Resident and Fellow
ACGME Orientation
Handbook

A Guide to the ACGME
Requirements

This booklet is intended to provide key information that residents
and fellows need to know about the ACGME requirements in a
concise, easy-to-reference handbook.

Residents and fellows will find tips and explanations of the
ACGME standards related to:

- Milestones and core competencies
- Duty hours
- Evaluations
- Information security and privacy
- Documentation

This guide may become your “go-to” resource as you learn the ins
and outs of your own program requirements.

We hope this will serve as that overview resource for accreditation
requirements.

June 2015
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>The ACGME and the Next Accreditation System</td>
<td>3</td>
</tr>
<tr>
<td>About the ACGME</td>
<td>3</td>
</tr>
<tr>
<td>The Next Accreditation System</td>
<td>5</td>
</tr>
<tr>
<td>Supervision and Transition of Care</td>
<td>7</td>
</tr>
<tr>
<td>The ACGME Resident Survey</td>
<td>9</td>
</tr>
<tr>
<td>Evaluation: The Six Core Competencies, Clinical Competencies, and Milestones</td>
<td>11</td>
</tr>
<tr>
<td>Program and Faculty Evaluations</td>
<td>13</td>
</tr>
<tr>
<td>Your Rights as a GME Trainee</td>
<td>14</td>
</tr>
<tr>
<td>Resident Duty Hour Restrictions</td>
<td>15</td>
</tr>
<tr>
<td>Duty Hour Rules</td>
<td>15</td>
</tr>
<tr>
<td>Why You Should Care about Duty Hours</td>
<td>20</td>
</tr>
<tr>
<td>Resident Fatigue Prevention</td>
<td>21</td>
</tr>
<tr>
<td>Fatigue Facts</td>
<td>21</td>
</tr>
<tr>
<td>Effects of Shift Rotation</td>
<td>22</td>
</tr>
<tr>
<td># of Consecutive Working Days</td>
<td>22</td>
</tr>
<tr>
<td>Time off between Duty Periods or Shifts</td>
<td>23</td>
</tr>
<tr>
<td>Privacy and Information Security</td>
<td>24</td>
</tr>
<tr>
<td>Acronym List</td>
<td>26</td>
</tr>
</tbody>
</table>
Introduction

Residency is one of the most important phases of your professional career. It is normal to feel pressed for time during training, and the purpose of this booklet is to provide as much information as is reasonable for a small manual or handbook to give you the key accreditation information you will need about ACGME policies and procedures.

You may not realize the extremely important role you play in assisting your program and our institution to main accreditation. We want to inform you about the rules and requirements mandated by the Accreditation Council for Graduate Medical Education (ACGME) that your institution, residency or fellowship program must follow.

We hope this handbook will be helpful to you in understanding these requirements throughout your graduate medical education (GME) training.
The ACGME and the Next Accreditation System (NAS)

About the ACGME

The Accreditation Council for Graduate Medical Education is a private, non-profit organization that accredits more than 9,000 residency programs in 135 specialties and subspecialties in the United States, affecting more than 116,000 residents. Formed in 1981 through a consensus need in the medical community for an independent accrediting organization for residency programs, the ACGME’s mission is to improve the quality of health care in the United States by accessing and advancing the quality of graduate medical education for physicians in training through accreditation. The ACGME’s member organizations – the American Board of Medical Specialties, American Hospital Association, American Medical Association, American Association of Medical Colleges and Council of Medical Specialty Societies – nominate members to the ACGME’s Board of Directors. The board also includes two resident representatives, the chair of the Council of Review Committees, three public members and a federal government representative.

Accreditation is voluntary. However, residency programs must be ACGME-accredited to receive Medicare graduate medical education funds, and residents must complete an ACGME-accredited residency program to be eligible to take board certification exams.

In February 2012, the ACGME announced major changes in how the nation’s medical residency programs will be accredited in the years ahead, putting in place an outcomes-based evaluation system where the doctors of tomorrow will be measured for their competency in performing the essential tasks necessary for clinical practice in the 21st century.
The ACGME’s next accreditation system for graduate medical education (GME) was fully implemented in 2014. Now, under the new system, each accredited medical residency program must demonstrate that its residents have the core competencies and clinical skills to deliver quality patient care and respond to rapid developments in health care delivery.

“Equipping the doctors of tomorrow with the clinical skills and perspectives needed to promote patient safety and quality and to respond to the rapid developments in healthcare delivery are the ACGME’s prime objectives in implementing a ‘next accreditation system’ for graduate medical education in the U.S.,” said Thomas Nasca, MD, MACP, chief executive officer of the ACGME. “There is now widespread consensus that moving to an outcomes-based accreditation system will prepare physicians to deliver quality patient care and be skilled in evidence-based medicine, team-based care, care coordination, and shared decision-making – all critical to practicing medicine in an increasing complex health care system.”

The ACGME’s next accreditation system is consistent with recommendations made by the Institute of Medicine (IOM) and such respected bodies as the Medicare Payment Advisory Commission (MedPAC) and the Josiah Macy Jr. Foundation. Under the ACGME’s next accreditation system: Residents and fellows must demonstrate competency in six core areas -- patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, and interpersonal skills and communication. And remember – the Next Accreditation is NOW.

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**The Next Accreditation System (NAS)**

As mentioned in the first section, the current movement in graduate medical education (GME) has led to an analysis of what it takes to be a physician who “has demonstrated sufficient competence to enter practice without direct supervision” (a quote directly from the ACGME Common Program Requirements). In 2013, the Accreditation Council for Graduate Medical Education (ACGME), the national accreditation organization, began implementation of the Next Accreditation System (NAS) for seven core specialties:

- Emergency Medicine
- Internal Medicine
- Neurosurgery
- Orthopaedic Surgery
- Pediatrics
- Diagnostic Radiology
- Urology

All other specialties transitioned to implementation under NAS in 2014, so you are actually beginning your training this year in the toddler stage of an exciting and changing time in the world of GME.

In the past, the ACGME was driven by a process-based approach to making sure your residency program was in substantial compliance with ACGME requirements. Programs were site visited by the ACGME every 2 – 5 years, and each program was required to prepare “mountains” of paperwork that would be presented to a site visitor during the accreditation site visits. However, most GME educators agree that there has never been a reliable way to assess the competency of graduates completing the program. With implementation of the NAS, educational Milestones have been introduced. Similar to developmental milestones for growing children, these educational Milestones are specialty-specific goals based on your post graduate year of training in the program (i.e., PGY-1, PGY-2, etc.) that you are expected to achieve throughout your residency training, as evaluated by the Clinical Competency Committee (CCC) in your program.
Note: The University of Tennessee has determined that in order that discussions and evaluations reviewed in CCC meetings will remain under peer review protection from legal discovery, our CCC’s are called “Clinical Competency and Residency Quality Improvement Committees.” Milestones and CCCs will be further discussed in the “Evaluation” section of this handbook.

In addition to Milestones, the ACGME will use other data points to evaluate your program in the future, including, the ACGME Residency Survey, similar Faculty Survey, specialty board pass rates, and operative and case log data.

Another important part of the NAS is the assessment of your Sponsoring Institution (here, the University of Tennessee College of Medicine Chattanooga) in providing an optimal educational experience in an environment that delivers safe, quality medical care. The ACGME is visiting Sponsoring Institutions – the entity that provides oversight for your collective training programs and usually issues resident paychecks – and their affiliated hospital (clinical training sites) with a team of site visitors who will examine how well that hospital is performing in six focus areas:

- Patient Safety
- Quality Improvement
- Transitions of Care
- Supervision
- Duty hours oversight, fatigue management and mitigation
- Professionalism

The ACGME calls this its CLER Program – “Clinical Learning Environment Review.” The ACGME’s goal is to ensure that residents and fellows are key participants in these six focus areas and that residents and fellows work hand-in-hand to safeguard and improve these areas. The ACGME has dictated that CLER visits would occur every 18 -24 months. The UT College of Medicine Chattanooga and Erlanger participated in our first CLER visit in April 2014. When our second CLER Visit occurs, you may be one of the peer-selected residents scheduled to meet with the CLER Visit Team. You might even be asked to host the CLER Team on their “walking rounds” to various clinical areas they choose important in the hospital, including the Emergency Department, operating rooms, critical care units, labor and delivery, and even resident call quarters. Most importantly, you will be an active participant throughout your training in improving the safety and quality of your care to your patients with the advent of the NAS.

### Supervision and Transition of Care

The ACGME 2011 regulations emphasized the importance of resident supervision. These standards stated that:

- Each patient must have an identifiable attending physician and the patient must be informed who that physician is.
- Residents and faculty members should explain their roles in the patient care team.
- In some cases, an advanced resident or fellow may provide supervision.
- The program must demonstrate appropriate supervision at all times.

There are two types of supervision: direct and indirect. Basically, direct supervision means your attending physician is present with you and the patient. Indirect supervision means that your attending may not be physically present, but he/she is available by telephone, electronic means, or in the hospital, and will become available if needed.

Additionally, the Transition of Care is another ACGME focus of the CLER Visit. Transition of Care must be monitored by the institution to facilitate continuity of care and patient safety. The ACGME will closely examine the program’s patient handoff system to make sure it is appropriate, effective, and safe for your patients.
Following our institution’s first CLER Visit in April 2014, the ACGME asked our Designated Institutional Official, Dr. Robert Fore, to serve as a volunteer CLER Visitor. Dr. Fore has received formal CLER training and has already served on a CLER visit team.

We anticipate that our 2\textsuperscript{nd} CLER visit will occur around April 2016 so you will be part of that process.

The ACGME Resident Survey

One of the most important surveys you will complete during your years of GME training is the Annual Resident Survey from the Accreditation Council for Graduate Medical Education (ACGME). The survey started years ago, but it has evolved over time into an instrument that asks pointed questions about your program that the ACGME can utilize as one of the data points it reviews in determining the quality of your educational experience. The ACGME Annual Resident Surveys are administered during the months of January through June (depending upon your specialty) each year. It is extremely important that you complete the online survey since failure to achieve at least a 70% response rate from the residents in program will result in a warning letter from the ACGME that if less than 70% response rate occurs the following year, your program could be subject to a special, focused site visit from the ACGME. Your Graduate Medical Education Office (GME Office) may conduct its own special review or investigation to determine why the residents in the program are non-compliant with the survey.

The Resident Survey takes only a few minutes to complete, and you should answer all questions honestly. Your Program Director only receives summary results from a compilation of all answers with others from your program. Eventually, your Program Director will receive data on all other programs in the U.S. in your specialty and how your program compares.

The survey includes questions about these topics:

- Duty hours (including information regarding fatigue and sleep deprivation)
- Supervision
- Evaluation
- Educational content
- Resources
- Patient safety
- Teamwork
GME leaders across the country recommend that you not use the ACGME Resident Survey as an outlet for your frustrations, as it can reflect negatively on your entire program and institution. If survey results suggest significant non-compliance with ACGME requirements, the DIO, Director of GME, and your GME Committee may conduct what the ACGME calls a “special internal review” to determine if there are real underperformance issues in your residency that are reflected in the survey. You should view the survey as a way to help build a more effective and higher quality program for your future.

If you become concerned about issues in your program that impact the learning environment, we recommend that you first work with your Program Director or faculty mentor to correct the problems and issues. If that is not feasible, pay a visit to your GME Director and the DIO or another administrator who may be able to offer potential solutions or suggestions for improvement.

We have a link on our website, www.utc.com/gme, to give you a way to send a comment or concern about your program and educational training. It is the second link on the left-hand menu, labeled “Confidential Resident/Fellow Comments.” The resident has the option to identify or not with the comment. When the form is submitted, it goes directly to the DIO and is not copied to anyone else.

Evaluation: The Six Core Competencies, Clinical Competency Committee, and Milestones

Core Competencies, CCS, and Milestones

Several years ago, the ACGME designated six General Core Competencies to shift the emphasis of evaluation to your accomplishments through assessment rather than the structure and process of an educational curriculum. Most of the evaluation of your skills during the course of your training will focus on these competencies:

- Medical Knowledge – What you know
- Patient Care – What you do
- Interpersonal and Communication Skills – How you interact with others
- Professionalism – How you act
- Systems-Based Practice – How you work with the system at your hospital and within the health care system in general
- Practice-Based Learning and Improvement – How you improve your skills and become more efficient and knowledgeable

During your residency you will be evaluated by several different mechanisms during the course of your training, and almost all will incorporate these six General Core Competencies in some manner. The evaluations you may receive over the course of your training include:
- Monthly or bimonthly (typically) competency evaluations by supervising residents and attending faculty.
- Evaluation done semi-annually by the Clinical Competency and Residency Quality Improvement Committee (CCC) regarding the Milestones approved for your specialty.
- Competency evaluations by ancillary staff (e.g., lab techs, nurses), medical students, peers, patients, and even self-evaluations. All of these types of evaluations are referred to as 360 degree or multi-source evaluations.
- Bi-annual evaluations from your Program Director.
- A final, summative evaluation by the Program Director indicating whether you are competent to enter practice independently in your specialty without direct supervision.

With the implementation of the Next Accreditation System (NAS), the American Board of Medical Specialties, in concert with the ACGME, has developed outcomes-based Milestones assessed by your program’s CCC. As mentioned previously, these Milestones are competency-based behavior outcome expectations demonstrated progressively from the time you enter your training until you are ready to enter practice. Twice each year your CCC will assess your development and report these to the ACGME. The seven specialties mentioned before regarding NAS have been designated as Phase I NAS Programs. These specialties have already had their first experience with their CCC’s assessing residents through the specialty Milestones. All other specialties have incorporated the Milestones and began assessing them as of last year, July 1, 2014.

Your program’s CCC is made up of at least three faculty members called Core Faculty. The ACGME has determined that Core Faculty are faculty members who spend a set number of hours per week, set by your specialty, involved in clinical supervision, research or scholarly activity, or giving didactics or supervising other training with residents. In general, Core Faculty must devote at least 15 hours per week in these areas. The CCC reviews each resident performance semi-annually, and your Program Director must report those results back to the ACGME. Your Program Director may or may not be a member of this committee, but typically the PD is a member.

The CCC advises the Program Director regarding each resident’s progress, which may include promotion, remediation, non-reappointment, or dismissal.

The CCC can evaluate your progress in the Milestones in several ways, including direct observations, simulation lab evaluation, in-training examinations, review of case or procedure logs, or structured case discussions. Some of the early learning that has been evidenced by CCC’s is that the committee’s work is an effective way to uncover some of the things your program should improve upon in providing you the best education possible. Also, since the CCC does an intense review of your performance, you may be informed about deficiencies in your performance that had not been previously been mentioned in any of your periodic evaluations at the end of rotations.

**Program and Faculty Evaluations**

The ACGME requires that all trainees have the chance to evaluate their teaching programs and teaching faculty, and that these evaluations must remain confidential (anonymous). This is an excellent opportunity for you to voice your opinion about the strengths and weaknesses of the various facets of your program. It is important that you take the time to complete these program and faculty evaluations because they provide extremely useful information for the Program Director.

The timing of each of these evaluations varies greatly, but at a minimum, per the ACGME, the faculty and program must be evaluated at least annually. Most of our programs permit you to evaluate the faculty and program semi-annually. If you feel you are unable to evaluate the program and faculty confidentially (anonymously), you should discuss your concerns about the process with your Program Director or with the GME Director and DIO.
Your Rights as a GME Trainee

Many of you will begin residency training as your first professional job. Your Sponsoring Institution is required to offer you a training program agreement (Letter of Agreement or Contract). Our campus refers to your first agreement as your Initial Letter of Agreement. Each year you may be reappointed to the program, given satisfactory performance and meeting program requirements, with a Reappointment Letter.

In the initial letter of agreement, many details are outlined as required by the ACGME such as salary, benefits, malpractice information, and due process. Read the agreement carefully so you can be fully informed of your trainee rights.

The ACGME requires that each program document criteria for determining your promotion from one level to another or reappointment each year. If you are being faced with an adverse action – such as suspension, non-reappointment, non-promotion, or dismissal from your program – the Sponsoring Institution and your program should have a due process mechanism. The due process should include informing you of the action the program is taking against you, your right to a grievance, and your right to the appeal the action, including the procedure for submitting and processing your grievance. You should know where all these issues are outlined in your resident agreement or an institutional intranet or website. For our campus, institutional policies are uploaded into the intranet of the web-based residency management software used to track resident demographics, schedules, duty hours, evaluations, and Milestones – New Innovations.

Resident Duty Hour Restrictions

In 2003, the ACGME first implemented duty hour standards for all accredited training program in the United States. Under increasing pressure from the Occupational Safety and Health Administration (OSHA), the Institute of Medicine (IOM), and the general public, the ACGME has re-assessed those standards, resulting in a new set of duty hour standards that became effective July 1, 2011.

Duty Hour Rules

There are eight duty hour requirements you must know and adhere to during your training. Our institution requires that all residents and fellows report their duty hours, including vacations or other leave, using the Duty Hours Reporting Module within the New Innovations web-based software system. All requirements, tweaked for each specialty and that program’s duty hour types, are managed by the system. Violations are flagged for the resident reporting hours and the Program Director reviewing them. There is a mechanism for explaining the reason for a violation so the Program Director can review and determine if the justification was appropriate or take steps to eliminate the system issue that contributed to the violation. Most programs require that residents enter a notation as documentation and tracking whenever a violation has occurred.

Standard #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.”

All clinical, research, and academic activities related to your program must be counted with reportable duty hour limits. This includes the following activities:

- Patient care
- In-house call
• Night/day float
• Patient handoffs
• Administrative duties that you perform for your patients or for your program, such as interviewing residency candidates

If you are on call at home and return back to the hospital, those hours worked must count toward the 80-hour limit. However, hours that you spend reading, preparing for conferences, or studying away from the patient care unit (such as at the Library), are not counted toward the 80-hours-per-week limit.

When calculating your hours per week, look at the length of your rotation, whether it is four weeks, one month, or any period shorter than four weeks. If you take vacation while on a rotation, exclude that amount of time when averaging your hours per week. For example, if you are on a four-week rotation and take a week of vacation, you must not average more than 80 hours per week during the remaining three weeks to be compliant with the duty hours requirements.

Note: The ACGME allows programs in some specialties to request an increase of up to eight additional weekly hours for residents (including chief residents). However, programs that request the increase must provide an educational rationale and receive approval from the Sponsoring Institution (the DIO and GMEC) as well as the Residency Review Committee (RRC). None of the programs within our institution have an approved exception to the duty hours limits.

Standard #2: “Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.”

All moonlighting (work done outside the scope of your training program for which you usually get paid additional money) that is performed by residents, both at the Sponsoring Institution or at another institution, must count toward the 80-hour weekly limit. PGY-1 residents are not permitted to moonlight in any institution. Our institution has a policy prohibiting moonlighting without prior approval from the Program Director and continual monitoring of the impact of moonlighting on the resident’s education. Some programs do permit limited moonlighting but it is closely monitored and always approved in advance.

Standard #3: “Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). Call from Home cannot be assigned on these free days.”

Ideally, the ACGME prefers your day off to be one where you wake up in your own home – not on a post-call day. It is acceptable (except for internal medicine) for residents to take call for an entire weekend so that their next weekend may be free, as long as the total duty hours, one-day-off-in-seven, and the frequency of call are compliant with the specialty requirements. If you take call twice during one weekend (i.e., Friday and Saturday), you must have 10 hours off between the two duty periods.

Standard #4: “Duty periods of PGY-1 residents must not exceed 16 hours in duration.”

PGY-1 residents are strictly limited to 16-hour shifts and may not remain on duty past that time for the transition of patient care. This means that all patient care responsibilities must be completed at the end of the 16 hours. Also, PGY-1 residents are not permitted to take at-home-call.

The literature reveals that many medical centers have hired more ancillary personnel or adopted a “night float” system to cover patients at night in order to make up for the gap in coverage this restriction creates.

Standard #5: “Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.”

In addition to the 24-hour period, PGY-2 and more senior residents may remain on duty an additional four hours (for a total of 28 hours) in order to provide transition of care for patients from one physician or team to another. Residents should use these four hours to transfer
patient care responsibilities or to attend educational conferences. You should not use this time to care for new patients, participate in procedures, or attend clinics, including continuity clinics.

The ACGME recognizes that, at times, residents will have to remain on duty to ensure continuity of care for a single patient. However, if a resident remains past the duty period, he or she must hand off patient care appropriately to the Team responsible for the patient’s continuing care. The resident must also document the reason for staying in each of these instance and submit documentation to the Program Director. This is managed via the New Innovations Duty Hours reporting system for our campus.

Additionally, the ACGME urges programs to encourage “strategic napping” for residents who are going to be in-house for at least 24 consecutive hours, particularly between 10 PM and 8 AM. This does not mean that programs should schedule naps for these residents. Instead, residents should have the option to nap if they feel fatigued and patient demand permits. The institution should provide adequate sleep facilities for your use. Our institution permits residents to utilize call rooms post call if they are too fatigued or sleepy to drive home. In addition, a resident who is too fatigued and does not wish to use a call room may take a taxi and then be reimbursed by the hospital with a taxi receipt.

Standard #6: “PGY-1 residents should have 10 hours, but must have eight hours, off between duty periods.”

Intermediate-level residents should have 10 hours off, and must have eight hours off between assigned duty periods. They must have at least 14 hours off after 24 hours of in-house duty. Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Ideally, scheduled duty hour periods should be separated by 10 hours, but there could be circumstances when that is not possible. With appropriate educational justifications, it may be acceptable that you not have 10 hours off duty. However, our experience with the

ACGME has been that “should” really means “must” to the ACGME so we discourage off periods less than 10 hours. If you are assigned Back-up Call from Home (or Home Call) and must return to the hospital, this time is not subject to the eight or 10 hours required between duty.

Standard #7: “PGY-2 residents and above must be scheduled for in-house (overnight) call no more frequently than every third night when averaged over a four-week period.”

This requirement refers to continuous on-call duty between the evening hours of the prior day and the next morning. Eight, 10, or 12 hour duty shifts (e.g., Emergency Medicine, Night Float, ICU, even Trauma rotations) are exempt from the requirement that call be scheduled no more than every third night since those duty or shift assignments are not true overnight call. They are shifts. You may work a maximum of four call nights in any seven-day period, but this can only be done one time per month, and you may not take night call (different from Night Float) for two consecutive nights. Taking in-house, overnight call every other night for two weeks and then being free of call for the following two weeks is not permitted.

Note: The ACGME does not permit Internal Medicine Programs to average in-house, overnight call time; residents may not take in-house, overnight call more frequently than every third night.

Standard #8: “Time spent in the hospital by residents on Home-Call or Back-up Call must count toward the 80 hour maximum weekly hour limit. The frequency of Home-Call or Back-up Call is not subject to the every third night limitation, but must still satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.”

If you return to the hospital while on Home-Call or Back-up Call, you must count those hours toward your 80-hour maximum weekly limit. Most programs using this type assignment at our institution have a designation of Home Call-Called In for this situation. You cannot be called to the hospital during your one-day-in-seven off duty.
Additionally, Home-Call or Back-up Call must not be so frequent that adequate rest and personal time are compromised.

**Why You Should Care about Duty Hours**

You are required to truthfully report your Duty or Work Hours. You must not feel pressured to under report or lie about your hours. If you suspect you are in danger of going over your duty hour limits, alert your Program Director or Chief Resident or the GME Director at your institution. The ACGME also requires that each program have a confidential mechanism for residents to report work hour violations. You should ask your Program Coordinator about that mechanism in case you need it. As mentioned earlier, you may use the link for Confidential Resident/Fellow Comments on our GME website to send a report directly to the DIO.

Although some members of the medical community argue that the duty hours standards interrupt continuity of care and deviate from a medical culture that traditionally equates longer hours to more dedication, the ACGME implemented duty hours restrictions to prevent fatigue-related errors, injuries, and illnesses, and you should familiarize yourself with these requirements.

You should know these rules and requirements, and, if you feel you will risk violating duty hour requirements, you should never feel intimidated or hesitant to contact your Program Director, GME Director, or the DIO to let them know before it becomes a problem.

**Resident Fatigue Prevention**

One of the reasons that the ACGME implemented the duty hour restrictions in response to data suggesting that sleep deprivation negatively impacts resident clinic and educational performance. It has not been a secret that medical residents may not get enough sleep. Even before the ACGME addressed the issue, there were residents, Program Directors, and others calling for change. Some studies have shown the negative effects of sleep deprivation. Eliminating extended work shifts and reducing first year resident hours each week may reduce the risk of serious medical errors.

A residency who is simply tired is not the problem. It becomes a cause for concern when residents are so fatigued that they are apt to make serious errors in judgment or physically injure a patient during a procedure.

An overly fatigued resident also will have more difficulty communicating clearly and working as part of a team.

**Fatigue Facts**

Ask yourself the following questions when you suspect that you are suffering from fatigue:

- Do you “look” tired? Are you pale?
- Are there dark circles under your eyes?
- Are you listless?
- Are you having difficulty completing assignments that usually don’t present problems?
- Do even routine tasks seem to overwhelm you?
- Are you the last to leave after your shift is complete because you need to “catch up” on charting and other non-direct patient care tasks?
- Are you suddenly accident prone?
Is there an increase in your sick-time use? Do you seem to be unusually susceptible to colds, flu, and other illnesses?

Has there been an increase in the occurrence of your medical errors?

Are you uninterested in activities and projects about which you are normally enthused?

Are you concerned about your interpersonal relationships?

If you are getting at least five hours of sleep for a limited amount of time (e.g., two to three days), you are probably still able to function at a reasonable level of safety, but below your normal level of activity.

However, if sleep deprivation is an ongoing problem, individuals develop what is called sleep debit, or an accumulation of lost sleep. Sleep debt leads to a significant reduction in general performance, alertness, and response time, and it also causes changes in mood, motivation, initiative, and morale.

Effects of Shift Rotation

People who work night shifts experience circadian rhythm disturbances, have poorer sleep quality compared to those who do not work night shifts (i.e., more awakenings and less restorative sleep), and are more likely to complain of sleepiness after awakening and during work hours. Additionally, research shows that sleep after working night shifts is generally shorter than sleep after day work. All of these factors contribute to sleep deprivation, as indicated by less alertness during night work and reduced reasoning ability.

Number of Consecutive Working Days

Working too many consecutive days creates two potential obstacles. First, you may suffer from an accumulation of fatigue (and, in some cases, of excessive exposure to substances).

Second, you may suffer from isolation from family and social activities. You need a recovery period from work at regular intervals. Although you may feel pressured to use time off to see family, visit friends, and catch up on your “to do list,” prioritizing sleep is important.

Time Off Between Shifts

As consecutive hours within a given shift or the number of consecutive workdays in a work block mount, so does cumulative fatigue and stress. Keep in mind the amount and distribution of time off between both consecutive workdays and blocks of workdays. The rest period between shifts should provide enough time for you to get adequate sleep.
Privacy and Information Security

We live in a generation of advanced technology and sometimes it is tempting to use that technology in a way that is not in conformance with Health Information Portability & Accountability Act (HIPAA) standards. Don’t be the resident whose car has been broken into, computer stolen, and the protected health information you had on that computer about your patients is compromised.

Here are some useful tips about privacy and information security:

- Store your data on a computer network drive affiliated with your university or hospital or in an encrypted local hard drive. Do not create electronic storage areas (i.e., cloud computing) because such storage does not meet minimum HIPAA standards.
- Password protect and encrypt your smartphone, tablet, laptop, and other mobile devices. Encryption is in addition to password protection and is the process of transforming information using an algorithm to make it unreadable to anyone except those possessing the key.
- Always log off or lock a computer when walking away from it (even for a few minutes).
- Minimize the transport of confidential information, including protected health information, between healthcare facilities or to other locations. If confidential information must be physically transported, take the minimum amount of information possible and safeguard it at all times. Do not leave confidential information unattended in a vehicle or other location where it can be stolen.
- Do not perform patient handoffs on your cell phone.

You often hear in the news about workers being fired from their jobs because they posted confidential or negative information about their own company or coworkers. As social media and networking is most likely a mainstay of your personal life, there are some critical points for your to remember:

- Do not talk about patients or patient care events on social networking sites. Even without the patient name, the information is still confidential.
- Do not take pictures of your patients and share them with your colleagues because you have seen a fascinating case – this will undoubtedly merit a call from the Compliance Office at your institution.
- Do not poke fun about your patients or your superiors on any networking site because it almost always backfires and you can be disciplined for lack of professionalism.
- Finally, you have an obligation to report suspected violations of privacy and information security. Contact your Program Director immediately if you feel there has been a breach in the security of your information.
# GME Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AAMC</td>
<td>Association of American Medical Colleges</td>
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<tr>
<td>ABMS</td>
<td>American Board of Medical Specialties</td>
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<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
</tr>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
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<tr>
<td>AMA</td>
<td>American Medical Association</td>
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<tr>
<td>AOA</td>
<td>American Osteopathic Association</td>
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<tr>
<td>ATLS</td>
<td>Advanced Trauma Life Support</td>
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<tr>
<td>BLS</td>
<td>Basic Life Support</td>
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<tr>
<td>CLER</td>
<td>Clinical Learning Environment Review</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>COMLEX</td>
<td>Comprehensive Osteopathic Medical Licensing Examination</td>
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<tr>
<td>CV</td>
<td>Curriculum Vitae</td>
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<tr>
<td>DEA</td>
<td>Drug Enforcement Agency</td>
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<tr>
<td>DIO</td>
<td>Designated Institutional Official</td>
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<tr>
<td>ECFMG</td>
<td>Education Commission for Foreign Medical Graduates</td>
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<td>ERAS</td>
<td>Electronic Residency Application Service</td>
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<tr>
<td>FREIDA</td>
<td>Fellowship &amp; Residency Electronic Interactive Database (by the AAMC)</td>
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<tr>
<td>GME</td>
<td>Graduate Medical Education</td>
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<td>GMEC</td>
<td>Graduate Medical Education Committee</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability &amp; Accountability Act</td>
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<td>JAMA</td>
<td>Journal of the American Medical Association</td>
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<tr>
<td>NBME</td>
<td>National Board of Medical Examiners</td>
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<td>NRMP</td>
<td>National Resident Matching Program</td>
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<tr>
<td>OSCE</td>
<td>Objective Structured Clinical Examination</td>
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<tr>
<td>PGY</td>
<td>Postgraduate Year (after medical school)</td>
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<tr>
<td>TJC</td>
<td>The Joint Commission (formerly Joint Commission on Accreditation of Healthcare or JCAHO)</td>
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<tr>
<td>TOEFL</td>
<td>Test of English as a Foreign Language</td>
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<tr>
<td>USMLE</td>
<td>United States Medical Licensing Examination</td>
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<tr>
<td>WebAds</td>
<td>Accreditation Data System through ACGME (for Resident Survey, Case Logs, etc.)</td>
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