INSTITUTIONAL GME POLICY - Duty Hours & Moonlighting

Approved by GMEC Jan. 28, 2011
Revisions approved by GMEC May 24, 2013; Oct. 4, 2013

The Sponsoring Institution, the University of Hawaii John A. Burns School of Medicine and its affiliated residency programs, in cooperation with Hawaii Residency Programs, Inc., adheres to and complies with all ACGME requirements (as follows). There will be no exceptions, or request to the ACGME for exceptions, in the implementation of this policy through the following documents pertaining to Duty Hours compliance:

- Hawaii Residency Programs (HRP) Policies and Procedures contained in the HRP Resident/Fellow Handbook
- Resident/Fellow Appointment Agreement
- In addition to the above, all individual programs will have program-specific policies

Residents are educated at all levels of training regarding the importance of Duty Hours compliance. As specified above, HRP includes reference to Duty Hours in the above listed documents. The respective Program Directors are required to include Principles, Supervision of Residents, Fatigue, the definition of Duty Hours, On-Call Activities, and Moonlighting restrictions in the respective Program Orientation at the beginning of each academic year, and periodically throughout the year.

No Duty Hours Exceptions:
Common Program Requirements provide that programs may request exceptions from duty hours. The institution and our programs have determined not to seek any exceptions.

Tracking and Monitoring Duty Hours:
1. Each month of the academic year, on a rotating basis, HRP will randomly select approximately 40 residents from all HRP programs to complete a Duty Hours questionnaire. This is done electronically; in addition, a hard copy of the questionnaire is attached to each of the selected Residents’ bi-monthly pay check. HRP requires 100% return from each program within thirty (30) days. HRP receives the responses and generates a report for review at the end of each cycle.
   a. If there are no “red flags”, no further action is required.
   b. If there is a “red flag”, the Incident Report will be forwarded to the Program Director for response and follow-up and to HRP to ensure review and action, if any, at the next scheduled GMEC meeting. All “red flags” are reported to the GMEC for consideration.
      i. If the incident is situational, the GMEC typically approves the resolution if resident has been counseled by the Program Director and a plan to avoid any future occurrence is agreed upon.
      ii. If the incident is determined by the Program Director or the GMEC to be systematic or ongoing, an independent investigation is commissioned by GMEC for follow-up and report to GMEC, which will take appropriate corrective and preventative action.

2. The Sponsoring Institution requires that each Program conduct a program-specific duty hour monitoring via New Innovations to identify potential issues which in turn will typically be managed within the respective program.
3. The Sponsoring Institution requires each Program complete the ACGME Annual Survey with a goal of 100% compliance. Once the RRC has notified a program of the survey, the DIO and GME Administrator will remind of the pendency of the survey. Survey results will be shared with all Program Directors to ensure awareness of potential issues as well as develop best practices and consistency amongst the Programs.

**Duty Hour Violation:**
As indicated above, all Duty Hour Violation reports, whether generated by the HRP survey, the Program Surveys, or the RRC surveys, should be reported to and be reviewed by the GMEC on a standardized form with the Program Director's response for review, approval, and closure.

**Moonlighting:**
During the term of Agreement, Resident or Fellow (a) shall not accept or receive fees for any service performed pursuant to Residents'/Fellows’ position with HRP or the Program; (b) shall not accept any employment, or otherwise engage in conduct, outside of the Agreement which involves actual or intended performance of medical services; and (c) shall not engage in any conduct which gives the appearance of moonlighting or which indicates or implies in any way that the Resident/Fellow is available or willing to practice medicine, except as a resident and employee of HRP pursuant to the agreement. All of the conduct described under this Section is prohibited regardless of whether it would be paid or unpaid basis, regardless of whether it would be done during duty hours or non-duty hours, and regardless of whether it would be done while on vacation or leave of absence (paid or unpaid).

Fellows (trainees who have completed a core program) may engage in such activities if authorized in writing by the Program Director and a document of additional professional liability coverage for such outside employment is presented. The liability coverage must include adequate tail coverage. A request for permission to obtain outside employment shall be made by using the “Request for Authorization to Accept Outside Employment” form and following the Program’s policy and guidelines for Other Employment. The Program Director may grant or deny the Request in his/her sole discretion based on the best interests of the Program and Fellow’s training. Absent such written approval by the Program Director, Fellow shall not represent, imply or indicate in any way during the term of the Agreement that Fellow is available to or can perform the practice of medicine except as an employee of HRP. It is the responsibility of the Program Director to monitor fatigue and the ability of the Fellow to achieve the goals and objectives of the educational program.

****************************

The ACGME Duty Hours Language effective July 1, 2013 is as follows:

**Professionalism, Personal Responsibility, and Patient Safety**

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

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

The learning objectives of the program must:
   a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
   b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

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

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.

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.
Alertness Management/Fatigue Mitigation

The program must:

a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

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.

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.

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

Supervision of Residents

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.

This information should be available to residents, faculty members, and patients.

Residents and faculty members should inform patients of their respective roles in each patient’s care.

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.

Levels of Supervision

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

Direct Supervision – the supervising physician is physically present with the resident and patient.

Indirect Supervision:

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.
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.

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

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.

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.

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.

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.

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.

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.

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.]

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.

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.]

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.]

**Resident Duty Hours**

**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.

**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.

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.

Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.

**Moonlighting**

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

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.

PGY-1 residents are not permitted to moonlight.

**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.

**Maximum Duty Period Length**

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

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.

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.

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.

Under those circumstances, the resident must:

i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

**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.

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.

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.

**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.]

**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).

**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.

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

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”.