ACGME Program Requirements for Graduate Medical Education in Child Neurology

Common Program Requirements are in BOLD

Effective: July 1, 2007

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. Duration and Scope of Training

Training in child neurology shall be three years. One year of training must be in clinical adult neurology. One year of training shall be referred to as flexible, and the fellow must learn the principles of neurophysiology, neuropathology, neuroradiology, neuro-ophthalmology, psychiatry, rehabilitation, neurological surgery, neurodevelopment, and the basic neurosciences. One year of training shall be in clinical child neurology.

Int.C. Prerequisite Training

Fellows may gain prerequisite training in one of three options:

Int.C.1. Two years of residency training in pediatrics, accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States or the Royal College of Physicians and Surgeons in Canada;

Int.C.2. One PG-1 year (as described in the Program Requirements for Graduate Medical Education in Neurology, Section I.A.1) and one year of residency training in pediatrics; or,

Int.C.3. One year of pediatrics plus one year of basic neuroscience training. The program director must review and determine the acceptability of these initial two years of training.

Int.D. Goals and Objectives for Residency Training

The purpose of the training program is to prepare the physician for the independent practice of clinical child neurology. This training must be based on supervised clinical work with increasing responsibility for outpatients and inpatients. It must have a foundation of organized instruction in the basic neurosciences.

Int.E. Relation to Core Programs

The three years of training in child neurology must take place in a center in which there are accredited residency programs in both pediatrics and neurology and with the approval and support of the program directors of both of these departments.

Int.F. Leave and Vacation Policy

Each program must have an equitable leave and vacation policy for fellows, in accordance with overall institutional policy.

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.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).**

I.B.3. The Review Committee must approve any site providing six months or more of training

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.2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**

II.A.3. **Qualifications of the program director must include:**

II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**

II.A.3.b) **current certification in the specialty by the American Board of** Psychiatry and Neurology with Special Qualification in Child Neurology**, or specialty qualifications that are acceptable to the Review Committee; and,**

II.A.3.c) **current medical licensure and appropriate medical staff appointment.**

II.A.4. **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.4.a)	**oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
II.A.4.b)	**approve a local director at each participating site who is accountable for fellow education;**
II.A.4.c)	**approve the selection of program faculty as appropriate;**
II.A.4.d)	**evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
II.A.4.e)	**monitor fellow supervision at all participating sites;**
II.A.4.f)	**prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program fellow updates to the ADS, and ensure that the information submitted is accurate and complete;**
II.A.4.g)	**provide each fellow with documented semiannual evaluation of performance with feedback;**
II.A.4.h)	**ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
II.A.4.i)	**provide verification of residency education for all fellows, including those who leave the program prior to completion;**
II.A.4.j)	**implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, and, to that end, must:**
II.A.4.j).(1)	**distribute these policies and procedures to the fellows and faculty;**
II.A.4.j).(2)	**monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
II.A.4.j).(3)	**adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
II.A.4.j).(4)	**if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
II.A.4.k)	**monitor the need for and ensure the provision of back up support systems when patient care responsibilities are**

unusually difficult or prolonged;

II.A.4.l) **comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows;**

II.A.4.m) **be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**

II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**

II.A.4.n).(1) **all applications for ACGME accreditation of new programs;**

II.A.4.n).(2) **changes in fellow complement;**

II.A.4.n).(3) **major changes in program structure or length of training;**

II.A.4.n).(4) **progress reports requested by the Review Committee;**

II.A.4.n).(5) **responses to all proposed adverse actions;**

II.A.4.n).(6) **requests for increases or any change to fellow duty hours;**

II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;**

II.A.4.n).(8) **requests for appeal of an adverse action;**

II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,**

II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**

II.A.4.o) **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.4.o).(1) **program citations, and/or**

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

II.A.4.p) ensure supervision of fellows through explicit written descriptions of supervisory lines of responsibility for patient care. Such guidelines must be communicated to all members of the program staff. Fellows must be provided with prompt, reliable systems for communication and interaction with supervisory physicians;

II.A.4.q) ensure that the program's goals and objectives for individual levels of fellow training are consistent with and linked to the program's overall goals and objectives, the educational experiences in the curriculum (both didactic and clinical), and the program requirements;

II.A.4.r) develop criteria to use in the assessment of the extent to which the program's goals and objectives are met; and,

II.A.4.s) prepare, at the conclusion of the fellow's period of training in the program, a detailed, written evaluation of the fellow's performance in relation to the program's learning and performance objectives, and discuss this evaluation with the fellow.

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location.

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of fellows, and

II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology with Special Qualification in Child Neurology**, or possess qualifications acceptable to the Review Committee.**

II.B.2.a) In addition to the program director, the program providing training in child neurology must have at least two child neurology faculty in addition to the adult neurology faculty. These faculty should be fully committed to the residency program who devote sufficient time to the training program to ensure adequate clinical training of the child neurology fellows. Within the section of child neurology, a faculty-to-fellow ratio of at least 1:1 in the total program is required. The program director may be counted as one of the faculty in determining the ratio.

II.B.2.b) There must be enough faculty with diverse interests and skills to make the breadth of teaching and research appropriate to a program meeting these program requirements; to ensure adequate clinical opportunities for fellows; and to provide continued instruction through seminars, conferences, and teaching rounds.

II.B.2.c) Faculty with special expertise in the disciplines related to child neurology, including cognitive development, neuro-ophthalmology, neuromuscular disorders, critical care, clinical neurophysiology, neuroimmunology, infectious disease, neuro-otology, neuroimaging, neurogenetics, neuro-oncology, and pain management must be available to child neurology fellows.

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding;

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.b).(4) participation in national committees or educational organizations.

II.B.5.c) Faculty should encourage and support fellows in scholarly activities.

II.B.5.d) Child neurology training must be conducted in centers where there is active research ongoing both in clinical and basic neuroscience fields.

II.B.5.e) The program must have a sufficient number of qualified staff teaching fellows at each site in the program.

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

During the clinical year of training in child neurology, the fellow must work in the outpatient clinic and on the inpatient service on a regular basis. The number and type of patients must be appropriate. The patient population must be diversified as to age and sex, short-term and long-term neurologic problems, and inpatients and outpatients. Child neurology fellows must have management responsibility for hospitalized patients with neurological disorders. Neurology residents must be involved in the management of patients with neurological disorders who require emergency and intensive care.

II.D.2. Facilities

II.D.2.a) The department or division of child neurology shall be part of the department of pediatrics and/or the department of neurology.

II.D.2.b) There must be adequate inpatient and outpatient facilities, examining areas, conference rooms, and research laboratories. There must be adequate space for faculty offices. Space for study, chart work, and dictation must be available for the fellows. There must be adequate contemporary clinical laboratory facilities that report rapidly the results of necessary laboratory evaluations, including clinical-pathological, electrophysiological, imaging, and other studies needed by neurological services. Adequate chart and record-keeping systems must be in use for patient treatment.

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

The program director must comply with the criteria for fellow eligibility as specified in the Institutional Requirements.

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.

III.B.1. The exact number of fellows that may be appointed to a given program is not specifically designated. However, the number of fellows appointed to the program must be commensurate with the educational resources specifically available to the fellows in terms of faculty, the number and variety of patient diagnoses, and the availability of basic science and research education.

III.C. Fellow Transfers

III.C.1. Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for fellows who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, fellows from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must distribute to fellows and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty annually, in either written or electronic form. These should be reviewed by the fellow at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and,

IV.A.5.	**ACGME Competencies**
	The program must integrate the following ACGME competencies into the curriculum:
IV.A.5.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.5.a).(1)	must have an optimal educational experience consistent with the best medical care that balances patient care and education. Patient care responsibilities must include inpatient, outpatient, and consultation experiences;
IV.A.5.a).(2)	must have at least 12 months (full-time equivalent) of clinical child neurology with management responsibility for patient care. This must include at least four months (full-time equivalent) of outpatient experience in clinical child neurology. The outpatient experience also must include a fellow longitudinal/continuity clinic with attendance by each fellow at least one-half day weekly throughout the program. The fellow may be excused from this clinic when a rotation site is more than one hour travel time from the clinic site;
IV.A.5.a).(3)	must have clinical teaching rounds that are supervised and directed by the faculty of the child neurology department or division. They must occur at least five days per week. The fellow in child neurology must present cases and their diagnostic and therapeutic plans;
IV.A.5.a).(4)	must have instruction and practical experience in obtaining an orderly and detailed history from the patient, in conducting a thorough general and neurological examination, and in organizing and recording data. The training must include the indications for neurodiagnostic tests and their interpretation. The fellow must learn to correlate the information derived from these neurodiagnostic studies with the clinical history and examination in formulating a differential diagnosis and management plan;
IV.A.5.a).(5)	must participate in the evaluation of and decision making for patients with disorders of the nervous system requiring surgical management. This experience must be part of the clinical child neurology experience. The existence of a neurosurgical service with close interaction with the neurology service is essential;

IV.A.5.a).(6) must participate in the management of children and adolescents with psychiatric disorders. They must learn about the psychological aspects of the patient-physician relationship and the importance of personal, social, and cultural factors in disease processes and their clinical expression. Fellows must become familiar with the principles of psychopathology, psychiatric diagnosis and therapy, and the indications for and complications of drugs used in psychiatry. This must be accomplished by at least a one-month experience (full-time equivalent) under the supervision of a qualified child and adolescent psychiatrist;

IV.A.5.a).(7) must participate in the management of pediatric patients with acute neurological disorders in an intensive care unit and an emergency department; and,

IV.A.5.a).(8) have opportunities for increasing responsibility and professional maturity. Early clinical assignments must be based on direct patient responsibility for a limited number of patients. Subsequent assignments must place the fellow in a position of taking increased responsibility for patients and in a liaison relationship with staff and referring physicians. Night call is essential in accomplishing this goal. Adequate faculty supervision is essential throughout the program. Neurological training must include assignment on a consultation service to the medical, surgical, and psychiatric services.

IV.A.5.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.5.b).(1) must learn the basic principles of rehabilitation for neurological disorders, including pediatric neurological disorders;

IV.A.5.b).(2) must receive instruction in the principles of bioethics and in the provision of appropriate and cost-effective evaluation and treatment for children with neurologic disorders;

IV.A.5.b).(3) must receive instruction in appropriate and compassionate methods of terminal palliative care, including adequate pain relief, and psychosocial support and counseling for patients and family members about these issues;

IV.A.5.b).(4) must learn the basic sciences on which clinical child neurology is founded, including neuroanatomy, neural and behavioral development, neuropathology,

neurophysiology, neuroimaging, neuropsychology, neurochemistry, neuropharmacology, molecular biology, genetics, immunology, and epidemiology and statistics. Concentrated training in one or more of these areas, accomplished with a full-time equivalent experience of at least two months total, is required for each fellow. Specific goals and objectives must be developed for this experience;

IV.A.5.b).(5) may have elective time assignments that differ to accommodate individual fellow interests and previous training. Elective time should be a minimum of three months;

IV.A.5.b).(6) must regularly attend seminars and conferences in the following disciplines: neuropathology, clinical neurophysiology, neuroradiology, neuro-ophthalmology, cognitive development, neuromuscular disease, epilepsy, movement disorders, critical care, neuroimmunology, infectious disease, neuro-otology, neuroimaging, neurogenetics, neuro-oncology, pain management, and general and child neurology. There must be gross and microscopic pathology conferences and clinical pathological conferences. The fellow must have increasing responsibility for the planning and supervision of the conferences; and,

IV.A.5.b).(7) must learn about major developments in both the basic and clinical sciences relating to child neurology. Fellows must attend periodic seminars, journal clubs, lectures, didactic courses, and meetings of local and national neurological societies.

IV.A.5.c) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;

IV.A.5.c).(2) set learning and improvement goals;

IV.A.5.c).(3) identify and perform appropriate learning activities;

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with

the goal of practice improvement;

IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;**

IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**

IV.A.5.c).(7) **use information technology to optimize learning; and,**

IV.A.5.c).(8) **participate in the education of patients, families, students, fellows and other health professionals.**

IV.A.5.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. Fellows are expected to:

IV.A.5.d).(1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**

IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;**

IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;**

IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals; and,**

IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable.**

IV.A.5.e) **Professionalism**

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Fellows are expected to demonstrate:

IV.A.5.e).(1) **compassion, integrity, and respect for others;**

IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;**

IV.A.5.e).(3) **respect for patient privacy and autonomy;**

IV.A.5.e).(4) **accountability to patients, society and the profession;**

and,

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.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. Fellows are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.

IV.B. Fellows' Scholarly Activities

IV.B.1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. Fellows should participate in scholarly activity.

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in 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 during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**

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);**

V.A.1.b).(3) **document progressive fellow performance improvement appropriate to educational level; and,**

V.A.1.b).(4) **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.1.d) Plans to correct any deficiencies must be discussed. Each fellow must be an active participant in formulating plans for his or her development. Evaluation data should be used to advise the fellow and to make decisions regarding the progression in the fellow's level of responsibility.

V.A.1.e) A written evaluation of the fellow's attainment of objectives specific to the rotation must be made after each rotation and reviewed with the fellow so that areas of weakness and strength can be communicated to the fellow. This evaluation must incorporate evaluations obtained from faculty in the department of neurology during the fellow's rotation on the adult clinical service and flexible year experiences, together with evaluations obtained from other faculty in the department or division of child neurology.

V.A.1.f) A written record of the contents of the semiannual review session must be prepared and filed in the fellow's permanent record. The written record of the evaluation and the review must be signed by the fellow. The fellow must have the opportunity to append a written response to the written record of the evaluation and review.

V.A.1.g) Each fellow's permanent record must include the written evaluations completed for each defined educational experience,

the written records from the semiannual reviews, results of formal assessments, and the fellow's final evaluation. Written descriptions of any deficiencies and problem areas, plans for correcting the deficiencies, disciplinary actions, and commendations, where appropriate, should be included.

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 the final period of 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.B.3. This evaluation must include at least annual written confidential evaluations by the fellows.

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;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,

V.C.1.d) program quality. Specifically:

V.C.1.d).(1) Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

V.C.1.d).(2) **The program must use the results of fellows' assessments of the program together with other program evaluation results to improve the program.**

V.C.1.d).(3) Evaluations of fellows' attainment of the program's learning and performance objectives must be used as the basis for program evaluation. Comparisons of these data against the program's own criteria, performance criteria set by the Review Committee, and attainment levels of fellows at comparable levels of training should be performed as a primary means of assessing attainment of goals and objectives.

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 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 resident or 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**

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

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

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

VI.D.3.b).(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.b).(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.c) **Oversight – the supervising physician is available to provide review of procedures/encounters 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) **Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or 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.5.a).(1) **In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.**

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.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.

The Review Committee for Neurology will not consider requests for exceptions to the 80-hour limit to the fellows' work week.

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.2.c) **PGY-1 residents are not permitted to moonlight.**

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**

VI.G.4.a) **Duty periods of PGY-1 residents must not exceed 16 hours in duration.**

VI.G.4.b) **Duty periods of PGY-2 residents and above 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.b).(1) **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).(2) **Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**

VI.G.4.b).(3) **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.b).(3).(a) **Under those circumstances, the fellow must:**

VI.G.4.b).(3).(a).(i) **appropriately hand over the care of all other patients to the team responsible for their continuing care; and,**

VI.G.4.b).(3).(a).(ii) **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.b).(3).(b) **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) **PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.**

VI.G.5.b) **Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.**

R1 fellows are considered to be at the intermediate level.

VI.G.5.c) **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.**

R2 and R3 fellows are considered to be in the final years of education.

VI.G.5.c).(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 residents in their final years of education 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.c).(1).(a) **Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.**

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

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.6.a) Fellows should not have more than two consecutive weeks of night call, and no more than six weeks of night call per year.

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

PGY-2 residents and above 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".

VII. Innovative Projects

Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to fellows for the duration of such a project.

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