The University of Texas Health Science Center at Houston
GMEC POLICY STATEMENT – *The Learning and Working Environment*

Effective April 23, 2003; Updated July 1, 2007; Revised April 1, 2011; Revised April 25, 2018; Revised October 2019

Background

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Learning objectives must be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill non-physician service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Clinical and educational work hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Clinical Experience and Education

Definitions:

A. **Clinical and Educational Work Hours** are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. These hours do not include reading and preparation time spent away from the clinical or educational work site.

B. **At-home call** (pager call) is defined as call taken from outside the assigned institution.

C. **Night Float** is defined as a rotation or educational experience designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and do not have daytime assignments. Rotation must have an educational focus.

D. **One day off:** One continuous 24-hour period free from all administrative, clinical, and educational activities.

E. **Moonlighting:** Voluntary, compensated, medically-related work performed beyond a resident's or fellow's clinical experience and education hours and additional to the work required for successful completion of the program.
    i. **External moonlighting:** Voluntary, compensated, medically-related work performed outside the site where the resident or fellow is in training and any of its related participating sites.
    ii. **Internal moonlighting:** Voluntary, compensated, medically-related work performed within the site where the resident or fellow is in training or at any of its related participating sites.

2. Policies:

A. Supervision of Residents

Programs must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Residents must be provided with rapid, reliable systems for communicating with supervising faculty. (Also see GMEC Policy on Supervision of Residents/Resident Training Protocols)

Level of Supervision
Supervision may be exercised through a variety of methods. To ensure oversight of resident supervision, Programs 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.

Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).

Resident must know the limits of their scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and 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 the resident the appropriate level of patient care authority and responsibility. Faculty schedules should be structured to provide residents with continuous supervision and consultation.

B. Clinical and Educational Work Hours (Formerly Duty Hours)

1. Clinical and educational work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

2. Residents should have eight hours off between scheduled clinical work and education periods.

a) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements

3. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

4. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over 4-weeks). At home call cannot be assigned on these free days. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

5. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
   a) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education
   b) Additional patient care responsibilities must not be assigned to a resident during this time.

6. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
   a) to continue to provide care to a single severely ill or unstable patient;
   b) humanistic attention to the needs of a patient or family; or
   c) to attend unique educational events
      i. These additional hours of care or education will be counted toward the 80-hour weekly limit.

7. In-House On-Call must not be assigned to Residents more frequently than every third night (when averaged over a four-week period).

8. At-Home Call may not be scheduled on the resident's one free day per week (averaged over four weeks).

   a) Time spent on patient care activities by residents on at-home call must count towards the 80 hour per week limit.
   b) The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for 1 day in 7 free of clinical work and education when averaged over a 4-week period.
   c) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
   d) 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".

C. Moonlighting

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program nor compromise patient safety.

2. Each program must have a written moonlighting policy that:

   a) specifies that residents must not be required to engage in moonlighting
   b) requires a prospective, written statement of permission from the program director that is made part of the resident's file; and,
   c) states that the residents' performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission.
   d) states that PGY-1 residents are not permitted to moonlight.
   e) time spent by residents in internal and external moonlighting (as defined by the ACGME) must be counted towards the 80-hour maximum weekly hour limit .

D. Oversight

1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

3. Programs 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.

4. 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.

Revision Approved by GMEC on October 23, 2019