

Frequently Asked Questions: ACGME Common Duty Hour Requirements
Effective July 1, 2011
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Note: The term “resident” in this document refers to both specialty residents and subspecialty fellows.

II.A.4.j).(2): Program Director

“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 monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements.

According to the Common and Institutional Requirements, programs and sponsoring institutions must have oversight for duty hours [Program Requirement II.A.4.j).(2) and Institutional Requirement IV.A.4.a).(7)]. Does this mean that a sponsoring institution must do electronic, “real-time” monitoring of duty hours for all accredited programs?

The ACGME requires that programs and their sponsoring institutions monitor resident duty hours to ensure they comply with the requirements, but does not specify how monitoring and tracking of duty hours should be handled. The ACGME does not mandate a specific monitoring approach, since the ideal approach should be tailored to each program and its sponsoring institution; for example the approach best suited for neurological surgery will be different from the one most appropriate for preventive medicine, dermatology, or pediatrics, etc.

VI.A.4.b): Professionalism, Personal Responsibility, and Patient Safety

“The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill non-physician service obligations.”

What is meant by “non-physician service obligations”?

Non-physician service obligations are those duties which in most institutions are performed by technologists, aides, transporters, nurses, or other categories of health care workers. Examples include transport of patients from the wards or units for procedures elsewhere in the hospital, routine blood drawing for laboratory tests, routine monitoring of patients when off the ward, and awaiting or undergoing procedures, etc.

VI.A.5.a-h): Professionalism, Personal Responsibility, and Patient Safety

“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 assurance of the safety and welfare of patients entrusted to their care; provision of patient- and family-centered care; assurance of their fitness for duty; management of their time before, during, and after clinical assignments; recognition of impairment, including illness and fatigue, in themselves and in their peers; attention to lifelong learning; the monitoring of their patient care performance improvement indicators; and, honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

How will compliance with this requirement be determined?

These requirements will be assessed by the Site Visitor's report of resident and faculty interviews, and the ACGME Resident/Fellow Survey Data Summary. Additional data will come from faculty participation in maintenance of certification and involvement in CME and scholarly activity. The program director is expected to regularly work with faculty members and residents to establish a milieu of professional behavior, personal responsibility, and a high regard for patient safety in the department.

The program director cannot be accountable for faculty and resident activity during time off. However, the program director must be sensitive to signs of lack of fitness for duty in not being mentally and physically able to effectively perform required duties and promote patient safety.

VI.B.1-4.: Transitions of Care

“Programs must design clinical assignments to minimize the number of transitions in patient care. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-over process. 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.”

What are the ACGME's expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions?

Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for that specific patient or group of patients. Programs and institutions are expected to have a documented process in place for ensuring the effectiveness of transitions. This can be accomplished in many different ways. For example, the program or institution can review and document on a regular basis a sample of a transition, to include review of a sample patient's chart and interview of the incoming responsible individual and/or team to ensure key elements in the patient care continuum for that patient have been transmitted and are clearly understood. Pertinent elements evaluated should include exam findings, laboratory data, any clinical changes, family contacts, and any change in responsible attending physician. Scheduling of on-call shifts should be optimized to ensure a minimum number of transitions, and there should be documentation of the process involved in arriving at the final schedule. The specifics of these schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident education.

VI.C.3.: Alertness Management/Fatigue Mitigation

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

What qualifies as an “adequate sleep facility,” and do call rooms meet this need?

“Adequate sleep facilities” are defined as an environment in which residents may sleep or rest for periods of time, ranging from minutes to hours. While traditional call rooms may meet this need, other technologies/areas may be useful as well.

The Institutional Requirements specify that “residents on call must be provided with adequate and appropriate sleeping quarters that are safe, quiet, and private.” There is an accompanying FAQ that specifies the following: “determination of what is ‘safe, quiet and private’ will most likely vary from institution to institution based on the culture of the institution. In general, residents of different gender should not be forced to share the same call room at the same time if a complaint is raised about the issue. Also, residents of either gender should be able to move to a shower without walking through other rooms where residents are sleeping or through public hallways. Call rooms should be relatively quiet. Residents should not share call rooms with maintenance staff or even other health professionals. Call rooms must also be secure.”

VI.D.2.: Supervision of Residents

“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.”

Who can be a supervising physician?

A physician, a member of the medical staff, or a more senior resident designated by the program director can supervise a junior resident. Such designation must be based on demonstrated competency in medical expertise and supervisory capability. In rare instances, a Review Committee may allow non-physician, licensed, independent practitioners designated by the program director to supervise residents. In all cases, each program’s supervision policies should clearly state the types of supervision that are permissible. Programs should ensure that any policy revisions are compliant with specialty-specific requirements.

VI.D.4.: Supervision of Residents

“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.”

What is meant by “progressive authority and responsibility, conditional independence, and a supervisory role in patient care” for residents?

Residents enter programs as novices and are expected to graduate as accomplished physicians capable of functioning competently and without supervision. Depending on the specialty or subspecialty, this transition may take several more years. The development and adoption of specialty-specific “milestones” (objective curricular criteria to be mastered during a given year of residency) that will govern residents’ advancement from one year of education to the next will provide one tool for guiding the authority and responsibility granted to residents. These milestones will help program directors and faculty members determine the levels of responsibility assigned to each individual

resident. Until those are in place, documented criteria for such assignments need to be included in the make-up of the program. Great care must be taken in determining the level of involvement each resident will have in direct patient care so as to ensure patient safety. Another level of advancement lies in the granting of supervisory authority to a resident over a more junior resident. This will require not only documentation of medical knowledge and procedural competency skill sets, but also documented ability to effectively teach and oversee the work of others. At any level of assignment, the initial few days or weeks should be carefully monitored to ensure that the individual resident is capable of functioning in his/her assigned role. If not, then remediation will be necessary before the assignment can continue.

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.”

What is included in the definition of duty hours under the requirement “duty hours must be limited to 80 hours per week.”?

Duty hours are defined as all clinical and academic activities related to the residency program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care such as completing medical records, ordering and reviewing lab tests, and signing verbal orders. For call from home, only the hours spent in the hospital after being called in to provide care count toward the 80-hour weekly limit.

Hours spent on activities that are required by the accreditation standards, such as membership on a hospital committee, or that are accepted practice in residency programs, such as residents’ participation in interviewing residency candidates, must be included in the count of duty hours. It is not acceptable to expect residents to participate in these activities on their own hours; nor should residents be prohibited from taking part in them.

Duty hours do not include reading, studying, and academic preparation time, such as time spent away from the patient care unit preparing for presentations or journal club.

How do the ACGME common duty hour requirements apply to research activities?

The ACGME duty hour requirements pertain to all required hours in the residency program (the only exceptions are reading and self-learning, and time on call from home during which the resident is not required to be in the hospital). Research of up to six months scheduled during one or more of the accredited years of the program is required in many specialties and may also contain a clinical element. When research is a formal part of the residency and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent duty hour requirements.

There are only two situations when the ACGME duty hour requirements do not apply to research. One is when programs offer an additional research year that is not part of the accredited years. In this case the ACGME requirements do not apply to that year. The other case is when residents conduct research on their own time, which makes these hours identical to other personal pursuits. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident when he or she participates in patient care.

How are the requirements applied to rotations that combine research and clinical activities?

Some programs have added clinical activities to “pure” research rotations, such as having research residents cover “night float.” This combination of research and clinical assignments could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments. This suggests limits on clinical assignments during research rotations, both to ensure safe patient care, resident learning, and resident well-being, and to promote the goals of the research rotation.

If a journal club is held in the evening for two hours, outside of the hospital, and is not held during the regularly scheduled duty hours, and attendance is strongly encouraged but not mandatory, would those hours count toward the 80-hour weekly total?

If attendance is “strongly encouraged,” the hours should be included because duty hours apply to all required hours in the program, and it is difficult to distinguish between “strongly encouraged” and required. Such a journal club, if held weekly, would add two hours to the residents’ weekly time

If some of a program’s residents attend a conference that requires travel, how should the hours be counted for duty hour compliance?

If attendance at the conference is required by the program, or if the resident is a representative for the program (e.g., he/she is presenting a paper or poster), the hours should be recorded just as they would be for an on-site conference hosted by the program or its sponsoring institution. This means that the hours during which the resident is actively attending the conference should be recorded as duty hours. Travel time and non-conference hours while away do not meet the definition of “duty hours” in the ACGME requirements.

Do tasks that can be completed at home (i.e., completion of medical records and similar tasks; submitting orders and reviewing lab tests; signing verbal orders; and time spent on research) count toward the 80-hour limit?

Any tasks related to performance of duties, even if performed at home, count toward the 80-hour limit.

VI.G.1.a): Duty Hour Exceptions

“A Review Committee may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale.”

Can duty hours for surgical chief residents be extended to 88 hours per week?

Programs interested in extending the duty hours for their chief residents can use the “88-hour exception” to request an increase of up to 10% in duty hours on a program-by-program basis, with endorsement of the sponsoring institution’s graduate medical education committee (GMEC) and the approval of the Review Committee. If approved, the maximum duration of the approval may not exceed the length of time until the program’s next site visit and review.

A request for an exception must be based on a sound educational justification. Most Review Committees categorically do not permit programs to use the 10% exception. Neurological Surgery is the only Review Committee that allows exceptions.

What is meant by “sound educational justification” for a request to increase the weekly limit on duty hours by up to 10 percent?

The ACGME specifies that an increase in duty hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve residents’ educational experiences. This requires that all hours in the extended work week contribute to resident education. An example is that a surgical program needs to demonstrate that residents do not attain the required case experiences in some categories, unless resident hours are extended beyond the weekly limit, and that the program has already made all reasonable efforts to limit activities that do not contribute to enhancing their surgical skills.

Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and for a subgroup of the residents/fellows in the program (e.g., the chief resident year), or for individual rotations or experiences.

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.

In addition to the 80-hour maximum weekly limit, do all other duty hour rules apply to moonlighting (maximum duty period length, minimum time off between shifts, etc.)?

The hours spent moonlighting are counted towards the total hours worked for the week. No other duty hour requirements apply, however, the following requirements also apply: VI.G.2 “Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program,” and VI.A.5.a)-e) “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: assurance of the safety and welfare of patients entrusted to their care; provisions of patient- and family-centered care; assurance of their fitness for duty; management of their time before, during, and after clinical assignments; recognition of impairment, including illness and fatigue, in themselves and in their peers.”

**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.”**

The common duty hour requirements state that residents must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period. How should programs interpret this requirement if the “day off” occurs after a resident’s on-call day?

The common duty hour requirements specify a 24-hour day off. Many Review Committees have recommended that this day off should ideally be a “calendar day,” e.g., the resident wakes up in his or her home and has a whole day available. Review Committees have also noted that it is not permissible to have the day off regularly or frequently scheduled on a resident’s post-call day, but understand that in smaller programs it may occasionally be necessary to have the day off fall on the post-call day. Note that in this case, a resident would need to leave the hospital post-call early enough to allow for 24 hours off of duty. For example, if the resident is expected to return to the

hospital at 7:00 a.m. the following day, he/she would need to leave the hospital at 7:00 a.m. on the on-call session day. Because call from home does not require a rest period, the day after a pager call may be used as a day off.

If a program only has a few residents and the residents prefer to be on call for two days during one weekend so that they can have another weekend completely free of duties, does this comply with the duty hour requirements?

In some programs residents take call for an entire weekend (e.g., Friday through Sunday), to allow them to take the entire next weekend off. This practice is acceptable as long as total duty hours, one-day-off-in-seven, and frequency of call are within the limits specified by the relevant requirements. For example, this would *not* be permissible in internal medicine programs, because the Program Requirements for Internal Medicine do not permit averaging of in-house call assignments.

Note that for in-house call, residents must be provided adequate rest time (usually 10 hours) between the two weekend duty periods. There are no exceptions to this rule. Thus, in-house call on two consecutive nights (e.g., Friday and Saturday) must include adequate rest (usually 10 hours) between the two duty shifts.

Does the “one day free of duty every week” mean that I must have one day per week off?

It is common in the smaller surgical residency programs to have residents on duty one weekend (Friday and Sunday for instance), so they can be off the next weekend. As long as duty hour requirements are met within the specified averages, this type of every other weekend schedule is acceptable.

If call from home is not included in duty hours, is it permissible for me to take call from home for extended periods, such as a month?

No. The requirements for one day free every week would prohibit being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workloads and intensity of the in-house activities.

VI.G.4.a): Maximum Duty Period Length

“Duty periods of PGY-1 residents must not exceed 16 hours in duration.”

Are first-year residents allowed to remain on-site for an additional four hours after their sixteen-hour shifts for didactics, patient follow-up, and care transition?

PGY-1 residents must not remain on-site after their 16-hour shifts. Periods of duty for first-year residents must not exceed 16 hours in duration.

VI.G.4.b): Maximum Duty Period Length

“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.”

How is the 24-hour limit on in-house call duty applied?

The activity that drives the 24-hour limit is “continuous duty.” If a resident spends 12 hours in the hospital caring for patients, performing surgery, or attending conferences, followed by 12 hours on-call, he/she has had 24 hours of “continuous duty” time, and is limited to up to four additional hours during which his/her activities are limited to participation in didactic activities, transfer of patient care, and maintaining continuity of medical and surgical care.

How should naps for residents be scheduled? What if a resident chooses not to nap?

Strategic napping is strongly suggested in the program requirements, especially between the hours of 10:00 p.m. and 8:00 a.m. Naps should not be scheduled, but rather should occur based upon patient needs and resident fatigue.

VI.G.4.b)(1-2): Maximum Duty Period Length

“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. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.”

What activities are permitted during the four hours allowed for transitions?

Residents who have completed a 24-hour duty period may spend up to an additional four hours to ensure an appropriate, effective, and safe transition of care and maintaining continuity of medical and surgical care. During this four-hour period, residents must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery, during this four-hour period. Residents who have satisfactorily completed the transition of care may, at their discretion, attend an educational conference that occurs during the four-hour period.

Can a resident attend continuity clinic during the four hours after a 24-hour period of continuous duty?

Residents must not be assigned any additional clinical responsibilities after a 24-hour period of continuous in-house duty; this includes attending continuity clinic. The additional four-hour period following a 24-hour shift is to ensure that effective transitions in care occur.

VI.G.5.a-c): Minimum Time Off Between Scheduled Duty Periods

“PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. 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. 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.”

What is meant by “should be 10 hours, must be eight hours”?

“Should” is used when a requirement is so important that an appropriate educational justification must be offered for its absence. It is important to remember that when an abbreviated rest period is offered under special circumstances, the program director and faculty must monitor residents for signs of sleep deprivation.

A typical resident work schedule specifies the number and length of nights on call, but does not always outline the length of each work day. Scheduled or expected duty periods should be separated by 10 hours.

There are however, inevitable and unpredictable circumstances in which resident duty periods may become prolonged. In these instances, residents must still have a minimum of eight hours free of duty before the next scheduled duty period begins. This requirement applies to PGY-1 and intermediate-level residents (as defined by the individual Review Committees). Review Committees do not expect the call period to be scheduled to the maximum allowable daily duty period (e.g., 16 hours) when it is expected that residents must have eight hours off between duty periods. Review Committees have outlined acceptable circumstances. See specialty-specific requirements and/or specialty-specific FAQs for additional details.

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).”

How is “on-call duty” defined?

On-call duty is defined as a continuous duty period between the evening hours of the prior day and the next morning, generally scheduled in conjunction with a day of patient care duties prior to the call period. Call may be taken in-house or from home, but home call is appropriate only if the service intensity and frequency of being called is low. Scheduled duty shifts (generally eight, 10, or 12 hours in length), such as those worked in the intensive care unit (ICU), on emergency medicine rotations, or on “night float”, are exempt from the requirement that call be scheduled no more frequently than every third night.

How many times in a row can a resident take call every other night?

The objectives for allowing the averaging of in-house call (in all specialties except internal medicine) is to offer flexibility in scheduling, not to permit call every other night for any extended length of time, even if done in the interest of creating longer periods of free time on weekends or later in the month. For example, it is not permissible for a resident to be on call every other night for two weeks straight and then be off for two weeks.

Residents can be assigned to a maximum of four call nights in any seven-day period. This can only be done one week per month. Residents must not take night call for two consecutive nights.

VI.G.8.a): At-Home Call
“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.”

Can PGY-1 residents take at-home call, and if so what are the work-hour restrictions for this?

PGY-1 residents are limited to a 16-hour duty period and are not allowed to take at-

home call. PGY-1 residents are not allowed to take at-home call because appropriate supervision (either direct supervision or indirect supervision with direct supervision immediately available) is not possible when a resident is on at-home call. Program directors should review the specialty specific FAQ related to this requirement for further clarification.

VI.G.8.a)(1): At-Home Call

“At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.”

Does the minimum of eight hours between shifts apply to at-home call?

Although it must count toward the 80-hour weekly maximum, when residents assigned to at-home call return to the hospital to care for patients a new off-duty period is not initiated, and therefore the requirement of eight hours between shifts does not apply. However, the frequency and duration of time returning to the hospital must not preclude rest or reasonable personal time for residents.

Which requirements apply to time in the hospital after being called in from home call?

For call taken from home (home or pager call), the time the resident spends in the hospital after being called in counts toward the weekly duty hour limit. The only other numeric duty hour requirement that applies is the one day free of duty every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call, through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.

If “At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident,” what are the ACGME’s expectations regarding compliance?

The Review Committees recognize that at-home call may, on occasion, be demanding. This may include frequent phone consultations or a return to the hospital to provide emergency care or consultation. However, if at-home call predictably prevents a resident from obtaining adequate rest, or if it is associated with extensive returns to provide hospital service, the Review Committee may cite the program for non-compliance with this program requirement.

General Questions

How should the averaging of the duty hour requirements (e.g., 80-hour weekly limit, one day free of duty every week, and call every third night) be handled? For example, what should be done if a resident takes a vacation week?

Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating duty hours, call frequency or days off (i.e., if a resident is on vacation for one week, the hours for that

rotation should be averaged over the remaining three weeks). The requirements do not permit a “rolling” average, because this may mask compliance problems by averaging across high and low duty hour rotations. The rotation with the greatest hours and frequency of call must comply with the common duty hour requirements.

Program directors should check with the specific Review Committee to determine if further guidelines or requirements apply to this regulation. For example, the Program Requirements for Internal Medicine do not permit averaging of the interval between in-house call.

If the results of a program’s completed ACGME Resident Survey show that a number of residents exceeded several of the duty hour limits, what will the Review Committee do?

The Resident/Fellow Survey has several objectives, but its most important function is to serve as a focusing tool for the ACGME site visit. If such a program is scheduled for a site visit soon, the site visitor will ask detailed questions about duty hour compliance to verify and clarify the information from the Resident Survey through on-site interviews and review of documents such as rotation and on-call schedules. This may reveal that residents misunderstood the question, or it may reveal problems with duty hour compliance. If such a program is not scheduled for a site visit in the near future, Resident Survey results that suggest non-compliance with the duty hours may result in the Review Committee’s following up to request data on duty hours and, if indicated, a corrective action plan. The Review Committees recognize that in many programs a few residents occasionally work beyond the limits, and limit follow-up to programs where the data suggest a potential program-level compliance problem. In some cases of egregious non-compliance, particularly over multiple years and warnings to improve, programs’ review cycles may be shortened and site visits scheduled.

Can the duty hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents are ill or on leave, or when there is an unusually large patient census or demand for care?

The ACGME expects that duty hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members on duty. During the holiday period, residents not on vacation may be scheduled more frequently, but the scheduling for the rotation (generally four weeks of a month) must comply with the common and Review Committee-specific duty hour requirements. Further, the schedule during the holidays themselves may not violate common duty hour requirements (such as the requirement for adequate rest between duty periods), or specialty-specific requirements.

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

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