Question	Answer
Are there any circumstances when it would be acceptable for the Program Evaluation Committee (PEC) to not include a resident/fellow member? *[Common Program Requirement: V.C.1.a)]*	A resident/fellow must always be included on a PEC unless there are no residents/fellows enrolled in the program. The PEC must meet annually, even when there are no residents/fellows enrolled in the program, to evaluate and review the program.
The Learning and Working Environment	
Does the ACGME require electronic, "real-time" monitoring of clinical and educational work hours for all accredited programs? *[Common Program Requirement: VI.F.1.; Institutional Requirement: IV.K.]*	The ACGME requires that Sponsoring Institutions and programs monitor residents'/fellows' clinical and educational work hours to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach since the ideal approach should be tailored to each program and its Sponsoring Institution. For example, the approach best suited for a neurological surgery program will be different from what is most appropriate for preventive medicine, dermatology, or pediatrics programs.
Are the requirements related to patient safety and quality improvement intended to apply solely in inpatient settings? *[Common Program Requirement: Section VI.A.1.]*	The requirements related to patient safety and quality improvement are not limited to inpatient experiences and are inclusive of care provided in outpatient settings.
With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided? *[Common Program Requirement: VI.A.1.a).(3).(a)]*	Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems, Centers for Medicaid and Medicare Services, Press Gainey, and National Surgical Quality Improvement Program.

Question	Answer
How should the appropriate level of supervision be determined for each resident or fellow? *[Common Program Requirements: VI.A.2.b)-VI.A.2.b).(3)]*	The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director and faculty members, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The program director determines the level of supervision required for an individual resident or fellow both by assessing the abilities and competence of the resident/fellow and the needs of the individual patient. Therefore, the level of supervision required for a resident or fellow may vary based on the circumstances.
How can residents and fellows identify the accountable attending physician for each patient for whom they are providing care? *[Common Program Requirement: VI.A.2.a).(1)]*	Residents and fellows must know who the accountable attending physician is prior to making any clinical decisions on behalf of a patient. The program and institution are responsible for providing that information to all residents and fellows. Residents and fellows are responsible for keeping the accountable physician informed.
How should residents/fellows communicate with the accountable physician? *[Common Program Requirement: VI.A.2.a).(1).(a)]*	This communication may occur in-person or via portal, fax, text, phone, or email. It is essential that each patient's primary physician be listed in the patient's chart. If that information is not in the chart, the patient should be asked to provide the name of their primary physician. If the patient does not have a primary physician, a determination regarding who will assume responsibility for overall care must be made and documented in that patient's chart.
Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours? *[Common Program Requirement: VI.C.1.d).(1)]*	The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution's policies regarding time off for such appointments.

Question	Answer
Can residents/fellows be encouraged to schedule medical, mental health, and dental care appointments on days they are not assigned call? *[Common Program Requirement: VI.C.1.c).(1)]*	The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days. Programs must not place restrictions on when residents and fellows may schedule these appointments, nor place pressure on them to schedule appointments on days when they are not assigned call.
How can programs located in areas where 24/7 in-person access to mental health professionals is not possible comply with this requirement? *[Common Program Requirement: VI.C.1.e)]*	The requirement is intended to ensure that residents and fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. Access to a psychiatrist or other mental health professional in the Emergency Department satisfies the expectation for 24/7 access to emergency care. In addition, telemedicine, or telephonic means may be used to satisfy this requirement.
What are the ACGME's expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions? *[Common Program Requirement: Section VI.E.3.]*	Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Sponsoring Institutions and programs are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education.

Question	Answer
How do the ACGME common clinical and educational work hour requirements apply to research activities? *[Common Program Requirement: Section VI.F.]*	The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements. When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when the resident/fellow participates in patient care. Some programs have added clinical activities to “pure” research rotations, such as having research residents/fellows cover “night float.” This combination of research and clinical assignments could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments.
Is there a provision for training pathways with alternative schedules to accommodate the needs of those with the ability to become excellent physicians but an inability to take on the demanding usual schedule described in the requirements? *[Common Program Requirement: Section VI.F.]*	The requirements do not prevent a program from providing an alternate pathway based on the needs of individuals, as long as the pathway adheres to other relevant dimensions of the requirements, including the maximums specified for clinical experience and education.

Question	Answer
What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week? *[Common Program Requirement: VI.F.1.]*	Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours. Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.
If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance? *[Common Program Requirement: VI.F.1.]*	If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.

Question	Answer
What is meant by “should have eight hours off”? *[Common Program Requirements: VI.F.2.a)]*	While it is expected that residents’ and fellows’ schedules will be structured to ensure they are provided with a minimum of eight hours off between scheduled work periods, it is recognized that individual residents or fellows may choose to remain beyond their scheduled time or return to the clinical site during this time-off period to care for a patient. The requirement preserves the flexibility for residents and fellows to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule. It is important to remember that when an abbreviated rest period is offered under special circumstances, the program director and faculty members must monitor residents/fellows for signs of excessive fatigue.
If a post-call resident/fellow remains on site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident/fellow leaves the hospital? *[Common Program Requirements: VI.F.2.b)]*	The 14-hour time-off period begins when the resident/fellow leaves the hospital, regardless of when the resident/fellow was scheduled to leave.
Since the requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the “day off” occurs after a resident’s/fellow’s on-call day? *[Common Program Requirement: VI.F.2.c)]*	The requirements specify a 24-hour day off. Many Review Committees have recommended that this day should ideally be a calendar day (i.e., the resident/fellow wakes up at home and has a whole day available). Review Committees have also noted that it is not permissible to have the day off regularly or frequently scheduled on a resident’s/fellow’s post-call day, but understand that in smaller programs this may occasionally be necessary. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off.

Question	Answer
What activities are permitted during the four hours allowed for activities related to patient safety and/or resident/fellow education? *[Common Program Requirement: VI.F.3.a).(1)]*	Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period.
Can clinical and educational work hours for surgical chief residents be extended to 88 hours per week? *[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(1)]*	Programs interested in extending the clinical and educational work hours for specific rotations for their chief residents can use the "88-hour exception" to request an increase of up to 10 percent in clinical and educational work hours on a program-by-program basis, with endorsement of the Sponsoring Institution's GMEC and the approval of the Review Committee. If approved, the exception will be reviewed annually by the Review Committee. A request for an exception must be based on a sound educational justification. Most Review Committees categorically do not permit programs to use the 10 percent exception. The Review Committee for Neurological Surgery is currently the only Review Committee that allows exceptions.
What qualifies as a "sound educational justification" for a rotation-specific increase in the weekly clinical and educational work hour limit by up to 10 percent? *[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(1)]*	The ACGME specifies that a rotation-specific increase in clinical and educational work hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve residents'/fellows' educational experiences. This requires that all hours in the extended work week contribute to resident/fellow education. Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and/or for a subgroup of the residents/fellows in the program.

Question	Answer
In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)? *[Common Program Requirements: VI.F.5.a)-c), VI.B.3.-VI.B.4.]*	The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do: VI.F.5.a) "Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program, and must not interfere with the resident's/fellow's fitness for work nor compromise patient safety." VI.B.3.-VI.B.4. "The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents/Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.
How many times in a row can a resident/fellow take call every other night? *[Common Program Requirement: VI.F.7.]*	The objectives for allowing the averaging of in-house call (in all specialties except internal medicine) is to offer flexibility in scheduling, not to permit call every other night for any extended length of time, even if done in the interest of creating longer periods of free time on weekends or later in the month. For example, it is not permissible for a resident/fellow to be on call every other night for two weeks straight and then be off for two weeks.
Is it permissible for residents/fellows to take call from home for extended periods, such as a month? *[Common Program Requirement: VI.F.8.a)]*	No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.
Can PGY-1 residents take at-home call, and if so, what are the work hour restrictions for this? *[Common Program Requirement, Residency version: VI.A.2.b).(1).(a).(i)]*	PGY-1 residents are not initially allowed to take at-home call because appropriate supervision (either direct supervision or indirect supervision with direct supervision immediately available) is not possible when a resident is on at-home call. However, a Review Committee may specify the circumstances and achieved competencies required for residents to progress to be supervised indirectly with direct supervision available at some point after the beginning and before the end of the PGY-1. Program directors should review the specialty-specific Program Requirements for further clarification.

Question	Answer
Why do the requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks? *[Common Program Requirement: VI.F.1.]*	The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident/Fellow decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.
What are the expectations regarding tracking and monitoring clinical work done from home? *[Common Program Requirements: VI.F.1., VI.F.8.a)]*	Types of work from home that must be counted include using an electronic health record and responding to patient care questions. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Residents/fellows are expected to track the time spent on these activities and report this time to the program director. The program director then will use this information when developing schedules to ensure that residents/fellows are not exceeding 80 hours per week, averaged over four weeks. Decisions about whether to report brief periods devoted to clinical work (e.g., a phone call that lasts just a couple of minutes) are left to the individual resident/fellow. There is no requirement regarding how this time is tracked and documented and no expectation that the program director assume a role in verifying the time reported by the residents/fellows.
Which requirements apply to time in the hospital after being called in from home call? *[Common Program Requirements: VI.F.8.a)-VI.F.8.a).(1)]*	For call taken from home (home or pager call), the time a resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities. When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows.

Question	Answer
General Questions	
How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?	Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance. If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. The requirements do not permit a "rolling" average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours and frequency of call must comply with the common clinical and educational work hour requirements.
Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care?	The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements.
What determines clinical and educational work hour limits for residents/fellows who rotate in another accredited program?	The clinical and educational work hour limits of the program in which the resident/fellow rotates apply to all residents/fellows, both those in the program and rotators from another specialty. This expectation also applies when a program has an exception, but it helps to remember that the standard defines the maximum allowable hours, not required hours or hours for all residents/fellows, so that it is always possible to work fewer hours than the limit.

Question	Answer
What is the ACGME Resident/Fellow Survey-Common Program Requirements Crosswalk document? How can it help me understand my ACGME resident survey results?	This is a new resource that helps programs understand and interpret their ACGME Resident/Fellow Survey results by mapping ACGME Survey questions to the respective and corresponding Common Program Requirements. If a program has a low compliance rate on a particular Resident/Fellow Survey item, the crosswalk document can help the program director identify the area for improvement to comply with the applicable Common Program Requirements. This resource can also help a program's residents/fellows understand the intent of the individual survey questions. The crosswalk document for the Resident/Fellow survey can be found on the ACGME website: Resident/Fellow and Faculty Surveys (acgme.org). A crosswalk document for the annual Faculty Survey is also available at the page linked above.