

	MOREHOUSE SCHOOL OF MEDICINE GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES	POLICY NUMBER	GME-05
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		PAGE (S)	06
	<u>SUBJECT</u> RESIDENT LEARNING AND WORKING ENVIRONMENT POLICY	SUPERSEDES	N/A

I. PURPOSE:

Graduate Medical Education (GME) is an integral part of the Morehouse School of Medicine (MSM) medical education program. 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.

II. SCOPE:

All MSM administrators, faculty, staff, Residents, and administrators at participating training affiliates shall understand and support these and all other policies and procedures that govern both GME programs and Resident appointments at MSM. Each Resident will receive a copy of this Resident Learning and Working Environment Policy.

III. THE RESIDENCY LEARNING AND WORKING ENVIRONMENT:

- 3.1. Within the Residency learning and working environment, standards must be in place to assist program administration, faculty Attendings, and Residents in performing their clinical and other duties in a safe and productive manner. Programs shall provide objectives, schedules, and faculty supervision to Residents to support learning.
- 3.2. Duty hours in this policy are defined as clinical and academic activities related to the program; i.e. direct patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
- 3.3. Resident Duty Hours in the MSM Learning and Working Environment consist of the following requirements and tenets:
 - 3.3.1. **Professionalism, Personal Responsibility, and Patient Safety**
 - 3.3.1.1. Programs and MSM 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.
 - 3.3.1.2. The program must be committed to and responsible for promoting patient safety and Resident well-being in a supportive educational environment.
 - 3.3.1.3. The Program Director must ensure that Residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

3.3.1.4. 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
- b) Not be compromised by excessive reliance on Residents to fulfill non-physician service obligations

3.3.1.5. The Program Director and MSM 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 roles 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) Monitoring of their patient care performance improvement indicators
- h) Honest and accurate reporting of Duty Hours, patient outcomes, and clinical experience data

3.3.1.6. 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. Refer to the MSM Transitions of Patient Care protocol.

3.3.2. Alertness Management/Fatigue Mitigation

3.3.2.1. For comprehensive guidance in the management of sleepiness and fatigue, refer to the MSM-GME policy on this subject, in addition to the institutional policy.

3.3.2.2. The program must develop procedures to:

- 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
- 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

3.3.2.3. Each MSM program must have a process to ensure continuity of patient care in the event that a Resident may be unable to perform his or her patient care duties.

- 3.3.2.4. MSM or a participating hospital must provide adequate sleep facilities and/or safe transportation options for Residents who may be too fatigued to return home safely.

3.3.3. Resident Duty Hours

- 3.3.3.1. Resident Duty Hours at MSM shall be structured by each program to address and/or conform to the requirements outlined below. Each Residency program will develop a policy and procedures to enforce and monitor ACGME Duty Hour requirements.
- 3.3.3.2. Programs shall review Resident activities weekly to ensure compliance by the program, Residents, and faculty supervisors.
- 3.3.3.3. These requirements must also be in place at each participating affiliate.
- 3.3.3.4. The MSM GMEC (through the DIO and GME Office) shall conduct periodic review of each program and its Residents.

3.3.4. Maximum Hours of Work per Week

- 3.3.4.1. 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.
- 3.3.4.2. Duty Hour Exceptions:
 - A Review Committee may grant exceptions to programs for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.
 - 3.3.4.2.1. 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.
 - 3.3.4.2.2. Prior to submitting the request to the Review Committee, the Program Director must obtain approval of the MSM-GMEC and DIO.

3.3.5. Moonlighting

Moonlighting at MSM must be in accordance with the MSM-GME Resident Outside Activities policy.

- 3.3.5.1. PGY-1 Residents are not permitted to moonlight.
- 3.3.5.2. Moonlighting must not interfere with the ability of the Resident to achieve the goals and objectives of the educational program.
- 3.3.5.3. Moonlighting must be approved in writing by the Program Director.
- 3.3.5.4. 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.

3.3.6. 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.

3.3.7. Maximum Duty Period Length

- 3.3.7.1.** Duty periods of PGY-1 Residents must not exceed 16 hours in duration.
- 3.3.7.2.** 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 (by ACGME).
 - 3.3.7.2.1.** 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.
 - 3.3.7.2.2.** Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
 - 3.3.7.2.3.** 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. Under those circumstances, the Resident must:
 - a) Appropriately hand over the care of all other patients to the team responsible for their continuing care
 - b) 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.

3.3.8. Minimum Time Off between Scheduled Duty Periods (exceptions must be recorded)

- 3.3.8.1.** PGY-1 Residents *should* have 10 hours, and *must* have eight hours free of duty between scheduled duty periods.
- 3.3.8.2.** 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.

3.3.8.3. 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.

3.3.8.3.1. This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off-in-seven standards.

3.3.8.3.2. 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.

3.3.8.3.3. 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.

3.3.9. 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. Refer to the MSM-GME Night Float protocol.

3.3.10. 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).

3.3.11. At-Home Call

3.3.11.1. 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.

3.3.11.2. 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.”

ACGME Glossary of Terms Related to Resident Duty Hours

September 29, 2010

Attending Physician: An appropriately credentialed and privileged member of the medical staff who accepts full responsibility for a specific patient's medical/surgical care.

Clinical Responsibility/workload limits: Reasonable maximum levels of assigned work for Residents/fellows consistent with ensuring a quality educational experience. Such work, and its level of intensity, varies by specialty and should be studied by all RRCs before a decision is made to incorporate specifics into the program requirements.

Conditional independence: Graded, progressive responsibility for patient care with defined oversight.

Continuity clinic: Setting for a longitudinal experience in which Residents develop a continuous, long-term therapeutic relationship with a panel of patients.

Duty hours: All clinical and academic activities related to the program, i.e. patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty Hours do *not* include reading and preparation time spent away from the duty site.

External moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the Resident is in training or at any of the institution's related participating sites.

Faculty: Any individuals who have received a formal assignment to teach Residents or fellow physicians. At some sites, appointment to the medical staff of the hospital constitutes appointment to the faculty.

Fatigue management: Recognition by either a Resident or supervisor of a level of Resident fatigue that may adversely affect patient safety, and enactment of a solution to mitigate the fatigue.

Fitness for duty: Mentally and physically able to effectively perform required duties and promote patient safety.

Scheduled duty periods: Assigned duty within the institution encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Strategic napping: Short sleep periods, taken as a component of fatigue management, which can mitigate the adverse effects of sleep loss.

Supervising Physician: A physician, either faculty member or more senior Resident, designated by the Program Director as the supervisor of a junior Resident. Such designation must be based on the demonstrated medical and supervisory capabilities of the physician.

Transitions of care: The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting.