

PHYSICIAN CONDITIONS OF APPOINTMENT AGREEMENT

CONTENTS		Page
I.	Resident Physician Conditions of Appointment Agreement	1
II.	Resident Responsibilities	2
III.	Medical Center Responsibilities	2
IV.	Appointment, Promotion, and Disciplinary Procedures	3
	Initial Appointment and Reappointment	3
	Non-Renewal of Appointment	3
	Non-Promotion to Next Training Level	3
	Periodic Evaluation	3
	Due Process	3
	CIR Memorandum of Understanding-Grievance Procedures	4
V.	Conditions Required for Postgraduate Training	4
	American or Canadian Medical School Graduates	4
	International Medical School Graduates (IMGs)	4
	Postgraduate Training Registration Form	4
	California Medical Licensure	4
	Renewal of California Medical License	4
	Dental Resident Requirements	5
	Drug Enforcement Agency Registration	5
	Program Security	5
VI.	Compensation and Benefits	5
	Salary	5
	Council of Interns and Residents (CIR)	5
	Patient Care Fund	5
	Living Quarters	5
	Laundry	6
	Meals	6
	Professional Liability Insurance	6
	Insurance	6
	Health Insurance	6
	Dental Insurance	6
	Life Insurance	6
	Accidental Death and Dismemberment Insurance	6
	Disability Insurance	6
	Vacation	6
	Sick Time	6
	Leave of Absence	7
	Professional Leave	7
	Parental Leave	7
	Effect of Leave on Duration of Training and Board Eligibility	7
	Call Rooms	7
	Parking	7
	Travel Expenses	7
	Specialty In-Service Training Examinations	7
	Loss or Damage to Personal Property	7
	Beepers	7
	Counseling and Support Services	7

VII.	County Employment Policies	8
	Fingerprinting	8
	Social Security Numbers.....	8
	Physical Examinations	8
	INS I-9 Documentation.....	8
	Visa Status	8
	Pay Procedure	8
	Professional Activities Outside the Education Program	8
	Electives.....	8
	Sexual Harassment and Exploitation Policies.....	9
	Substance Abuse Policy	9
	Services Rendered.....	9
	Loyalty Oath	9
	Soliciting Business for Attorneys (Capping)	9
	Conflict of Interest	9
VIII.	Restrictive Covenants	9
IX.	Duty Hours.....	10
	Attachment.....ACGME Common Program Requirements Effective July 1, 2011	

II. RESIDENT RESPONSIBILITIES

1. The resident must take advantage of all aspects of the educational opportunities that are listed in the Medical Center Responsibilities noted below.
2. The resident should be familiar with the Institutional Requirements of the ACGME Essentials of Accredited Residency Programs and with the Program Requirements for their individual training program.
3. The resident must be familiar with the requirements for licensure by the Medical Board of California. Residents who fail to become licensed within the period provided by California law will be terminated from their training program. The resident is responsible for maintaining a current, valid license at all times.
4. All licensed residents must obtain DEA numbers. Exemptions from this requirement require the written approval of the Medical Director or Chief Medical Officer of the Medical Center.
5. The resident must complete the form "Report of Outside Employment" if he/she participates in employment activities outside of the residency program. Outside employment must not detract, in any way, from the resident's performance or provision of patient care in the residency program.
6. The resident must complete all medical records within 14 days. This includes, but is not limited to, admission history, physical examination, progress notes, orders, operative reports, radiologic reports, and written and dictated discharge summaries. Failure to comply with this requirement may result in disciplinary action with documentation that becomes a part of the resident's permanent record and may be conveyed to future employers, medical staff offices, or hospital privileges committees.
7. The resident must return all patient charts to the Medical Records Department and films to the Radiology Department in a timely manner. Failure to comply with this requirement may lead to disciplinary action.
8. The resident must adhere to all applicable County policies and procedures (e.g., infection control).
9. Residents are expected to participate in institutional, departmental, divisional, and interdisciplinary quality assurance/improvement activities. Any breach of confidentiality concerning these activities may result in disciplinary action.
10. Residents should contact their department, the Office of Graduate Medical Education, Human Resources and/or the Joint Council of Interns and Residents (CIR) to familiarize themselves with policies affecting their appointment.

III. MEDICAL CENTER RESPONSIBILITIES

The Medical Center agrees to provide each resident with the opportunity to:

1. Develop a personal program of self-study and professional growth with guidance from the teaching staff.
2. Participate in safe, effective, and compassionate patient care under supervision, commensurate with the resident's level of advancement and responsibility.
3. Participate fully in the educational and scholarly activities of the program and, as required, assume responsibility for teaching and supervising other residents and students.
4. Participate as appropriate in Medical Center programs and medical staff activities and adhere to established practices, procedures, and policies of the Medical Center and affiliating institutions.
5. Have appropriate representation on Medical Center committees and councils, whose actions affect the resident's education and or patient care.
6. Submit to the training program director at least annually confidential written evaluations of the faculty and of the educational experience.
7. Have training in BCLS and ACLS; and specialized training in PALS, NALS, and ATLS as applicable to the specialty. This training is at no cost to the resident physician.
8. Have access to their academic and personnel files, as well as the right to copy the documents therein.

IV. APPOINTMENT, PROMOTION, AND DISCIPLINARY PROCEDURES

Initial Appointment and Reappointment

The initial appointment is made for one year unless otherwise specified. Reappointment for subsequent years leading to the completion of the residency program is expected of residents in categorical programs. Reappointment is contingent upon satisfactory progress in the residency program as determined by evaluation and remediation policies of the individual residency program. It is the resident's responsibility to understand the evaluation and promotion policies of his/her individual residency program.

Non-Renewal of Appointment

Those residents who will not be retained for the succeeding training year will be so informed in writing by no later than four months prior to the end of this agreement. If the primary reason (s) for non-renewal occurs within four months prior to the end of this agreement, residents will be notified of intent not to renew as circumstances will reasonably allow prior to the end of this agreement. Residents participating in resident training who do not receive written notice of non-renewal in a timely manner will be renewed for the next postgraduate training year. Residents receiving notice of non-renewal may appeal through the Due Process procedure described in this section.

Non-Promotion to Next Training Level

Residents who will not be promoted to the next level of training for academic reasons will be notified in writing no later than four months prior to the end of this agreement. If the primary reason (s) for non-promotion occurs within four months prior to the end of this agreement, residents will be notified of intent not to promote as circumstances will reasonably allow prior to the end of this agreement. Residents receiving notice of non-promotion may appeal through the Due Process procedure described in this section.

Periodic Evaluation

Each resident will undergo periodic evaluation by his/her residency program. Each resident should understand the details of these evaluations, the criteria used, the periodicity of evaluations, those individuals responsible for making evaluations, etc. It is Medical Center policy that the resident may review his/her evaluations.

Due Process

Due process is an established course of proceedings utilized by an individual or group for responding to allegations regarding their behavior. All County employees are entitled to due process. The right to due process includes entitlement to a full exposition of the reasons and conditions for disciplinary action and the utilization of established grievance procedures. The integrity of grievance procedures as they apply to residents are protected by ACGME Guidelines for Academic Due Process and the Memorandum of Understanding between the County and the CIR.

Within the training program, there are two pathways a resident can take to respond to allegations regarding academic performance or non-academic behavior.

Guidelines for Academic Due Process: A resident should consult these guidelines if he/she receives, or suspects, notification from his/her department of failure to meet academic standards. Notification to the resident that disciplinary action will be undertaken shall include specification of the standard(s) violated or not fulfilled through the resident's action(s) and/or performance. Further, in the case of academic performance, the notification will describe the course of action the resident should undertake to remedy the deficiency(ies). The guidelines for the grievance procedure mandate that prior to the implementation of any disciplinary action leading to termination, a hearing must convene that allows the resident to present his/her position to department representatives. Following a decision, the resident may appeal, as a final step, to the Medical Director/Chief Medical Officer at the Medical Center. Should the resident choose to appeal, an independent committee will be appointed, with the specific role of reviewing the matter and making recommendations to the Medical Director/Chief Medical Officer, whose decision is final. The Guidelines can be obtained in the office of the Medical Director/Chief Medical Officer or the Office of Graduate Medical Education.

CIR Memorandum of Understanding -- Grievance Procedures: The CIR Grievance Procedures are found in Article 14 of the CIR Memorandum of Understanding. These procedures may be utilized when a resident is threatened with discipline or termination, and if provisions in the CIR Memorandum of Understanding (MOU), such as compensation and benefits, governing personnel practices, and working conditions, have not been granted.

The MOU also provides for a Pre-Termination Hearing for the resident. The CIR grievance procedure is a three-step process that may end in binding arbitration. Copies of the CIR Memorandum of Understanding are available in the offices of the Medical Director/Chief Medical Officer, Graduate Medical Education, or Human Resources at the Medical Center, or from the CIR.

V. CONDITIONS REQUIRED FOR POSTGRADUATE TRAINING

American or Canadian Medical School Graduates

Regardless of citizenship, graduates of American or Canadian schools are permitted to begin the GY-1 year without a qualifying examination; however, residents must show proof that a Doctor of Medicine or similar medical degree has been issued to them.

International Medical School Graduates (IMGs)

Regardless of citizenship, IMGs must have the following documents to begin GY-1 training:

1) Written permission from the Medical Board of California to begin training; 2) A passing score from the USMLE or other qualifying examination; 3) A valid ECFMG Certificate; and 4) a copy of their medical school diploma. This documentation is also required at the GY-2 level if the GY-1 year was done in another American or Canadian facility.

Postgraduate Training Registration Form

If the resident does not have a California Physician's and Surgeon's License, he/she is required by law to be registered with the Medical Board of California on a "Postgraduate Training Registration Form," L3-A. Subject to annual renewal, this registration is valid until the last day of the resident's 24th month of postgraduate training in the USA or Canada (combined) for a graduate of an American or Canadian medical school and until the last day of the resident's 36th month of training for an IMG.

California Medical Licensure

Graduates of American and Canadian Medical Schools. The Medical Board of California requires that residents who are graduates of American and Canadian medical schools and have had 24 months of training and are continuing training in California be licensed by the first day of their 25th month of training no matter what year level of training he/she is entering. Any resident failing to meet this requirement will be subject to termination from the program.

International Medical Graduates (IMGs). Effective January 1, 2001, California law permits International Medical Graduates (IMGs) to practice medicine within an accredited residency program for a maximum of 36 months of training under registration with the Medical Board of California. IMG residents should contact the Medical Board of California to ensure they have accurate information concerning their individual licensing requirements. In instances where resident physician training continues beyond 3 years, a California medical license is required by the last day of the 36th month of training. An IMG resident that fails to meet this requirement will be subject to termination from the program.

Resident physicians are requested to successfully complete all examination requirements for licensure in California within the first 24 months of their postgraduate training.

Renewal of California Medical License

Resident Physicians at the GY-3 for graduates of American or Canadian medical schools or GY-4 for IMGs through GY-7 year levels must have a valid California medical license at all times and it must be renewed promptly. If a license has expired, evidence of renewal must be presented before the resident may continue training. Failure to have a valid California medical license will result in suspension of employment without pay until a valid license is obtained.

Dental Resident Requirements

The state of California does not require a valid dental license for dentists engaged in training in a reputable dental program approved by the Board of Dental Examiners. Dental residents will be advanced in accordance with program requirements. Dental residents who hold the MD degree and are enrolled in the 6-year MD/DDS program at LAC+USC Medical Center are required to hold a valid medical license as described in the section of this agreement entitled "California Medical Licensure".

Drug Enforcement Agency Registration

Unless the Medical Center's Medical Director or Chief Medical Officer issues a specific written exemption, licensed residents are required to obtain and use their assigned DEA registration number. A copy of this DEA license must be on file in the Office of Graduate Medical Education and the appropriate departmental office. Effective July 1, 1996, all residents (GY-3 and above) must present documentation that they have applied for or possess a current DEA registration. Failure to do so will result in suspension of employment without pay until the deficiency is corrected.

Program Security

It is the Medical Center's obligation to provide the opportunity for continuation and completion of any academic training program for which a resident physician covered under the CIR Memorandum of Understanding is accepted.

In the event of the termination of any residency program for any reason whatsoever, the Medical Center shall make every reasonable effort to place any affected residents in another accredited residency program. The Department of Health Services (DHS) shall make every reasonable effort to place any affected residents in the following order: at another DHS facility; at another accredited program within the Southern California area; or at another accredited program within California.

VI. COMPENSATION AND BENEFITS

Salary

Salary and other benefits shall be provided as established periodically by the Los Angeles County Board of Supervisors, by way of County ordinance and or through an applicable Memorandum of Understanding with the Council of Interns and Residents (CIR).

Council of Interns and Residents (CIR)

The Council of Interns and Residents (CIR), a local affiliate of the nationwide Committee of Interns and Residents (CIR), member AFL-CIO, is the legal bargaining representative for all residents employed by the Los Angeles County. Economic standards, health benefits, program security, due process rights, and other standards of employment are established through the Memorandum of Understanding that is negotiated between the Department of Health Services and CIR. Copies of the Memorandum of Understanding are available through the offices of the Medical Director/Chief Medical Officer, Graduate Medical Education, or Human Resources, or through the CIR.

A periodic membership fee or the equivalent (for residents who chose not to join CIR/CIR) will automatically be deducted (monthly) from each resident's payroll check.

Patient Care Fund

A Patient Care Fund totaling \$2 million was established by the CIR to purchase hospital equipment for LAC+USC (\$1.21 million), King/Drew (\$450,000) and Harbor-UCLA (\$450,000) Medical Centers. These funds are allocated by DHS and administered through CIR.

Living Quarters

Living quarters are not provided.

Laundry

County issued uniforms will be laundered free of charge.

Meals

Three meals per day are provided to residents while they are on duty in a County institution.

Professional Liability Insurance

The County is self-insured and provides liability coverage while working in a County facility. This coverage during the period of employment continues even after leaving County Service (“tail coverage”). Similar coverage is provided during resident rotations to affiliating institutions that are designated as part of the resident training program.

Insurance

The County offers a cafeteria-style benefit program under Internal Revenue Code 125. The program called CHOICES permits flexibility and tax saving advantages for health insurance costs as well as the initiation of spending accounts, health care reimbursements and dependent care reimbursement. The CHOICES program includes health, dental, life, and accidental death and dismemberment options. If the resident does not enroll in a CHOICES plan within sixty (60) days of employment, he/she must wait until the next open enrollment period to enroll. Coverage is effective sixty to ninety (60 to 90) days after enrollment. **Please understand clearly that this delay of 60 to 90 days in the effective date for your health insurance means that you and any dependents will NOT have health insurance coverage AT THE FIRST RECOGNIZED DAY OF YOUR RESIDENCY OR FELLOWSHIP PROGRAM unless you have your own health insurance AS PER COUNTY CODE, CHAPTER 5.33 SECTIONS 5.33.030A (2) AND 5.33.060A.** These benefits are subject to negotiated change. Enrollment counselors are available on Registration and/or Orientation days to provide assistance.

Residents who have health, dental, and life insurance coverage prior to beginning County employment should continue this coverage until the CHOICES coverage begins (60 to 90 days after enrollment in the CHOICES plan). For residents who are not able to continue prior coverage, inexpensive “gap” insurance may be purchased to cover this period.

Health Insurance: Residents are entitled to enroll in one of several programs approved by the County. Dependents are eligible for enrollment. Depending on which plan is selected, a minimal fee is charged.

Dental Insurance: Several dental plans available to choose from.

Life Insurance: A \$2,000 term life policy is provided at no cost. Additional life insurance may be purchased for the resident and his/her dependents.

Accidental Death and Dismemberment Insurance: The County offers Accidental Death and Dismemberment coverage as an employee option. This coverage includes the resident, as well as dependents, for a maximum of \$250,000 or 10 times the resident’s annual salary, whichever is less.

Disability Insurance: The County provides Long-Term Disability Insurance, administered through the CIR. This coverage is automatic and is provided at no cost to County-employed residents and fellows who are on the County payroll as of July 1. This policy provides group and individual coverage with no sign-up requirements, plus conversion rights. Further information may be obtained by contacting the CIR office.

Vacation

In lieu of other vacation or holiday allowances, residents are entitled to 24 days paid vacation each year. Unused vacation, up to 10 days per year, may be deferred until the end of training and will then be paid.

Sick Time

Sick time is accrued to a maximum of eight (8) days per year. Residents who have worked at least 12 consecutive months of continuous service and who have not used any sick leave are afforded the opportunity for “cash reimbursement” of up to 24 hours of unused sick leave. The two time periods are from January 1 to June 30 and from July 1 to December 31.

A “Certification for Cash Reimbursement for Unused Sick Leave” form must be submitted for the

appropriate time period for which the resident wishes to receive reimbursement. Forms are available in departmental office and must be approved and signed by the resident's supervisor.

Leave of Absence

Should a leave of absence be necessary or desirable for a resident, it is the resident's responsibility to discuss the impact of the leave on the successful completion of the residency program. Any resident contemplating a leave of absence should discuss the issue with his/her program director. The resident should be familiar with any constraints placed on training time by either the Program Requirements of the Accreditation Council for Graduate Medical Education, by the Specialty Board, or by the Medical Board of California if the resident is unlicensed.

Professional Leave

The County does not offer professional leave to residents.

Parental Leave

A resident may take sick leave and vacation as parental leave. In compliance with the Family and Medical Leave Act, 12 weeks of unpaid leave may be taken as parental leave or to provide care for children, parents, or certain relatives.

Effect of Leave on Duration of Training and Board Eligibility

Absence from the training program for any reason, including leaves described in this section, may affect the overall duration of the residency training necessary to meet the ACGME or Specialty Board criteria for completion of training. It is the resident's responsibility to assure completion of the program in a timely manner. The resident's program will provide written policy in compliance with its Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program and information relating to access to eligibility for certification by the relevant certifying board. Information regarding Board eligibility at: www.abms.org.

Call Rooms

When on duty, residents are expected to use the designated Call Rooms of the Medical Center that are provided at no charge.

Parking

Parking at no cost is provided, but not guaranteed, in designated areas by the Medical Center. If hospital parking is used, the resident assumes the responsibility for any loss or damage to his/her vehicle and/or its contents, i.e., personal liability coverage. Violation of parking rules will result in citations, and repeated violations will result in termination of the resident's parking privileges. A \$20 deposit may be required for an access card. There will be a charge for access cards that are lost, stolen, etc.

Travel Expenses

There are no provisions for the reimbursement for travel or other expenses when assigned to an affiliate hospital, clinic or other designated training facility as part of the training program.

Specialty In-Service Training Examinations

If required by the Residency Program, residents must take prescribed specialty specific in-service training examinations at specified times. These examinations are given at no cost to the resident.

Loss or Damage to Personal Property

The County assumes no liability for loss or damage to personal property that is suffered by its employees or affiliates while at the Medical Center.

Beepers

Beepers will be provided to all residents. A replacement fee of \$100 will be charged. The fee may be waived if the loss is due to conditions identified in the Memorandum of Understanding with the County.

Counseling and Support Services

Counseling and support services are available at the Medical Center through the Mental Health Services

for Physicians in Training. Consult the Director of Graduate Medical Education.

VII. COUNTY EMPLOYMENT POLICIES

Fingerprinting

As part of the registration process, residents may be fingerprinted.

Social Security Numbers

A Social Security Number is required for County employment.

Physical Examinations

New residents must complete a physical examination before beginning training. Annual reexamination is a condition of continuing employment.

INS I-9 Documentation

For employment purposes, Federal Law requires the County to obtain documented proof of employment eligibility to work in the United States from all employees upon registering with the Human Resources office.

Visa Status

It is the responsibility of residents who are not U.S. citizens to have a valid visa or visa renewal before beginning or continuing training at the Medical Center. It is the resident's responsibility to obtain the necessary documentation. Failure to have a valid visa or visa renewal will result in suspension of employment without pay and/or termination from the residency program.

Pay Procedure

Residents are responsible for signing their own timecard twice a month in order to receive their paycheck or direct deposit paystub. Timecards, paychecks, and paystubs are available in the resident's departmental office.

County employees are paid monthly on the 15th of every month. However, if the resident signs up for direct deposit, paychecks are deposited directly to his/her bank account on the 15th and 30th of each month.

The first payday for GY-1 residents commencing employment on June 24 will be on July 15 for the six days worked in June (June 24-30). The next regular payday will be August 15 for the entire month of July unless the resident is on "direct deposit". Residents registered for "direct deposit" will be paid for the first 15 days of July on July 30. Residents wishing to sign up for direct deposit should bring a blank check with the word "VOID" written on the face to registration/orientation. If the resident has a credit union checking account, a form must be completed instead of writing "VOID" on the blank check.

The direct deposit request form must be submitted by June 30 for those residents starting on June 24 in order to receive a check on July 30. For residents starting July 1, the form must be received by July 14.

Professional Activities Outside the Educational Program

The County limits outside employment to 96 hours per month. However, each residency program establishes individual policies regarding outside employment. It is the responsibility of the resident to be aware of the program's policy. Residents must complete, annually, a "Report of Outside Employment" form provided by the Human Resources office.

Electives

Elective rotations approved by the resident training program director that are taken at non-County institutions are allowable ONLY if the resident takes a leave of absence without pay and malpractice insurance is provided by the receiving institution. It is the responsibility of the resident to make sure that malpractice insurance is provided when at non-County institutions. Health insurance coverage may be lost during such leave.

Sexual Harassment and Exploitation Policies

Sexual harassment is an illegal and prohibited behavior. It is a violation of the Federal Civil Rights Act of 1964, Title VII, as well as Los Angeles County Department of Health Services and Medical Center policies. The Medical Center also strictly prohibits unlawful harassment because of race, religious creed, color, national origin, ancestry, physical handicap, medical condition, marital status, sex or age. Actions by any County employee that are in violation of these policies shall be subject to immediate and appropriate disciplinary action (up to and including discharge). Detailed procedures for residents who feel that they have been harassed or sexually harassed are available through the Medical Director or Chief Medical Officer's Office or the Office of Human Resources.

Substance Abuse Policy

It is the policy of the Medical Center's graduate medical education programs that the abuse of drugs, including alcohol, by residents is unacceptable because it adversely affects health, safety, security, and progress in the training programs. Further, it jeopardizes public confidence and trust.

Using, possessing, selling, or being under the influence of illegal drugs by residents is unlawful, dangerous, and is absolutely prohibited in the workplace. Further, the use of alcohol in the workplace or the misuse of alcohol or prescribed drugs to any extent that impairs safe and effective performance by residents is prohibited.

Violation of any element of this policy shall result in disciplinary action, up to and including termination.

The Medical Center's Graduate Medical Education Committee recognizes drug and alcohol dependency as treatable illnesses. Residents with dependency problems are encouraged to seek assistance through their program director, the Director of Graduate Medical Education, or Mental Health Services for Physicians in Training.

Information obtained regarding a resident during participation in counseling or psychological services will be treated as confidential, in accordance with Federal and State laws.

Services Rendered

Any form of payment to residents for services rendered to patients as part of their training program is not permitted.

Loyalty Oath

As a condition of employment, County employees must be willing to take a Loyalty Oath that reads as follows:

"YOUR NAME, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter."

Soliciting Business for Attorneys (Capping)

It is illegal for County employees to solicit business for attorneys, on or off County property. To do so is illegal under Sections 6151, 6152, and 6153 of the Business and Professions Code of the State of California.

Conflict of Interest

It is illegal for a person employed in a full-time position in the County Service to engage, outside of his/her regular working hours, in any gainful profession, trade, business or occupation whatsoever for any person, firm, corporation or governmental entity, or be so engaged in his/her own behalf, which profession, trade, business or occupation is incompatible or involves a conflict of interest with his/her duties as a County Officer or employee, or with the duties, functions or responsibility of his/her appointing officer or of the department by which he/she is employed.

VIII. RESTRICTIVE COVENANTS

Residents shall not be required to sign non-competition guarantees.

IX. DUTY HOURS

The Institution, the resident training programs, and the Graduate Medical Education Committee regularly assess compliance with ACGME duty hour requirements as per policy #551.1 (Attachment I).

There is a Hotline for reporting of duty hour violations. You may report duty hour violations by calling the following 24-hour telephone number. Your message may be anonymous or you may leave your name. The Director, of Graduate Medical Education, checks all messages once per working day.

HOTLINE: 323-409-5463 (409-LINE)

White – GME; Yellow – Department; Pink – PPG

GME 51401 appointmentagree51401.doc 4/02; 12/04; 4/19/09; 4/10/10

Common Program Requirements

Effective: July 1, 2011

Note: The term “resident” in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms “resident” and “fellow” will be used respectively.

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 members 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 each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

I. Institutions

I.A. Sponsoring Institution

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

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

I.B. Participating Sites

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

The PLA should:

- I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
- I.B.1.c) specify the duration and content of the educational experience; and,
- I.B.1.d) state the policies and procedures that will govern resident education during the assignment.
- I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

[As further specified by the Review Committee]

II. Program Personnel and Resources

II.A. Program Director

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

[As further specified by the Review Committee]

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

- II.A.3. Qualifications of the program director must include:

- II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;
- II.A.3.b) current certification in the specialty by the American Board of _____, or specialty qualifications that are acceptable to the Review Committee; and,
- II.A.3.c) current medical licensure and appropriate medical staff appointment.

[As further specified by the Review Committee]

- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:
- II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
 - II.A.4.b) approve a local director at each participating site who is accountable for resident education;
 - II.A.4.c) approve the selection of program faculty as appropriate;
 - II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;
 - II.A.4.e) monitor resident supervision at all participating sites;
 - II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
 - II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;
 - II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
 - II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;
 - II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
 - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;
 - II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
 - II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
 - II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

- II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
 - II.A.4.n).(1) all applications for ACGME accreditation of new programs;
 - II.A.4.n).(2) changes in resident complement;
 - II.A.4.n).(3) major changes in program structure or length of training;
 - II.A.4.n).(4) progress reports requested by the Review Committee;
 - II.A.4.n).(5) responses to all proposed adverse actions;
 - II.A.4.n).(6) requests for increases or any change to resident duty hours;
 - II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;
 - II.A.4.n).(8) requests for appeal of an adverse action;
 - II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,
 - II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.
- II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
 - II.A.4.o).(1) program citations, and/or
 - II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.

[As further specified by the Review Committee].

II.B. Faculty

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

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

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

[As further specified by the Review Committee]

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

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

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

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding;

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.b).(4) participation in national committees or educational organizations.

II.B.5.c) Faculty should encourage and support residents in scholarly activities.

[As further specified by the Review Committee]

II.C. Other Program Personnel

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

[As further specified by the Review Committee]

II.D. Resources

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

[As further specified by the Review Committee]

II.E. Medical Information Access

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

III. Resident Appointments

III.A. Eligibility Criteria

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

[As further specified by the Review Committee]

III.B. Number of Residents

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

[As further specified by the Review Committee]

III.C. Resident Transfers

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

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

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMCC in accordance with sponsoring institution guidelines.

[As further specified by the Review Committee]

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

IV.A.5.a) The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.b) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

[As further specified by the Review Committee]

IV.A.5.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

[As further specified by the Review Committee]

IV.A.5.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- IV.A.5.d).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;
- IV.A.5.d).(2) set learning and improvement goals;
- IV.A.5.d).(3) identify and perform appropriate learning activities;
- IV.A.5.d).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- IV.A.5.d).(5) incorporate formative evaluation feedback into daily practice;
- IV.A.5.d).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- IV.A.5.d).(7) use information technology to optimize learning; and,
- IV.A.5.d).(8) participate in the education of patients, families, students, residents and other health professionals.

[As further specified by the Review Committee]

IV.A.5.e) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- IV.A.5.e).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- IV.A.5.e).(2) communicate effectively with physicians, other health professionals, and health related agencies;

- IV.A.5.e).(3) work effectively as a member or leader of a health care team or other professional group;
- IV.A.5.e).(4) act in a consultative role to other physicians and health professionals; and,
- IV.A.5.e).(5) maintain comprehensive, timely, and legible medical records, if applicable.

[As further specified by the Review Committee]

IV.A.5.f) Professionalism

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

- IV.A.5.f).(1) compassion, integrity, and respect for others;
- IV.A.5.f).(2) responsiveness to patient needs that supersedes self-interest;
- IV.A.5.f).(3) respect for patient privacy and autonomy;
- IV.A.5.f).(4) accountability to patients, society and the profession; and,
- IV.A.5.f).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

[As further specified by the Review Committee]

IV.A.5.g) Systems-based Practice

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

- IV.A.5.g).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- IV.A.5.g).(2) coordinate patient care within the health care system relevant to their clinical specialty;
- IV.A.5.g).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

- IV.A.5.g).(4) advocate for quality patient care and optimal patient care systems;
- IV.A.5.g).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- IV.A.5.g).(6) participate in identifying system errors and implementing potential systems solutions.

[As further specified by the Review Committee]

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. Residents should participate in scholarly activity.

[As further specified by the Review Committee]

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

[As further specified by the Review Committee]

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

- V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.
- V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
- V.A.2. Summative Evaluation
 - The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:
 - V.A.2.a) document the resident's performance during the final period of education, and
 - V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
- V.B. Faculty Evaluation
 - V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
 - V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
 - V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.
- V.C. Program Evaluation and Improvement
 - V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
 - V.C.1.a) resident performance;
 - V.C.1.b) faculty development;
 - V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,
 - V.C.1.d) program quality. Specifically:
 - V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

- V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.
- V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
- VI. Resident Duty Hours in the Learning and Working Environment
- 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.
- VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
- VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
- VI.A.4. The learning objectives of the program must:
- VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
- VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.
- VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- 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.
- VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes 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.
- VI.B. Transitions of Care
 - VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
 - VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
 - VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.
- VI.C. Alertness Management/Fatigue Mitigation
 - 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 alertness management and 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, such as naps or back-up call schedules.
 - 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.
 - 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.

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

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

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

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

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 or fellow. 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.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 hospital or other 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 hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, 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.
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
- 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.
- 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.
- 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.
- 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 patient to an intensive care unit, or end-of-life decisions.
- VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
- VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]
- 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.
- VI.E. Clinical Responsibilities
- The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.
- [Optimal clinical workload will be further specified by each Review Committee.]

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 interprofessional teams that are appropriate to the delivery of care in the specialty.

[Each Review Committee will define the elements that must be present in each specialty.]

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.

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 approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

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

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.

- VI.G.4. Maximum Duty Period Length
- VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- 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.
- 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.
- VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
- 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.
- 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,
- VI.G.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.
- 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.

- 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.
- VI.G.5.c) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
- VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
- VI.G.5.c).(1).(a) 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.
- 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.]
- VI.G.7. Maximum In-House On-Call Frequency
- PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
- 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, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- VI.G.8.a).(1) At-home call must not be so frequent or taxing as 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”.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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