

Summary and Impact of Major Program Requirement Revisions

Common Program Requirements

Introduction

Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring the development of the skills, knowledge, and attitudes in the resident required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Should improve patient care quality and safety.**
- 2) improves the quality of resident education; **Will improve education as residents will be better able to take advantage of learning opportunities.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **May require minimal increase in resources to conduct this education.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.A.2. The program must be committed to and be responsible for promoting patient safety and resident well-being in a supportive educational environment.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Will improve quality of patient care and safety.**
- 2) improves the quality of resident education; **Will enhance education by making a more supportive environment for learning.**

- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **Some limited increase in resources required.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **To provide a safer environment and more supportive environment there may be need for patient caps and this might create a need for additional resources.**
impacts residency education in other specialties. **May have indirect impact of shifting more primary care responsibility to fellows and higher level trainees and faculty.**

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Will improve quality and safety by integrating education about quality improvement with hospital's quality improvement mission.**
- 2) improves the quality of resident education; **Residents will learn more for "real life" quality improvement projects.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Quality improvement projects may lead to more continuous care.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.A.4.a. The learning objectives of the program must be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **N/A**
- 2) improves the quality of resident education; **Eliminating the service versus education dichotomy leads to clearing away an existing myth and has residents realizing that service is education.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **May lead to a change in patient volumes but not a change in patient variety.**
impacts residency education in other specialties. **N/A**

VI.A.4.b. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This should improve safety and quality by lessening the distractions of non-clinical (non-physician) work done by residents.**
- 2) improves the quality of resident education; **Will improve education by having more time for education.**

- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This will require an increase in institutional resources if done correctly.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **There may be an opportunity for each resident to care for more patients if other non physician work is taken away from them.** impacts residency education in other specialties. **N/A**

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Improves patient care and safety.**
- 2) improves the quality of resident education; **Improves education in the realm of several of the competencies.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A** impacts residency education in other specialties. **N/A**

Residents and faculty must demonstrate:

VI.A.5.a. assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b. provision of patient and family-centered care;

VI.A.5.c. assurance of their fitness for duty;

VI.A.5.d. management of their time before, during, and after clinical assignments;

VI.A.5.e. recognition of impairment, including illness and fatigue, in themselves and in their peers;

VI.A.5.f. attention to lifelong learning;

VI.A.5.g. the monitoring of their patient care performance improvement indicators; and,

VI.A.5.h. honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **All the provisions will improve quality and safety.**
- 2) improves the quality of resident education; **Will enhance education particularly provision g,f,h.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A** impacts residency education in other specialties. **N/A**

VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersede self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Will improve both quality and safety.**
- 2) improves the quality of resident education; **N/A**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **May lead to changes in the way continuous care is provided.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **May cause a need for increased resources.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.B. Transitions of Care

VI.B.1 Programs must design clinical assignments to minimize the number of transitions in patient care.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Fewer transitions should lead to improved care.**
- 2) improves the quality of resident education; **Fewer transitions should make each patient care experience a better learning experience .**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Should improve continuity.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **May require increased resources.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.B.2. Institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Improved handovers will lead to better patient care quality and safety.**
- 2) improves the quality of resident education; **Residents will learn the elements of good handovers and thus be educated to an improved level.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Should lead to perception of more continuity because of better information transfer.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **May cause a small increase in resource allocation to get up and running with this improvement effort.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Improved patient care quality and safety.**
- 2) improves the quality of resident education; **N/A**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Provides more continuity if care plans are team cohesive.**

- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.B.4. Institutions must ensure the availability of schedules that inform all members of the health care team of faculty members and residents currently responsible for each patient's care.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Will improve patient care quality and safety.**
- 2) improves the quality of resident education; **N/A**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Will lead to more continuity of care.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **Will require that institutions develop a methodology for this which will require resources.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
- 6) impacts residency education in other specialties. **Should enhance communication between specialists.**

VI.C. Alertness Management

VI.C.1. The program must:

VI.C.1.a. educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b. educate all faculty members and residents in fatigue mitigation processes; and,

VI.C.1.c. adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, including naps and back-up call schedules.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Will enhance quality and safety.**
- 2) improves the quality of resident education; **Indirectly will improve education.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **Will require an improved education program over what now exists.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**

impacts residency education in other specialties. **N/A**

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Puts patient care quality and safety at less risk.**
- 2) improves the quality of resident education; **N/A**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **If misused may lead to less continuity.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **May require additional resources for alternate staffing patterns.**

- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **not directly applicable**
- 2) improves the quality of resident education; **not directly applicable**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **not directly applicable**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **will require resources to provide facilities and/or transportation**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and **N/A**
impacts residency education in other specialties. **N/A**

VI.D. Supervision of Residents

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

VI.D.1 In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged, supervising faculty member who is ultimately responsible for that patient's care.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Both quality and safety of patient care will be enhanced by having an identifiable supervising faculty member. Responsibility for care will be designated clearly to both trainees and other health professionals. Designated staff will allow more direct communication between other care givers and patients and families as well as trainees.**
- 2) improves the quality of resident education; **The tenets of supervision outlined in this requirement's preamble should be met with this clear delineation of responsibility. The trainees will also have increased feedback and be able to be evaluated on various milestones in order to progress in graduated responsibility.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **A clear chain of command and, thus, responsibility, is established; it also explicitly allows for residents to have indirect supervision upon reaching various levels of competency.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A; this requirement should in theory be practiced now, particularly in an institutional setting, due to requirements of credentialing and reimbursement and thus has no impact on addition of faculty and no financial impact**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and
impacts residency education in other specialties. **N/A**

VI.D.1.a. This information should be available to residents, faculty members, and patients.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Transparency will be evident for residents, faculty, patients and families regarding who is responsible, thus improving the communications and the quality and safety of patient care.**
- 2) improves the quality of resident education; **N/A**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **By having the information available to all concerned, there should be one designated supervising physician who will manage the continuum of patient care through changes in residents.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **There may be small increases in system development (white boards in patient rooms, pamphlets, handouts, etc.) but these should not be significant.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.1.b. Residents and faculty members should inform patients of their respective roles in each patient's care.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **It is essential that, during the educational process, the need to inform patients of specific roles be inculcated in residents. From a patient perspective, transparency of specific roles is essential communication; further, it inculcates a culture of honesty and transparency in medicine. By patients and families understanding who plays what role, communication between families, patients and staff will increase.**
- 2) improves the quality of resident education; **This enhances patient care, professionalism, communications, and systems-based competencies**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **The knowledge of the patient and their families to the exact roles, played by various team members assists in providing the appropriate directions for continuing care.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all patients cared for by all residents.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Ensuring appropriate supervision is essential for assuring the quality and safety of patient care. Ensuring the appropriate level of supervision provides the trainee with graduated responsibility in order to ensure the end-product of a competent physician.**
- 2) improves the quality of resident education; **The quality of resident education is highly dependent on availability of appropriate supervision; Ensuring the appropriate level of supervision provides the trainee with graduated responsibility in order to ensure the end-product of a competent physician.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other

services; addition of faculty; financial impact); **Variable; if institutions already have adequately ensured supervision and the documentation of such supervision, there should be no cost associated with the change, those who have not may have substantial costs to come into compliance.**

- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.3. Levels of Supervision.

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) Direct Supervision – The supervising physician is physically present with the resident and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via phone, and is available to provide Direct Supervision.

VI.D.3.c) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **N/A; above is definitional**
- 2) improves the quality of resident education; **This statement clearly defines differing levels of supervision, and will enhance resident education. Defining levels of supervision allows graduated responsibility to occur, resulting in a well-trained, competent physician, ready to enter the unsupervised practice of medicine.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **These definitions should enhance patient care by assuring that an appropriate level of supervision be provided and informing other attending and health care professionals what level of supervision is required for which trainees.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **In certain circumstances, this may indeed require the addition of faculty. If, for instance, the specific level of supervision is defined by a specialty as needing direct supervision, programs will need to provide this 24/7 and may need to add significant financial expense.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.4. The privilege of progressive responsibility, authority and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This should not impact the quality and safety of today's patients in programs with appropriate supervision in place. Allowing for graduated independence will enhance future patient safety and quality of care as the residents should be trained in the provision of the best and safest care. In addition, it allows for more immediate supervision of more junior trainees.**
- 2) improves the quality of resident education; **Progressive responsibility towards full**

independence in practice is the purpose of residency training; this statement makes this goal explicit.

- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.4.a. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **A residency-specific, outcomes-based approach allows for following national quality and patient safety goals while keeping the focus on the resident. Referencing national quality criteria (where available) should result in local and national improvements in care, as closer levels of supervision will need to be provided for those trainees at lower levels of competency based in specific standards.**
- 2) improves the quality of resident education; **The responsibility for assuring that specific milestones are met by each resident is placed with the program director. Trainees are knowledgeable about the specific national standards needed to be reached to progress in training, and at decreased levels of supervision.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Such evaluation will focus attention on the care residents provide, and the quality of this care; if care is substandard this attention should drive improvement in care.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This responsibility entrusted to the program director may require more time from the program director; if so it may require greater institutional support of the program director and/or the addition of faculty as associate program directors to monitor and evaluate the achievement of these standards by the trainee.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.4.b. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Quality and safety of patient care should be positively impacted as long as the supervising physician understands and attends to the limits of the resident's abilities. If levels of supervision are assigned based on achievement of national standards (milestones), the quality and the safety of the care delivered should be improved.**
- 2) improves the quality of resident education; **By proper delegation, the resident should gain valuable experience, and realize and wish to improve areas in which they have shortcomings. In addition, residents will gain invaluable experience in teaching more junior trainees and in assessing the competency of more junior trainees as they will be expected to do at the completion of training.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Specific delegation of authority by the attending will clarify the role of the**

resident; requiring that the needs of the patient be considered in this delegation of authority may result in attending physicians performing or more directly supervising some tasks. Attention will need to be made to the efficiency of the resident's provision of services: if the alternative would have been to have the supervising physician perform a task, then it is highly probable that the supervising physician might be more efficient. Conversely, if there is a waiting period for the patient that might be eliminated having a resident perform a task, then efficiency from the patient's viewpoint may be enhanced.

- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **The delegation of more portions of care to trainees may result in decreased income to the institution because of billing practices. Depending on the skill and competence of the residents, more attending time may be required for teaching and supervision.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **If the supervising physician is delegating less care to a resident, there might be a very minor reduction in the volume and variety of patients for that resident.**

VI.D.4.c. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement clarifies what is already being done and in theory should not alter the quality and safety of patient care.**
- 2) improves the quality of resident education; **It is essential to the tenet of graduated responsibility that senior residents assume a supervisory role.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a resident to an intensive care unit, or end-of-life decisions.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Quality and safety of patient care should be enhanced.**
- 2) improves the quality of resident education; **Quality of resident education should be enhanced through emphasizing recognition of and communication in situations where patients are in jeopardy and learning about the development of clinical judgment in these cases.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **The need for attending physicians to be involved in the care of patients under their care when they are not present and the need for residents to inform their attending physicians of changes in the status of their patients will be made explicit. This will also assist the staff in understanding the roles of each trainee and physician and allow for a more interdisciplinary approach to care.**

- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **There will be increased time of the program director in order to assure that these guidelines are being met. There may be an increase in the time attending physicians spend in clinical care. There may be the need for more associate program directors to assist in monitoring these guidelines. Systems may need to be developed where the competencies of the individual trainees are tracked for others to check, based almost on real-time data.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.D.5.a. Each resident is responsible for knowing the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Quality and safety of patient care should be enhanced.**
- 2) improves the quality of resident education; **Education should be enhanced significantly; junior residents will have guidelines for when they can act independently.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Interdisciplinary care will be improved in that staff will understand the limits and upper boundaries of trainees' abilities and degrees of independence in order to provide continuing care.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **The financial impact analysis should specifically assist in determining the impact of 16-hour PGY1 limit and, thus, provision of direct or indirect provision of supervision. The direct or indirect level of supervision requirement may result in an increase in resources expended by departments, but is more likely to simply require programs to make implicit coverage explicit.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **Surgical disciplines may find the need for increased patient exposure in certain areas where the supervision is direct or indirect for the PGY 1s to be able to advance to the next level of competency. The interactions with other specialties are difficult to ascertain at this time, although they should not be significant.**

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Quality and safety of patient care should be enhanced by insisting upon continuity of care of "sufficient duration" by the attending.**
- 2) improves the quality of resident education; **Quality of resident education should be enhanced through more knowledgeable assessments and supervision.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **There may be a need to re-assign attending service and resident rotations in order to allow for "sufficient duration" supervision.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other

services; addition of faculty; financial impact); **see #3 There may be a need for increased financial resources to allow attending periods to be of “sufficient duration.”**

- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **By enhancing continuity of supervision, the variety of patients and the volume of cases may be reduced. The impact of this CPR will need to be monitored carefully.**

VI.E. Clinical Responsibilities

VI.E.1. The clinical responsibilities for each resident must be based on the PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

[As further specified by the Review Committee]

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Quality and safety of patient care should be enhanced.**
- 2) improves the quality of resident education; **Quality of resident education should be enhanced, in part due to a greater ability for self assessment/ reflection.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **The potential exists that this requirement will result in the need for more faculty/services, but may also enhance clinical revenue by reducing length of stay. This will be highly specialty-specific with a greater impact on hospital-based services, and the impact will need to be followed closely.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **In all likelihood, this will “cap” volume, with the tradeoff being the potential for a reduction in the variety of patients for an increase in the quality of thought/time given the patients seen and cared for. In addition, the possibility of reduced patient volume and exposure may result in longer periods of time to achieve competency.**

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interdisciplinary teams that are appropriate to the delivery of care in the specialty.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Quality and safety of patient care should be enhanced**
- 2) improves the quality of resident education; **Resident education, particularly in the competency of professionalism and interpersonal and communication skills, should be enhanced In addition this will train the resident to function effectively not only in interdisciplinary teams, but also as a leader of an interdisciplinary team.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **This program requirement should positively affect patient care by making explicit the role of the individual resident, keeping the focus on patient care needs, and how these are to be achieved. This should enhance the delivery of**

interdisciplinary team care and improve patient care delivery.

- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **As guidelines for effective handovers are developed, there may be a financial impact on institutions as a part of the development process or the upkeep of these systems; cost savings may be achieved by reducing errors and length of stay but they may not exceed total costs.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); and impacts residency education in other specialties. **N/A**

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement is relatively unchanged from prior requirement and should have little impact.**
- 2) improves the quality of resident education; **This requirement is relatively unchanged from prior requirement and should have little impact.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **This requirement is relatively unchanged from prior requirement and should have little impact.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This requirement is relatively unchanged from prior requirement and should have little impact.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **This requirement is relatively unchanged from prior requirement and should have little impact.** and impacts residency education in other specialties. **N/A**

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain the approval of the institution's GMEC and DIO.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement is unchanged and in and of itself should have no impact.**
- 2) improves the quality of resident education; **This requirement is unchanged and in and of itself should have no impact.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **This requirement is unchanged and in and of itself should have no impact.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This requirement is unchanged and in and of itself should have no impact.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **This requirement is unchanged and in and of itself should**

have no impact. and
impacts residency education in other specialties. **N/A**

VI.G.2. Moonlighting

VI.G.2.a) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.b) PGY-1 residents are not permitted to moonlight.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Eliminating PGY 1 moonlighting will improve the quality and safety of patient care because it will require that these most inexperienced residents provide care only within the safety net of an accredited program. Counting all moonlighting, both internal and external, will improve the quality and safety of patient care because hours spent working as a doctor are as tiring outside of accredited programs as they are within them.**
- 2) improves the quality of resident education; **Eliminating PGY 1 moonlighting will improve resident education because it will prevent PGY 1 residents from splitting their focus between their responsibilities to their patients within the program and their responsibilities to their outside jobs. In addition, PGY 1 residents will only be providing care within an accredited program and in the context of the other regulations to follow. Counting all moonlighting, both internal and external, may have two contrary effects on the quality of resident education. First, counting all hours toward the 80-hour work week will likely result in less fatigued residents who are better able to concentrate and learn while working in their programs. Secondly, however, counting all hours may eliminate the opportunity for some residents to perform external moonlighting. While not a formal educational experience, some residents find external moonlighting to be a next step in their development as independent practitioners.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Counting all moonlighting, both internal and external, may eliminate the opportunity for some residents to perform external moonlighting. This may affect the staffing at many sites, such as urgent care centers and after hours clinics, and therefore, may decrease availability of such services to patients.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **Counting all moonlighting, both internal and external, may eliminate the opportunity for some residents to perform external moonlighting. This may impact the financial state for some residents and may actually affect their decisions to pursue additional training, such as fellowships. If programs do elect to allow residents to continue to moonlight externally, the programs will have to develop the systems necessary to monitor those activities.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and
impacts residency education in other specialties. **N/A**

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.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This revision does not represent a change from the prior requirements but is in opposition with the**

recommendations made by the IOM. We believe that the IOM recommendation that residents have five days off per month is untenable for many reasons. The first of these is practical: adding another day off for every resident on an inpatient service would almost eliminate the occasion for the team to be present in its entirety – for a three-resident team, half of the days each month would have to be used as days “off” for one resident on the team. In order to “cover” for residents who are “off”, the remaining residents will have an increased workload, a potentially dangerous situation. The program and/or institution may also have to develop other methods of provider coverage in order to account for these extra days “off”. In addition, increasing the number of days off per month will decrease continuity of care, something that we believe is associated with high quality care. Finally, although the recommended change would only decrease one day of exposure each month, in five year residency programs, such as general surgery, it would amount to a full two months’ time. Decreasing that period of clinical exposure would decrease the educational opportunities for those residents and may change the volume and variety of patients required to provide proper educational resources in the institution(s).

- 2) improves the quality of resident education; **This requirement is unchanged (aside from minor wording differences) and in and of itself should have no impact.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **This requirement is unchanged (aside from minor wording differences) and in and of itself should have no impact.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This requirement is unchanged (aside from minor wording differences) and in and of itself should have no impact.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **This requirement is unchanged (aside from minor wording differences) and in and of itself should have no impact.** and impacts residency education in other specialties. **N/A**

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **The sleep literature indicates that an individual’s ability to successfully complete repetitive computer vigilance testing decreases at 16 hours of wakefulness. Although these activities neither simulate clinical care nor approximate the skills required to take care of patients, there has been one study of PGY 1 residents in the high-intensity environment of the pediatric ICU showing that there was increased risk of error with shifts longer than 16 hours in duration. Decreasing the shift length for PGY 1 residents is indicated by this study, in order to promote the quality and safety of patient care. This requirement may, however, impair the education for PGY 1 residents by eliminating their opportunities to watch the evolution of disease over time in a single patient. They will therefore have to see more patients with the same diseases in order to fully experience the spectrum of those diseases. Conversely, this requirement will likely improve the quality of PGY 1 education by eliminating the post-call day, when learners are thought to retain less of the information they are taught. This requirement will change the structure of the inpatient team at many institutions, likely resulting in the transition of the intern year to include more night float rotations. This change will impact the provision of care to**

patients, but may result in both an increase and a decrease in continuity of care, depending upon your perspective. Patients may have more than one primary team (i.e., they may have both a day team and a night team), but they may also experience less “cross-coverage.” In programs that do not adopt a night float approach, this change in the availability of PGY 1 residents may necessitate changes in the availability of other providers and therefore may result in the requirement for institutions to hire additional people to cover when the PGY 1 residents are not present. Some programs may also choose to schedule PGY 2 residents to cover the shifts previously performed by PGY 1 residents. This would result in a decrease in the education of the PGY 2 residents, as they would be performing a “service” that is not necessarily educational.

- 2) improves the quality of resident education; Reducing the maximum shift length will foster a more gradual initiation of the PGY1 resident into the demanding workloads and intensity of postgraduate medical training, facilitating a more reflective learning environment and allowing more free time for pursuing the didactic elements of clinical medicine.
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; The limitation of shift length to 16 hours maximum for PGY1 residents may require some services to shift some coverage responsibilities to more senior residents. Since PGY1 residents can still work 80 hours per week, reshuffling the scheduling of all residents should allow normal continuation of patient care. It is not likely that the number of residents needed to provide adequate coverage will need to be increased, or substituted by physician extenders or faculty.
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); See above. If institutions can successfully reschedule all housestaff to compensate for the somewhat shorter shifts for PGY1 residents, a task which should be accomplished with only moderate effort since the maximum hours worked each week remain the same for residents at all levels, there will likely be little or no need for additional institutional fiscal and personnel resources to comply with this standard.
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); N/A and

impacts residency education in other specialties. N/A

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; This requirement does not represent a change from the current requirement, but is contrary to the IOM recommendation on this topic. Although sleep science indicates a decrement of performance of repetitive vigilance activities after 16 hours of wakefulness, this neither relates to clinical decision making nor simulates the activities involved in providing care to patients. There have been no studies of prolonged shifts worked by residents above the PGY 1 year. Residents who have completed the PGY 1 year have greater preparation and increased knowledge and are therefore better prepared to make decisions and care for patients during prolonged shifts. Residents must have the opportunity to care for patients over prolonged periods of time while under the supervision provided during residency so that they are prepared to do

so independently after graduation. Sleep science has demonstrated that alertness management strategies, including strategic napping, are quite successful in mitigating the effects of prolonged wakefulness. We therefore recommended their use without prescribing the specific method of strategy selected or duration of nap used. This is because the few studies that have looked at a required nap have shown that it is neither a practical nor a safe alternative. Not only are residents reluctant to give up the care of “their” patients, but they are also often in a high adrenaline state, in which it would be difficult if not impossible to nap when instructed to do so. In addition, requiring a protected nap period would have several undesirable downstream effects; first, programs and institutions would have to supply additional providers to “cover” for the residents who are napping. Second, continuity of care would decrease and handovers of patient care would increase, thereby risking both patient safety and resident education. Third, situations may arise when patients will be held in the emergency department during the nap period, awaiting the opportunity to be admitted to the hospital. Emergency departments are not prepared to provide continuing care for patients and patient safety literature has shown that “prolonged boarding” is associated with worsened outcomes.

- 2) improves the quality of resident education; **It remains imperative that residents experience the full progression of medical and surgical disease during residency if they are to be able to practice independently and without supervision upon completion of training. It can be argued that a resident who appropriately avails him/herself of the ability to nap when there are no pressing clinical responsibilities would be more alert, facilitating more a more reflective learning environment.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **It is presumed that the institution, the service, and the resident will work together in recognizing the need for strategic napping and facilitating such napping during periods of reduced clinical responsibilities during the night time hours.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement represents a decrease in the time provided for transitions in the current requirements. We believe that a four-hour period allows time for residents to attend rounds, thereby transmitting the important overnight information to the providers who will care for the residents during the “post-call” day, and providing for continuity of care and patient safety. In addition, attending rounds ensures that residents are exposed to the discussions about both the decisions that they made overnight and the critical learning about the patients who were admitted. Decreasing the time from six to four hours emphasizes that this is truly a transition period, not a race to complete all of the work for the “post-call” day. This decrease may, however, require programs and institutions to reorganize their structures and coverage**

schemes.

- 2) improves the quality of resident education; **The two-hour reduction in transition time compared to current standards should benefit the well-being and sleep time of the resident, both of which can result in more alert time spent in reflective learning and pursuit of clinical didactics. It is unlikely the resident's education will be adversely affected in any way by the two fewer hours spent in the transition of care process.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Since the resident is prohibited from participating in Continuity Clinics during the transition period after a 24-hour scheduled duty period (see below) as has been the case in some specialties in the past, it will likely be necessary in such cases for the service to schedule the clinics in a different way if the goal is to ensure follow-up of specific patients by specific residents.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **see above. It is unlikely additional fiscal or personnel resources would be necessary to rearrange times for Continuity Clinics.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.4.b).(2) Residents must not attend continuity clinics after 24 hours of continuous in-house duty.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement recognizes that patient safety expectations should extend into the outpatient world as well. The addition time after a 24 hour shift is intended for transitions of care and continuity clinic does not represent a transition. This requirement may force some specialty RCs to rethink their continuity clinic requirements, and may also force programs to reorganize the structure of continuity clinics.**
- 2) improves the quality of resident education; **This requirement will likely improve the quality of resident education if Continuity Clinics can be scheduled at times when the resident is rested and better able evaluate and reflect on patient response to treatment regimens.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **See discussions above.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **See discussions above.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement provides the opportunity for residents to experience critical events without putting the needs of other patients at risk. This requirement allows residents to fully participate in the continuing care of their patients, by being present for critical discussions and**

occurrences. It also provides the residents with the educational experience of deciding which events and activities are critical to their professional development. Documentation requirements ensure that residents will make the decision to stay with a reason in mind.

- 2) improves the quality of resident education; **The ability of the resident to experience continuity of care in such very limited circumstances will result in improved education by observation of the natural history of the disease process or participation in unique/rare surgical therapy, and will build a sense of professionalism/altruism in those cases where humanistic needs warrant the special attention of the resident who initiated care.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.4.b).(3).(a) Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement is unlikely to affect patient care if an orderly transition of patient care occurs between the residents going off shift and the team coming on.**
- 2) improves the quality of resident education; **See discussion above regarding the benefit to resident education.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **This requirement should have minimal impact.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **N/A**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and

impacts residency education in other specialties. **N/A**

VI.H.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **N/A**
- 2) improves the quality of resident education; **N/A**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This requirement will create increased workload for the program director. Given, however, that the spirit of this requirement is that it apply only in exceptional circumstances, the documentation should only be required on an infrequent basis. This requirement also provides the PD an opportunity to review the reflections of the resident; therefore, it provides another chance for resident education on the topic.**

- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **Any requirement, such as this one, that protects sleep time for the resident, and therefore results in a more rested resident, can be expected to positively impact quality and safety of patient care.**
- 2) improves the quality of resident education; **Any requirement, such as this one, that protects sleep time for the resident, and therefore results in a more rested resident, can be expect to improve the quality of resident education.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **This requirement maintains the 10 hours off between scheduled duty periods, but allows the leeway, when such can be justified to the satisfaction of individual RRCs, to reduce that time to a mandated minimum of eight hours to allow scheduling within a 24-hour (full day) time frame. The service will have to be judicious in the use of the mandatory eight hours off, and will be encouraged to adopt the more generous 10 hours off in scheduling housestaff for clinical duties.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This requirement in and of itself should not require additional institutional resources.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.5.b) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **The change in this requirement for a mandatory eight hours off between scheduled duty periods as opposed to the current 10 hours should have little or no impact on quality and safety of patient care. It is anticipated that most services will continue with 10 hours off between scheduled duty periods as is currently required. The addition to the requirement of at least 14 hours off after 24 hours of in-house duty should result in a more rested resident providing patient care on subsequent shifts, thus improving the safety of patient care.**
- 2) improves the quality of resident education; **The same rationale as above apply to resident education (see prior discussions above regarding the “rested resident” and resident education)**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Any changes in time off between scheduled duty periods will require the service to modify coverage schedules appropriately. In some instances, the increased time off required after a 24-hour shift may result in the need for coverage of the service by other residents. Again, it must be kept in mind that residents at all levels can be scheduled to the same 80 hours per week maximum.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **See discussion above. Since residents**

at all levels can be scheduled to the same 80 hours per week maximum, appropriate modification of scheduling should negate the need for more residents, physician extenders or faculty.

- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.5.c) Residents in the final years of education should have 10 hours free of duty, and must have eight hours between scheduled duty periods. However, these residents must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. Under circumstances defined and approved by the Review Committee, residents in their final years of education (as determined by the Review Committee) may be permitted to return to duty with fewer than eight hours between in-hospital activities. This must occur only within the context of the 80-hour and one-day-off-in-seven standards.

VI.G.5.d) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement, when administered with judicious attention to time management, fatigue management and determination of fitness for duty on the part of the resident as well as the supervising faculty, should result in no impact on patient care.**
- 2) improves the quality of resident education; **This requirement, when administered with judicious attention to time management, fatigue management and determination of fitness for duty on the part of the resident as well as the supervising faculty, should result in the increased ability of the senior resident to remain directly involved in the continuity of either the medical or surgical care of specific patients and thus improve his/her ability to practice independently and without supervision upon completion of training.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **N/A**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This requirement will increase the documentation and review responsibilities of the program director. In large programs additional protected time for the program director may be necessary, requiring coverage of his/her clinical responsibilities by other faculty or physician extenders. If this special privilege is invoked in a limited fashion, as intended, the additional burden on program directors in most programs should be minimal.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float. (The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.)

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement should have no impact on patient care because there will likely be no change in current practices of scheduling night float. Current standards do not address this issue. However,**

it is known that current night float systems typically schedule at least five, and more commonly six, consecutive nights of night float in the hospital. Experience indicates that during periods of five to six consecutive nights on night float duty, residents are able to adjust their diurnal rhythms and obtain restful sleep during the day. Further, the current night float system has proved to be an effective tool in reducing overall resident work hours and in providing the flexibility needed by various specialties in scheduling coverage.

- 2) improves the quality of resident education; **Since there is no current standard on the number of consecutive nights of night float that may be scheduled, and since most programs are felt to schedule either five or six nights consecutively already, it is unlikely that this requirement will affect the quality of resident education one way or the other.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **Since there is no current standard on the number of consecutive nights of night float that may be scheduled, and since most programs are felt to schedule either five or six nights consecutively already, it is unlikely this requirement will affect how the service operates.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **Since there is no current standard on the number of consecutive nights of night float that may be scheduled, and since most programs are felt to schedule either five or six nights consecutively already, it is unlikely this requirement will require a change in institutional resources.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and impacts residency education in other specialties. **N/A**

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 (no averaging).

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement decreases the risk of fatigue in residents by eliminating the possibility of every other day on call. It will, however, also decrease flexibility in the call schedule and may decrease resident quality of life by eliminating the possibility for 2 days off in a row during a month of Q3 call. It may also require a shift in resources in some small programs if residents have vacation or fall ill during a Q3 month, as the other residents sharing that call will be unable to “cover”.**
- 2) improves the quality of resident education; **this requirement modifies the current standard by not allowing averaging. This will guarantee no periods where scheduled duty in-house can occur every other night, resulting in an overall more rested resident. A more rested resident, as previously noted, generally translates into improved resident education.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **this requirement will require the service to modify the way scheduling occurs to accommodate the change from the current standard**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **this requirement should not require additional institutional resources**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **N/A** and

impacts residency education in other specialties. **N/A**

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation.

VI.G.8.a).(1) At-home call must not be so frequent or taxing to preclude rest or reasonable personal time for each resident.

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”

Describe, as appropriate, how the revision:

- 1) impacts the quality and safety of patient care; **This requirement is essentially unchanged from the current standards with the exception of some rewording and clarification and in and of itself should have no impact.**
- 2) improves the quality of resident education; **This requirement is essentially unchanged from the current standards with the exception of some rewording and clarification and in and of itself should have no impact.**
- 3) affects the way the resident, the service, and the staff provide patients with continuing care; **This requirement is essentially unchanged from the current standards with the exception of some rewording and clarification and in and of itself should have no impact.**
- 4) requires a change in institutional resources (e.g., facilities; organization of other services; addition of faculty; financial impact); **This requirement is essentially unchanged from the current standards with the exception of some rewording and clarification and in and of itself should have no impact.**
- 5) may change the volume and variety of patients required to provide proper educational resources in the institution(s); **This requirement is essentially unchanged from the current standards with the exception of some rewording and clarification and in and of itself should have no impact.** and
impacts residency education in other specialties. **N/A**