence must be justified." This allows programs to provide somewhat shorter rest periods, when an appropriate educational justification is offered. Interpretation of what constitutes "appropriate justification" cannot truly be made a priori, but allowing added time for didactic lectures of high importance or for surgical experience, especially rare cases or cases with particular educational value of the given resident, are examples most RRCs would consider appropriate. It is important to remember that any abbreviated rest period must be justified from an educational perspective, and the program director and faculty must monitor the resident for the signs of sleep deprivation.

Question: *Some programs have interpreted the standard for averaging the 80-hour weekly limit, call frequency and days off as allowing a constantly rolling 4-week average. Does the use of a "rolling average" comply with the common duty hour standards?*

Answer: No. Averaging must be done by individual clinical rotation or by four-week block. Nowhere do the standards call for a "rolling" average. A rolling average would not be acceptable, because it may make it possible to average across high and low duty hour rotations to hide a compliance problem. In addition, call frequency should be averaged for periods with call, e.g., it is not appropriate to include call rotations and ambulatory rotations that do not include call together in the numerator or the denominator to calculate on-call frequency. Essentially, because they are minimum standards, the rotations with the greatest hours and frequency of call must comply with the common duty hour standards.

Question: I have heard about interest in the surgical community to have duty hours for chief residents extended to 88 hours per week. If I am interested in extending hours for my chief residents, what are my options?

Answer: In February 2004, the chairs of the surgical Residency Review Committees (RRCs) presented a proposal to the ACGME to extend duty hours for residents in the surgical chief resident year (the final accredited year in a surgical core residency) to 88 hours. At its June 2004 meeting, ACGME voted to not to allow this general extensions. Reasons cited included a lack of data thus far showing that surgical operative has declined under the application of the common duty hour standards, and the option for surgical residency programs interested in extending the duty hours for their chief resident year to use an exception allowing their the Board determined that such requests could be addressed through the current "88-hour exception" procedure allowing an up to 10% increases in duty hours on a program-by-program basis, with approval by the sponsoring institution's graduate medical education committee (GMEC) and the RRC. Such an exception must have a sound educational rationale. Once approved, it allows programs to extend weekly duty hours to 88 hours. Like the 80-hour limit, this is averaged over four weeks. ACGME and the surgical RRCs are expecting that a number of surgical programs will take advantage of this option and designated institutional officials (DIOs) should be aware that they may see requests for extending weekly duty hours to 88 hours to be applied just to the chief resident year.

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 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.

Also, programs may ask for an extension that is less than the maximum of 8 additional weekly hours, and extension in duty hours may be requested for a given level of the program (the chief resident year) or for individual rotations or experiences.