

# ACGME Program Requirements for Graduate Medical Education in Sleep Medicine

One-year Common Program Requirements are in BOLD

Effective: July 1, 2004

## Introduction

**Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.**

**The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s and fellow’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.**

**Int.B. Definition and Scope of the Specialty**

Sleep medicine is a discipline of medical practice in which sleep disorders are assessed, monitored, treated, and prevented by using a combination of techniques (clinical evaluation, physiologic testing, imaging, and intervention) and medication. Specialists in sleep medicine are expected to:

- Int.B.1. participate in an interdisciplinary care of patients of all ages that incorporates aspects of psychiatry, neurology, internal medicine, epidemiology, surgery, pediatrics and basic science;**
- Int.B.2. acquire detailed knowledge of the sleep and respiratory control centers, aphasiology, and neurobiology underlying sleep and wakefulness; and,**
- Int.B.3. diagnose and manage sleep disorder patients in outpatient and inpatient settings.**

- Int. B.4. Appropriate expertise in the areas defined above in Int. B. must be present among the program director and faculty members. The Review Committee recognizes that expertise in sleep medicine is available from physicians who are Board-certified in many medical specialties, particularly in internal medicine, pulmonology, psychiatry, pediatrics, neurology, and otolaryngology. The Review Committee encourages multidisciplinary cooperation in educating fellows.
- Int. C. A subspecialty educational program in sleep medicine must be organized to provide educational and supervised experience at a level sufficient for the fellow to acquire competence in the field.
- Int. D. The educational program must be one year in duration.
- Int.D.1. The sponsoring specialty (internal medicine, neurology, otolaryngology, pediatrics, or psychiatry) must have a core education program accredited by the Accreditation Council for Graduate Medical Education (ACGME).
- Int. D.2. All 12 months of the program must be devoted to the inpatient and ambulatory clinical experiences.
- Int. D.3. Education must be separate and distinct from all education required for certification in the core sponsoring specialties and in pulmonary disease.

## **I. Institutions**

### **I.A. Sponsoring Institution**

**One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.**

**The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.**

- I.A.1. The sponsoring institution may have only one accredited sleep medicine program.

### **I.B. Participating Sites**

- I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

**The PLA should:**

- I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;**
- I.B.1.b) specify their responsibilities for teaching, supervision, and**

**formal evaluation of fellows, as specified later in this document;**

- I.B.1.c) specify the duration and content of the educational experience; and,**
- I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.**

**I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

## **II. Program Personnel and Resources**

### **II.A. Program Director**

**II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**

**II.A.1.a) The program director must be fully committed to the fellowship program, and devote sufficient time to provide leadership and supervision to the program and its fellows.**

**II.A.2. Qualifications of the program director must include:**

**II.A.2.a) requisite specialty expertise, and documented educational and administrative experience acceptable to the Review Committee;**

**II.A.2.b) current certification in the subspecialty by the American Board of in Internal Medicine, Pulmonology, Psychiatry, Pediatrics, Neurology, or Otolaryngology, or specialty qualifications that are acceptable to the Review Committee; and,**

**II.A.2.b).(1) The Review Committee only accepts current certification in specialties identified in II.A.2.b).**

**II.A.2.c) current medical licensure and appropriate medical staff appointment.**

**II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:**

- II.A.3.a) prepare and submit all information required and requested by the ACGME;
- II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
  - II.A.3.c).(1) all applications for ACGME accreditation of new programs;
  - II.A.3.c).(2) changes in fellow complement;
    - II.A.3.c).(2).(a) This applies only for those Review Committees that approve fellow complement.
  - II.A.3.c).(3) major changes in program structure or length of training;
  - II.A.3.c).(4) progress reports requested by the Review Committee;
  - II.A.3.c).(5) responses to all proposed adverse actions;
  - II.A.3.c).(6) requests for increases or any change to fellow duty hours;
  - II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;
  - II.A.3.c).(8) requests for appeal of an adverse action; and,
  - II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.
- II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
  - II.A.3.d).(1) program citations, and/or
  - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.
- II.B. Faculty
  - II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

- II.B.2.**                    **The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.**
  
- II.B.3.**                    **The physician faculty must have current certification in the specialty by the American Board of Internal Medicine, Pulmonology, Psychiatry, Pediatrics, Neurology, or Otolaryngology, or possess qualifications acceptable to the Review Committee.**
  
- II.B.4.**                    **The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
  
- II.B.4.a)                    Physician faculty members must be appointed in good standing to the staff of an institution participating in the program.
  
- II.B.5.                      There must be a minimum of two core clinical faculty members, including the program director. In programs with more than four fellows, a ratio of one core clinical faculty member to every two fellows must be maintained.

**II.C.                      Other Program Personnel**

**The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.**

**II.D.                      Resources**

**The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements.**

- II.D.1.                      Patient Population
  
- II.D.1.a)                    There must be an adequate number and variety of patients of all ages in both inpatient and outpatient settings to expose fellows to the broad spectrum of sleep disorders.
  
- II.D.1.b)                    Experience should include evaluation of hospitalized sleep disorder patients. Fellows should make regular patient management rounds and record reviews with the attending faculty.
  
- II.D.1.c)                    Experience should include longitudinal management of patients for whom the fellow is the primary physician (but acting under the supervision of a faculty member).
  
- II.D.1.d)                    The patients seen by fellows must have a balance of age, gender, and short- and long-term disorders.
  
- II.D.1.e)                    The patient population should include patients with the major

categories of sleep disorders, including:

- II.D.1.e).(1) apnea and other sleep-related breathing disorders;
- II.D.1.e).(2) parasomnias;
- II.D.1.e).(3) circadian rhythm disorders;
- II.D.1.e).(4) insomnia;
- II.D.1.e).(5) narcolepsy and related excessive daytime sleepiness disorders; and,
- II.D.1.e).(6) sleep problems related to other factors and diseases such as medications, and psychiatric and medical disorders.

## II.D.2. Facilities

- II.D.2.a) The sleep laboratory facility should be appropriately equipped, and have a minimum of two fully-equipped polysomnography bedrooms and support space. The American Academy of Sleep Medicine or an equivalent body should accredit the sleep laboratories and other related facilities and equipment for use for both adults and children.
- II.D.2.b) There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with audiovisual and other educational aids, office space for staff and fellows, pertinent library materials, and diagnostic, therapeutic, and research facilities.

## II.E. Medical Information Access

**Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.**

## III. Fellow Appointments

### III.A. Eligibility Criteria

**Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.**

- III.A.1. All applicants entering a sleep medicine program must have completed a core educational program accredited by the ACGME in a sponsoring specialty. The sponsoring specialties are family medicine, internal medicine, neurology, otolaryngology, pediatrics, and psychiatry.

**III.B. Number of Fellows**

**The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.**

**IV. Educational Program**

**IV.A. The curriculum must contain the following educational components:**

**IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;**

**IV.A.2. ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:**

**IV.A.2.a) Patient Care**

**Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:**

**IV.A.2.a).(1) must have formal instruction, clinical experience, and demonstrated competence in the following:**

**IV.A.2.a).(1).(a) performing competent physical, neurological, and mental status examinations, and recording the findings completely and systematically;**

**IV.A.2.a).(1).(b) integrating information obtained from patient history, physical examination, physiologic recordings, imaging studies, psychometric testing, pulmonary function testing, and biochemical and molecular tests results to arrive at an accurate and timely diagnosis and treatment plan;**

**IV.A.2.a).(1).(c) diagnosing medical and psychiatric sleep disorders, as well as sleep disorders associated with common medical, neurologic, and psychiatric conditions;**

**IV.A.2.a).(1).(d) formulating appropriate treatment plans and making appropriate referrals;**

**IV.A.2.a).(1).(e) observing, evaluating, and managing patients of all ages with a wide variety of sleep disorders; and,**

- IV.A.2.a).(1).(f) the administration of sleep disorders center, especially leadership of interdisciplinary teams.
- IV.A.2.a).(2) should have clinical experiences that provide for basic and advanced education, as well as professional development, including:
- IV.A.2.a).(2).(a) opportunities to formulate a clinical diagnosis and to order and use laboratory data to clinically evaluate a patient's condition and to support outpatient and inpatient diagnostic evaluations;
- IV.A.2.a).(2).(b) progressive experience for education that includes caring for a sufficient number of sleep disorder patients to achieve competence in the assessment of patients with a wide range of sleep medicine disorders;
- IV.A.2.a).(2).(c) experience with medical, neurologic, and psychiatric disorders displaying symptoms likely to be related to sleep disorders (e.g., the relationship between hypertension and snoring);
- IV.A.2.a).(2).(d) experience with the interactions between treatment for sleep disorders and other medical, neurologic, and psychiatric treatment;
- IV.A.2.a).(2).(e) experience and/or familiarity with the major types of therapy, including psychotherapy, pharmacotherapy, surgical treatment, behavioral treatments, and other somatic therapies.
- IV.A.2.a).(2).(f) clinical consults and teaching from the following disciplines as related to sleep disorders: cardiology, neurology, otolaryngology, oral maxillofacial surgery, pediatrics, pulmonary medicine, psychiatry, and psychology including neuropsychology, pathology, and radiology services; and,
- IV.A.2.a).(2).(g) supervised experience in teaching sleep medicine to students in the health professions.
- IV.A.2.a).(2).(g).(i) It is suggested that the above-listed experiences (IV.A.2.a).(1)-(4)) be attained with multidisciplinary cooperation in the diagnosis and treatment of sleep patients.

#### **IV.A.2.b)**

#### **Medical Knowledge**

**Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:**

- IV.A.2.b).(1) must have formal instruction in, and demonstrate comprehensive knowledge of:
- IV.A.2.b).(1).(a) fundamental mechanisms of sleep, major theories in sleep medicine, and the generally-accepted facts of basic sleep mechanisms:
- IV.A.2.b).(1).(a).(i) basic neurological sleep mechanisms;
- IV.A.2.b).(1).(a).(ii) chronobiological mechanisms;
- IV.A.2.b).(1).(a).(iii) respiratory physiology during sleep and pathophysiology;
- IV.A.2.b).(1).(a).(iv) cardiovascular physiology during sleep and pathophysiology;
- IV.A.2.b).(1).(a).(v) endocrine physiology during sleep and pathophysiology;
- IV.A.2.b).(1).(a).(vi) gastrointestinal physiology during sleep and pathophysiology;
- IV.A.2.b).(1).(a).(vii) ontogeny of sleep; and,
- IV.A.2.b).(1).(a).(viii) sleep across the life span.
- IV.A.2.b).(1).(b) airway anatomy;
- IV.A.2.b).(1).(c) nosology for sleep disorders: The International Classification of Sleep Disorders;
- IV.A.2.b).(1).(d) etiopathogenic characterization of sleep disorders;
- IV.A.2.b).(1).(e) pharmacology of sleep (i.e. medication effects on sleep);
- IV.A.2.b).(1).(f) clinical manifestations of sleep disorders:
- IV.A.2.b).(1).(f).(i) evaluation of patients presenting with excessive sleepiness;
- IV.A.2.b).(1).(f).(ii) evaluation of patients presenting with difficulty initiating or maintaining sleep;
- IV.A.2.b).(1).(f).(iii) evaluation of patients presenting with

	parasomnias;
IV.A.2.b).(1).(f).(iv)	biological rhythm disorders;
IV.A.2.b).(1).(f).(v)	pediatric and neonatal sleep medicine;
IV.A.2.b).(1).(f).(vi)	SIDs and related respiratory distress; and,
IV.A.2.b).(1).(f).(vii)	medical, neurologic, and psychiatric disorders displaying symptoms likely to be related to sleep disorders (e.g., the relationship between hypertension and snoring).
IV.A.2.b).(1).(g)	biological, psychological, social, economic, ethnic, and familial factors which significantly influence the evaluation and treatment of sleep disorders;
IV.A.2.b).(1).(h)	the nature of the interactions between treatment for sleep disorders and other medical, neurologic, and psychiatric treatment;
IV.A.2.b).(1).(i)	diagnostic strategies in sleep disorders, including:
IV.A.2.b).(1).(i).(i)	etiologies, prevalence, diagnosis, and treatment of all of the sleep disorders in the current nosology of sleep medicine;
IV.A.2.b).(1).(i).(ii)	the use, reliability, and validity of the generally-accepted techniques for diagnostic assessment; and,
IV.A.2.b).(1).(i).(iii)	administration and interpretation of psychological tests.
IV.A.2.b).(1).(j)	treatment strategies in sleep disorders:
IV.A.2.b).(1).(j).(i)	treatment approaches for obstructive sleep apnea, to include nasal CPAP, bilevel PAP, upper airway surgery, oral appliances, and position education;
IV.A.2.b).(1).(j).(ii)	treatment approaches for insomnia, to include cognitive-behavioral therapies and pharmacological therapy;
IV.A.2.b).(1).(j).(iii)	treatment approaches for narcolepsy and idiopathic CNS hypersomnolence;
IV.A.2.b).(1).(j).(iv)	treatment approaches for parasomnias; and,

- IV.A.2.b).(1).(j).(v) treatment of circadian rhythm disorders.
- IV.A.2.b).(1).(k) operation of polysomnographic monitoring equipment, including:
  - IV.A.2.b).(1).(k).(i) polysomnographic troubleshooting;
  - IV.A.2.b).(1).(k).(ii) ambulatory monitoring methodology; and,
  - IV.A.2.b).(1).(k).(iii) polysomnogram interpretation.
- IV.A.2.b).(1).(l) financing and regulation of sleep medicine;
- IV.A.2.b).(1).(m) medical ethics and its application in sleep medicine;
- IV.A.2.b).(1).(n) legal aspects of sleep medicine; and,
- IV.A.2.b).(1).(o) epidemiological issues, including:
  - IV.A.2.b).(1).(o).(i) research methods in the clinical and basic sciences related to sleep medicine; and,
  - IV.A.2.b).(1).(o).(ii) critically appraising the professional and scientific literature, and applying new contributions to management and care of patients.

**IV.A.2.c) Practice-based Learning and Improvement**

**Fellows are expected to develop skills and habits to be able to meet the following goals:**

- IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,**
- IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.**

**IV.A.2.d) Interpersonal and Communication Skills**

**Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.**

**IV.A.2.e) Professionalism**

**Fellows must demonstrate a commitment to carrying out**

**professional responsibilities and an adherence to ethical principles.**

**IV.A.2.f) Systems-based Practice**

**Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.**

IV.A.2.f).(1) Fellows must have formal instruction and clinical experience in systems-based skills that include working in outpatient and inpatient settings and effectively utilizing health care resources.

**IV.A.3. Didactics**

IV.A.3.a) The educational program must conduct a monthly, multidisciplinary teaching conference and a monthly journal club organized by the faculty on topics that cover the scope of sleep medicine.

IV.A.3.b) The educational program must conduct seminars and core conferences. This instruction must be relevant for pediatric and adult patients.

**IV.A.4. Procedures and Technical Skills**

IV.A.4.a) Fellows must have formal instruction, clinical experience, and demonstrated competence at the completion of education in the following:

IV.A.4.a).(1) the indications for and potential pitfalls and limitations of diagnostic tests and the interpretation of the results in the context of the clinical situation. These diagnostic tests must include the following:

IV.A.4.a).(1).(a) polysomnography, scoring and interpretation of polysomnograms and recognition of artifacts, including montages with additional EEG leads for seizure detection;

IV.A.4.a).(1).(b) multiple sleep latency testing;

IV.A.4.a).(1).(c) maintenance of wakefulness testing;

IV.A.4.a).(1).(d) actigraphy;

IV.A.4.a).(1).(e) portable monitoring related to sleep disorders;

IV.A.4.a).(1).(f) imaging studies, magnetic resonance imaging; and

- IV.A.4.a).(1).(g) psychological and psychometric tests as they relate to sleep disorders.
- IV.A.4.a).(2) skills necessary to perform polysomnographies from preparation and hookup of the patient to the completion of the study, including multiple sleep latency and maintenance of wakefulness tests;
- IV.A.4.a).(3) scoring and interpretation of polysomnograms and recognition of artifacts, including full montages with additional EEG leads for seizure detection;
- IV.A.4.a).(4) consultative skills in sleep medicine in a variety of medical, surgical, and psychiatric settings;
- IV.A.4.a).(5) certification in cardiopulmonary resuscitation; and,
- IV.A.4.a).(6) relating to patients and their families, as well as other members of the health care team, with compassion, respect, and professional integrity.

#### **IV.B. Fellows' Scholarly Activities**

Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and fellows must participate actively in such scholarly activities.

### **V. Evaluation**

#### **V.A. Fellow Evaluation**

##### **V.A.1. Formative Evaluation**

##### **V.A.1.a) The faculty must evaluate fellow performance in a timely manner.**

V.A.1.a).(1) Assessments by a faculty member must occur at least once every two months. Such evaluations are to be communicated to each fellow in a timely manner.

##### **V.A.1.b) The program must:**

**V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

**V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,**

- V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.
- V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.
- V.A.2. **Summative Evaluation**
  - The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:
    - V.A.2.a) document the fellow's performance during their education, and
    - V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.
- V.B. **Faculty Evaluation**
  - V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
  - V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
- V.C. **Program Evaluation and Improvement**
  - V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
    - V.C.1.a) fellow performance, and
    - V.C.1.b) faculty development
  - V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
- VI. **Fellow Duty Hours in the Learning and Working Environment**
  - VI.A. **Professionalism, Personal Responsibility, and Patient Safety**
    - VI.A.1. Programs and sponsoring institutions must educate fellows and

**faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**

- VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**
- VI.A.4. The learning objectives of the program must:**
  - VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
  - VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.**
- VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
  - VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
  - VI.A.5.b) provision of patient- and family-centered care;**
  - VI.A.5.c) assurance of their fitness for duty;**
  - VI.A.5.d) management of their time before, during, and after clinical assignments;**
  - VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
  - VI.A.5.f) attention to lifelong learning;**
  - VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,**
  - VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**
- VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the**

patient may be served by transitioning that patient's care to another qualified and rested provider.

**VI.B. Transitions of Care**

**VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.**

**VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**

**VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.**

**VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.**

**VI.C. Alertness Management/Fatigue Mitigation**

**VI.C.1. The program must:**

**VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;**

**VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,**

**VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**

**VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.**

**VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.**

**VI.D. Supervision of Fellows**

**VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**

**VI.D.1.a) This information should be available to fellows, faculty members, and patients.**

**VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care.**

**VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.**

**Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.**

**VI.D.3. Levels of Supervision**

**VI.D.3.a) To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:**

**VI.D.3.b) Direct Supervision – the supervising physician is physically present with the fellow and patient.**

**VI.D.3.c) Indirect Supervision:**

**VI.D.3.c).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**

**VI.D.3.c).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**

**VI.D.3.d) Oversight – the supervising physician is available to provide review of procedures/counters with feedback provided after care is delivered.**

**VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**

**VI.D.4.a) The program director must evaluate each fellow's abilities**

**based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**

- VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
- VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**
- VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
  - VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.**
- VI.E. Clinical Responsibilities**

**The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.**
- VI.F. Teamwork**

**Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.**

  - VI.F.1. Contributors to effective interprofessional teams may include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.**
- VI.G. Fellow Duty Hours**
  - VI.G.1. Maximum Hours of Work per Week**

**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.**

**VI.G.1.a) Duty Hour Exceptions**

**A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.**

**VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**

**VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

**VI.G.2. Moonlighting**

**VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.**

**VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.**

**VI.G.3. Mandatory Time Free of Duty**

**Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.**

**VI.G.4. Maximum Duty Period Length**

**Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.**

**VI.G.4.a) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**

**VI.G.4.b) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**

**VI.G.4.c) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to**

continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

- VI.G.4.c).(1)** Under those circumstances, the fellow must:
- VI.G.4.c).(1).(a)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
- VI.G.4.c).(1).(b)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- VI.G.4.c).(2)** The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.
- VI.G.5. Minimum Time Off between Scheduled Duty Periods**
- VI.G.5.a)** Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
- Sleep medicine fellows are considered to be in the final years of education.
- VI.G.5.a).(1)** This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
- VI.G.5.a).(1).(a)** Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.
- VI.G.5.a).(1).(b)** In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the

events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.'

VI.G.5.a).(1).(c)

Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director.

VI.G.5.a).(1).(d)

The program director must review each submission of additional service and track both individual residents' and program-wide episodes of additional duty.

**VI.G.6. Maximum Frequency of In-House Night Float**

**Fellows must not be scheduled for more than six consecutive nights of night float.**

**VI.G.7. Maximum In-House On-Call Frequency**

**Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).**

**VI.G.8. At-Home Call**

**VI.G.8.a)**

**Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.**

**VI.G.8.a).(1)**

**At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.**

**VI.G.8.b)**

**Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".**

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