Graduate Medical Education Policies
University of Nebraska Residency Program
University of Nebraska Medical Center College of Medicine
Approved May, 1982, General Faculty, amended January, 1991, amended May, 1993, amended December, 1997, amended March, 2000, amended January, 2002, amended December, 2004, amended September 2007

I. INSTITUTIONAL ORGANIZATION AND COMMITMENT

A. Sponsoring Institution

1. The University of Nebraska College of Medicine sponsors graduate medical education programs to provide specialty education opportunities for physicians and to prepare highly qualified physicians to practice the various disciplines of medicine for the health care benefit of the people of the State of Nebraska. The College is committed to providing the necessary educational, financial, and human resources to support these programs. These graduate medical education programs are established under the authority of the Board of Regents of the University of Nebraska.

B. Educational Administration

1. The Graduate Medical Education Committee of the College of Medicine oversees all residency programs sponsored by the institution. It is responsible for advising on and monitoring all aspects of residency education.

2. Membership: Members are appointed by the Dean, College of Medicine, and approved by vote of the General Faculty of the College. Members include representatives from affiliated institutions, faculty members and residents. Program directors from all residencies are appointed *ex officio* with vote.

3. The Committee shall meet monthly. Minutes will be kept by the Office of Graduate Medical Education.

4. Duties and responsibilities of the Graduate Medical Education Committee
   a. Establishment of institutional policies for Graduate Medical Education
   b. Liaison with directors and administrators of affiliated programs
   c. Review of all ACGME letters of accreditation and review of program action plans in response to comments
   d. Regular review of all residency programs:

5. Resident evaluations. A system shall be in effect which documents, at least semi-annually, evaluation of the knowledge, skills, and professional growth of each resident including a final evaluation upon completion of the resident's graduate medical

education.

6. The Office of Graduate Medical Education together with the Graduate Medical Education Committee will periodically assess, following review of the program, all actions which have been taken to address the identified problems.

7. Internal Review Committees:

A. Membership:
   a. None of the committee members can be from the department being reviewed.
   b. The committee is appointed by the associate dean for graduate medical education.
   c. Committee is chaired by a member of the GMEC and additionally includes at least one faculty member of the GMEC and at least one house officer and the coordinator for graduate medical education. Other faculty or administrators from outside the program may be included.

All reviews will be in process and documented in the GMEC minutes by the midpoint of the accreditation cycle.

B. The internal review consists of the following steps.
   a. The DIO appoints the committee
   b. The DIO notifies the program director and the chair of the department ofthe dates of the upcoming review.
   c. The GME office surveys all residents in the program regarding the program's previous citations, the ACGME special requirements, and the items in the ACGME survey.
   d. The committee interviews all residents in the program in a group meeting. (The residents are been given the results of the ACGME survey and the specialty requirements prior to the meeting.)
   e. The committee interviews all teaching faculty of the program in a group meeting. (The teaching faculty are also given the specialty requirements and the results of the ACGME surveys of residents.)
   f. The committee interviews the program director.
   g. The written report is sent to committee members for suggestions and approval.
   h. The written report is sent to the GMEC along with recommendations for follow up and progress reports.
   i. The written report is sent to the program director, the chair of the department involved and the education officer or rotation chief at the affiliated hospitals in which the program has rotations.

C. The Internal Review Committee assesses the following aspects of the program being reviewed.
   a. Compliance with the common, specialty, subspecialty program and institutional requirements

b. Educational objectives and effectiveness in meeting those objectives
c. Educational and financial resources
d. Effectiveness in addressing areas of non-compliance and concerns in previous ACGME accreditation letters of notification and previous internal reviews
e. Effectiveness of educational outcomes in the ACGME general competencies
f. Effectiveness in using evaluation tools and outcome measures to assess a resident's level of competence in eacho of the ACGME general competencies and
g. Annual program improvement efforts in
   i. Resident performance using aggregated resident data;
   ii. Faculty development
   iii. Graduate performance including performance of program graduates on the certification examination
   iv. Program quality (annual evaluation of the program and use of resident assessments and other evaluation results to improve the quality of the program)

D. Materials and data reviewed include but are not limited to the following.

a. The previous internal review reports and GME committee actions.
b. The results of the questionnaire sent to the residents by the review committee and the most recent ACGME resident survey
c. The Institutional and Program Requirements that pertain to the program.
d. Letters of notification and from RC reviews and any progress reports submitted to the ACGME
e. Interviews with the program director, faculty and residents in the program as well as any other individuals outside the program as deemed appropriate by the committee.
f. Program written policies for selection, evaluation, promotion, discipline and dismissal of residents.
g. Annual program evaluations

E. If a program has no residents or fellows at the midpoint of the review cycle a modified internal review will be done as described in ACGME Institutional Requirements IV.A,3:
a. The review committee will be appointed as above
b. The committee will review whether the program has maintained adequate faculty and staff resources, clinical volume and the necessary curricular elements required.
c. When a resident or fellow is enrolled, a new internal review will be completed during the second six months of their first year in the program.

F. Other review components.
a. Policies and procedures for the selection, evaluation, promotion, discipline,

adjudication of complaints and grievances, and dismissal of residents.

b. Assessment of resident contracts including working conditions and duty hours.

c. Provision of the following opportunities and/or activities for residents.

   i. Participation in institutional committees which relate to patient care activities.

   ii. Participation in evaluation of the quality of education provided by the program.

   iii. Participation in quality assurance activities of the clinical service including review of all deaths and autopsies.

   iv. Provision of appropriate clinical supervision as specified by the RRC.

a. Provision of ancillary support including sleeping quarters, food services, patient support services, medical/clinical information retrieval system and security measures.

II. INSTITUTIONAL POLICIES AND PROCEDURES

A. Quality Assurance

1. House officers shall participate in the quality assurance activities of the clinical services to which they are assigned.

B. Resident Financial Support and Benefits

1. The Dean of the College of Medicine in concert with the Chancellor of the Medical Center is operationally responsible for the allocation of the institutional resources in any given year based on the requirements and capabilities of the individual programs.

2. Residency positions are apportioned with consideration of many factors: the quality of educational experiences that can be provided, the availability of qualified instructors, case mix and number of patients available, specialty health manpower requirements of the state, and availability of support funds.

3. House officer salary, at the time of appointment, is based on the number of prior years of ACGME recognized accredited residency training. Credit toward an advanced house officer level may be given for no more than one year of education outside of the specialty the house officer is entering and only if the training fulfills board requirements of that specialty. House officers who enter an advanced fellowship position following residency training outside of the United States will start at the level defined by the minimum prerequisite training for that fellowship, regardless of their years of prior training abroad. For the purpose of determining salary level, a chief resident year done after the required training is completed will be counted as a year of training provided the house officer is

entering a subspecialty in the same discipline.

4. Residents' responsibilities, duration of appointment, financial support, conditions under which living quarters, meals, and laundry services are provided, conditions of reappointment, grievance procedures and due process, professional liability insurance, health and disability insurance, leaves of absence, duty hours, moonlighting, residency closure/reduction, and restrictive covenants are specified in the current House Officer Agreement.

5. Malpractice coverage during leave of absence is not ordinarily provided. To apply for coverage, a written request from the program director giving the number days of the leave, specific activities, dates, and location as well as reason it should be considered a part of the individual's training program should be submitted to the Graduate Medical Education Office at least two months in advance of the leave.

6. Each program must assure that the house officer's name on prescriptions is clearly legible so that they can be contacted by pharmacists when questions arise. The committee recommends that each program supply house officers with prescription forms bearing their name and medical license number.

C. Resident Supervision and Working Environment

1. Introduction:
Graduate medical education in the United States has evolved into a highly formalized system requiring that programs meet the requirements of the Accreditation Council for Graduate Medical Education (ACGME) and that house officers are prepared to meet the certification requirements of those specialty Boards approved by the American Board of Medical Specialties. The hospitals in which these programs are housed are members of the Council of Teaching Hospitals of the Association of American Medical Colleges. These teaching hospitals, in general, provide high quality care, admit patients with more severe conditions and provide more care to medically indigent persons than non-teaching hospitals. Over time, the system of residency education in this country has surpassed that of all others and is recognized as the international leader.

Graduated Responsibility:
The philosophy of education that has pervaded this system as it evolved has included graduated responsibility for all house officers culminating in the final year in which a high level of individual responsibility is achieved prior to graduation. Supervision and education are provided by faculty

[1]The term "house officer" as it appears in this document refers to any intern, resident or clinical fellow in training at the University of Nebraska Medical Center.

who may be full-time academicians in schools of medicine, highly qualified practitioners who voluntarily contribute their time and knowledge to the program, or combinations of the two. Supervision and education are also provided by the house officers on to another as they progress through their program with a major responsibility shouldered by the senior house officers or chief residents in their final year.

While the need for graded responsibility in the provision of patient care is an important tenet of the

educational system, it is critical that the education of house officers be accomplished in a high quality, expeditious and cost-effective manner.

University of Nebraska Medical Center house officers are physicians with an M.D. or D.O. degree and who have, at a minimum, a Nebraska Temporary Education permit which permits practice in the training program and many have unrestricted Nebraska licenses. They enter with basic medical knowledge and continue to add special skills and knowledge that will allow them to become fully certified in a medical or surgical specialty. The house officers utilize their superiors as consultants as their ability to assume more responsibility is developed and the need for direct supervision declines. They become competent to make judgments of increasing complexity and to perform procedures of increasing difficulty throughout their house officer training. The outcome of this philosophy of education produces a physician who has had responsibility for self-learning, for teaching, for graded responsibility in patient care and for obtaining consultation when appropriate.

Relationship Between House Officers and Faculty:

The supervisory relationships that exist between faculty and house officers can be at several levels. Inexperienced house officers require a greater level of supervision and the physical presence of a faculty member in the role of either the “attending physician” or the “consulting physician” to ensure that patients are receiving optimal care.

In order to qualify as an “attending physician,” the teaching physician must at a minimum:

1. review the patient’s history, the record of examinations and tests in the institution and make frequent reviews of the patient’s progress; and

2. personally examine the patient or see the patient; and

3. confirm or revise the diagnosis and determine the course of treatment to be followed; and

4. either perform the physician’s services required by the patient or supervise the treatment so as to assure that appropriate services are provided by house officers and that the care meets a proper quality level; and

5. be present and ready to perform any service that would be performed by an attending physician in a non-teaching setting when a surgical or medical procedure is performed; and

6. be recognized and/or accepted by the patient as his/her personal or responsible physician, or a member of the personal physician’s group and be personally responsible for the continuity of the patient’s care, at least throughout the period of illness or hospitalization.

Some specialists provide their services to patients from a site which is remote from where direct patient care is rendered. These “consulting physicians” provide expertise that is critical to the

successful provision of patient care by the "attending physician."

In order to qualify as a "consulting physician," the teaching physician must, at a minimum:

1. either perform the consulting physician's services required by the patient or supervise the procedure so as to assure that appropriate services are provided by house officers and that the care meets a proper quality level; and

2. be present and ready to perform any service that would be performed by a consulting physician in a non-teaching setting when a surgical or medical procedure is performed.

B. As house officers progress satisfactorily in their training, they must be granted graded responsibility commensurate with their abilities. In this setting, house officers may provide patient care under the supervision of, but without direct participation by, the attending physician. Under these conditions, the attending physician, although fully responsible for the care of the patient, is considered to be fulfilling an administrative/educational role.

C. Participation, for the purpose of this document, is defined as the attending physician being physically present on site during the delivery of health care. Participation includes supervision. On the other hand, a faculty member does not have to be physically present to supervise a house officer and, therefore, supervision does not imply participation. **The faculty cannot bill a patient for services rendered unless there is participation in patient medical care.**

The UNMC COM and the program in which house officer education is provided each have a responsibility to see that policies and procedures exist that describe the specific levels of supervision required for house officers. They are responsible to ensure that house officers, faculty and administration are informed of these requirements, that the requirements are met and that the requirements are re-evaluated on a regular basis. It is not possible to define specific levels of supervision or responsibility that could be applied to all programs and all situations because of variations in the requirements of specialties. Therefore, standards should be determined by each program and individualized commensurate with the clinical circumstance and the abilities of the house officer.

Certain principles should guide institutional and programmatic policies:

1. ACCREDITATION STANDARDS: The national standards for house officer supervision as defined by the Accreditation Council for Graduate Medical Education and individual Residency Review Committees must be met as approved and published by the Accreditation Council for Graduate Medical Education.

2. UNMC COMMITMENT:

   A. The UNMC has responsibilities for support of house officers who are physicians engaged in postgraduate study and who provide institutional patient care.

B. The UNMC COM has a responsibility to help meet the cost to implement these guidelines.

3. PROGRESSIVE RESPONSIBILITY:

A. House officer education must continue to be progressively graduated in both experience and responsibility with due attention to the benefit and safety of the patient. Development of mature clinical judgment requires that each house officer be involved in the decision-making process. This process should be determined by each program and individualized commensurate with the clinical circumstance and the abilities of the house officer.

B. Progressive responsibility for "first decision" making prior to faculty involvement is important for the maturation of each house officer, whereas "final decision" making after involvement is the province of the faculty. In the process of allowing a house officer the opportunity to make the "first decision," the attending physician must ensure that the process does not delay the provision of cost-effective and expeditious care.

C. It is appropriate and desirable that house officers who are more senior have responsibility for supervision and education of those house officers junior to them. House officers' roles and supervisory relationships should be defined in writing by each program.

D. Faculty must supervise the total care for each hospitalized patient as well as the admission and discharge process and must follow program policy. There must be documented knowledge of every hospitalized patient as indicated by, at a minimum, initials or signature on the attending History and Physical, daily progress notes, procedure reports and the discharge summary.

E. Faculty have authority for patient care; however, both faculty and house officers at all levels have individual responsibility for their actions in patient care.

4. EMERGENCIES: In an emergency situation to preserve life or prevent serious impairment to health, house officers shall be permitted to implement life support services and notify the attending physician as soon as possible. The responsibilities of the attending physician to the patient and to the house officer are not changed by these circumstances.

5. ADMISSIONS AND DISCHARGE: House officers may admit patients to and discharge them from the hospital under the authority of, and only with the consent of, the appropriate faculty member. The only exception is an emergency where delay of permission could result in injury or loss of life. Appropriate faculty member(s) must be informed of all admissions, transfers and discharges.

6. QUALITY MONITORING: The overall quality of patient care is the collaborative concern of house officers, faculty, nursing staff and the administration. Clearly defined and carefully reviewed Quality Monitoring should regularly determine that the institutional standards are

being met.

7. CRITICAL DECISION AREAS: In areas of the hospital where rapidity of critical decisions or interventions are common, a supervisory attending will always be available for consultation.

8. CONSULTATION SERVICE: A readily available consultation service should be provided by each department and/or division. All consultations given by house officers must be reviewed by a faculty member in a timely manner and any necessary revisions conveyed promptly.

9. AMBULATORY CARE: Every house officer must have the opportunity to participate in ambulatory care. Designated faculty must be available on-site, or readily available according to their respective RRC special requirements, for supervision of house officers in such settings.

10. PROGRAM POLICY:

1. The development, implementation and enforcement of this policy is the responsibility of the program directors. Oversight for the compliance of individual programs is the responsibility of the Graduate Medical Education Committee acting on behalf of the Dean of the College of Medicine.

   Departmental policies on supervision should include description of the role, responsibilities and patient care activities by level of house officers in the program. The policy should describe the means by which the program makes decision about a resident's degree of independence in patient care and procedural duties. These policies should be provided to all hospitals at which the residents are assigned.

2. Each program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients.

   a. Departmental policies shall be based on an educational rationale and patient need, including continuity of care.

   b. The educational goals of the program must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Residents must have backup support when patient care responsibilities are especially difficult or prolonged.

   c. Resident duty hours and on-call schedules must not be excessive. Duty hours must be consistent with the General and Special Requirements of the ACGME that apply to each program.

3. Affiliated institutions must provide services and develop systems to minimize the work of residents that is extraneous to their educational programs.

D. Ancillary Support

1. Policies regarding on call rooms and food services are contained in the current resident agreement.

E. Conditions of Resident Employment

F. Evaluation and advancement of residents.

1. Written evaluation of house officers.
Written evaluation of resident progress in each program will be done at a minimum of every six months with copies sent to the house officer and the Office of Graduate Medical Education. Programs must prepare a written report at the end of each year of training and at the completion of residency stating the overall performance and the number of months of training successfully completed. These summary reports may be substituted for the regular evaluation at the end of the year.

K. Reappointment of House Officers.

1. Reappointment of house officers will depend upon the house officers' academic and clinical performance, professional behavior, the availability of funding and the continuation of the residency program itself.

2. House officers must pass USMLE Step 2 or COMLEX Exams to advance to the HO II level and must pass USMLE Step 3 or COMLEX Exams or Part II of the Medical Council of Canada Qualifying Exam to advance to the HO III level. A house officer who does not meet these requirements will be placed on unpaid leave for a maximum of 6 months in order to prepare for and pass the exam. Failure to pass the required examination by the end of this leave period will results in dismissal from the program. The house officer’s program director may apply to the GMEC for a one-time extension of the requirement for a period of 6 months or less. The letter must present compelling reasons for the extension and must be co-signed by the house officer. At the end of the extension, if the requirements are not met, the house officers will go on unpaid leave and must pass the test within 6 months as above. Until the requirements are met, the house officers will not advance in pay level.

3. Notification of non-reappointment. Programs must provide house officers with a written notice of intent not to renew a house officer’s contract no later than four months before the end of the house officer’s current contract. If the primary reasons for the non-renewal occur within the four months before the end of the contract, the program must provide the house officer with notice of non-renewal as early as circumstances will allow.

4. 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.

   A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion. (Common Program Requirements II.C.1,2)

H. Certificates: Period of service.

An official certificate of service will be issued for those house officers who complete a recognized training program. This would include recognized one year preliminary programs and special fellowships. For house officers leaving after one year but have not completed a program of training, the institution will provide a letter attesting to their training and the department may award a certificate or letter of their own.

I. Procedures relating to unsatisfactory performance and dismissal.

1. **"On Review".**

If questions are raised regarding the adequacy of a house officer's performance, the house officer may be placed "on review". "On review" status does not signify unsatisfactory performance but merely indicates the house officer's performance is being more closely scrutinized. The house officer is placed "on review" through written notification to both the house officer and the Office of Graduate Medical Education. Should the concerns placing the house officer "on review" prove unfounded or be corrected, the related documentation will be purged from the record.

2. **Probation.**

If a house officer's performance is deemed to be unsatisfactory from academic or professional aspects or as a consequence of a breach of the House Officer Agreement or the Bylaws of the Board of Regents, the house officer may be placed on probation. If so, the house officer, the Office of Graduate Medical Education, and the Graduate Medical Education Committee shall be notified in writing. The notice shall include: the specific problems in the house officer's performance, what will constitute evidence that the problems have been remedied, and the date at which the house officer's performance will next be reviewed.

A review of the house officer's performance must take place within three months following the initiation or extension of probation. At the designated time the department may extend the house officer's probation, end the probation, or dismiss the house officer.

3. **Dismissal**

Unsatisfactory academic performance, or breach of the terms of the house officer agreement or of the Bylaws of the Board of Regents shall be sufficient grounds for dismissal. Gross failure to perform duties, or illegal or unethical conduct may result in immediate dismissal. The Office of Graduate Medical Education must be notified and provided with all supporting documentation prior too initiating dismissal action.

4. **Grievance and appeals.**

Policies regarding appeal of academic dismissal, unsatisfactory academic performance, or grievances involving terms of the House Officer Agreement are contained in the House Officer Agreement.

IV. PROGRAM PERSONNEL

A. Program Director

1. The director of each program is designated by the respective department chair and approved by the Dean, College of Medicine in consultation with the institutional Graduate Medical Education Committee. All program directors must meet Requirement IV.A.1 of the ACGME General Requirements.

B. Teaching Staff

1. Each program must have a sufficient number of teaching staff with documented qualifications to instruct and supervise adequately all residents in the program.

2. The program director must assure that all members of the teaching staff demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, support of the goals and objectives of the program, a commitment to their own continuing medical education and participation in scholarly activities.

3. Each program must designate a member of the teaching staff at each participating institution who is responsible for the day-to-day activities of the program at that institution under the overall direction of the program director.

4. The teaching staff of each program must have regularly documented meetings to review program goals and objectives and review how well the program is meeting those goals. At least one resident representative should be participate in the reviews.

5. The teaching staff of each program should periodically evaluate the utilization of the resources available to the program, the contribution of affiliated institutions if applicable, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.

V. PROGRAM RESEARCH AND SCHOLARLY ACTIVITY

1. Each program must establish an environment supportive of research and scholarly activity by their residents. The graduate medical education committee, through its periodic review of programs assesses programs' success in this regard.

VI. ELIGIBILITY

Applicants with one of the following qualifications are eligible for appointment to UNMC postgraduate training programs.

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:

    - Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), or

    - Have successfully completed a Fifth Pathway program provided by an LCME accredited medical school.

4. Acceptance of applicants into a postgraduate training program (residency or fellowship) at the:

        - HO II year requires the passage of USMLE Steps 1 and 2 or its equivalent.*

        - HO III year or beyond requires the passage of the USMLE Steps 1, 2 and 3 or its equivalent.*

5. Prior to entrance into the program, the applicant must provide appropriate documentation satisfying the University's requirements as stated above.

6. Prior to beginning postgraduate training, each house staff physician must possess either a Temporary Educational Permit or a permanent license in Nebraska.

*Footnote: Equivalent exams include: COMLEX, Licentiate of the Medical Council of Canada Qualifying Exam (LMCC), NBME, FLEX, or a combination of exams recognized by the State of Nebraska Regulations and Licensure Agency known as "Hybrid Exams" include: 1) Any combination of NBME Parts I, II, III and USMLE Steps 1, 2 and 3; 2) Flex Component I with USMLE Part 3; 3) Combination of NBME Components I, II or USMLE Steps 1, 2 with Flex Component 2.

VII. SELECTION

1. Each program selection committee must ensure that the program selects from among eligible applicants on the basis of their preparedness, ability, academic credentials, communication skills and personal qualities such as motivation, integrity and professionalism. Programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability or veteran status.

2. UNMC Graduate Medical Education programs participate in the National Resident Matching Program (NRMP), if applicable. Selection of house staff through the NRMP is preferable, when possible. When programs are enrolled in the NRMP, house staff accepted outside of the match must be approved by the Associate Dean for Graduate Medical Education.

3. All candidates for postgraduate training will submit a completed application with

appropriate documentation of training and other materials requested, and when possible, have a personal interview with members of the program selection committee.

4. The program selection committee will rank the candidates for entrance into the NRMP, where appropriate, for selection based on qualifications.

VIII. PROGRAM REDUCTION OR CLOSURE

If a postgraduate program is at risk for reduction or closure either by the University of Nebraska Medical Center for financial or administrative reasons or by loss of ACGME accreditation, the University will inform the housestaff physicians as soon as possible and will make every effort available to place the current housestaff physicians into another similar approved program elsewhere or transfer the housestaff physicians to another program within the institution. Where possible, housestaff physicians will be allowed to complete the academic year in progress.

IX. DUTY HOURS AND WORKING CONDITIONS

I. Duty Hours (from the ACGME Common Program Requirements, July 2007)

Duty hours are defined as 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.

A. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

B. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

C. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

2. On-call Activities

A. In-house call must occur no more frequently than every third night, averaged over a four-week period.

B. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

C. No new patients may be accepted after 24 hours of continuous duty.

3. At-home call (or pager call)

A. The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

B. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

C. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

4. Moonlighting

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

B. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

5. Work Hours Exception

A program who wishes to request an exception to the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours must first obtain GMEC approval. The application should be made to the GMEC in writing and will be distributed to members for review before the next meeting. The request should include the services affected and the rationale for the request. The GMEC will review the letter at the meeting along with discussion with the program director of the program requesting the exception. The exception may be turned down, returned to the program for more information, or approved for transmittal to the RRC.