

Frequently Asked Questions: Neurological Surgery
Review Committee for Neurological Surgery
ACGME

Question	Answer
Program Director	
<p>What type of change in the program's structure is considered major and requires RRC approval?</p> <p><i>[Program Requirements: II.A.4.n).(2)-(3); II.A.4.n).(6); II.A.4.p)]</i></p>	<p>Major changes in program structure that require approval by the RRC include: changes in participating sites; anticipated changes in resident complement (unless a temporary increase is due to a medical leave or remediation of three months or less); the presence of other programs (such as a fellowship program); new elective rotations; or a change in block rotations that significantly alters resident experience. Program directors should contact the executive director of the RRC at the ACGME if they are unsure whether RRC approval is needed. All such requests must be approved by the Review Committee at a regularly scheduled RRC meeting. Consequently, programs are advised to remain aware of the agenda closing dates. These are published on the RRC website at least one year in advance of each meeting.</p>
<p>An immediate RRC decision is needed. Why is it not possible to receive an immediate review and response?</p>	<p>The Review Committee meets twice annually. As such, expedited review of interim requests can be disruptive to its work. Timelines for the submission of program requests for each committee date are listed under "Agenda Closing Dates" on the RRC webpage. http://www.acgme.org/acWebsite/navPages/nav_160.asp</p> <p>The committee will make an exception to review a request to appoint a resident who has been displaced due to a program closing.</p>
Resident Appointments	
<p>How must a request for a change in resident complement be submitted?</p> <p><i>[Program Requirement: II.A.4.n).(2)]</i></p>	<p>All requests for changes in resident complement, whether permanent or temporary, must be made through ADS. Note that ACGME staff will not receive the resident complement request until the DIO has approved the request. Requests must be submitted to and approved by the Review Committee prior to accepting the resident(s) into the program. Except as noted below, requests will only be reviewed at a regularly scheduled RRC meeting.</p> <p>Additional information about requesting a change in resident complement for neurological surgery programs is posted on the ACGME website at http://www.acgme.org/acWebsite/RRC_160/160_resComp.doc</p>
<p>If accepting a transfer resident into the program, what procedures must</p>	<p>Prior to accepting a transferring resident, the program director must receive written verification of the resident's previous educational experiences, case logs, and a statement regarding the</p>

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<p>be followed?</p> <p><i>[Program Requirement: III.C.]</i></p>	<p>performance evaluation of the transferring resident. This information must be maintained in the resident's file. The Review Committee does not need to be notified of the acceptance of a transfer resident, provided there is an open position for the resident and the appointment does not exceed the total approved resident complement. A newly appointed transfer resident must be entered into the ACGME Accreditation Data System (ADS) before they can be added to the ACGME case log system of the receiving program. The American Board of Neurological Surgery may have requirements governing resident transfers. Accordingly, it is recommended that plans to accept a resident from another program be discussed with the Board prior to appointment of the resident.</p>
<p>A resident is in need of transferring from another program that may close. All positions in our program are filled. Can we accept the resident?</p> <p><i>[Program Requirement: III.C.]</i></p>	<p>A request for a temporary increase in resident complement must be submitted following the procedures outlined above. However, the Committee will expedite review of requests to appoint a resident who has been displaced due to a program closing.</p>
Program Curriculum	
<p>Can a resident participate in a rotation at a facility abroad in order to obtain unique operative and educational experiences? Can operative cases completed during these rotations be included in the ACGME case log system?</p> <p><i>[Program Requirement: Int.C.8.]</i></p>	<p>If the program wishes to incorporate an elective international rotation that will be made available to residents in the program on an ongoing basis, it should be (1) made known to residents prior to appointment, (2) described in the program narrative section of the PIF, and (3) approved by the American Board of Neurological Surgery and the Review Committee <u>before</u> the rotation starts. (Please communicate with the Board regarding this requirement.)</p> <p>Resident cases completed during international rotations <u>cannot</u> be entered into the case log system.</p>
<p>What are the Review Committee's expectations for entering cases into the ACGME case log system?</p> <p><i>[Program Requirement: II.A.4.q)-r);</i></p>	<p>Resident cases must be entered into the ACGME case log system. Only those cases in which a resident had a significant surgical role should be entered. If more than one resident participated in the case, each resident should enter only those CPT codes that represent their actual participation. Each resident may claim for credit only one CPT code per case. If two residents participated in the same case, each resident cannot claim the same CPT code for credit for that case. Programs must monitor the accurate and timely</p>

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V.A.1.b).(4)]	entry of cases into the system. As part of monitoring resident progress towards developing competence in surgical skills, cumulative operative experience reports should be generated from the case log system and reviewed with each resident as part of their semiannual review.
<p>What are the required numbers for institutional operative cases?</p> <p><i>[Program Requirement II.D.9; II.D.11]</i></p>	<p>The institution should have a total of 500 major neurological surgery procedures available per year per finishing resident. In addition, each participating site should have at least 100 major neurological surgery procedures per year. Major surgical procedures are defined as index cases. The minimum number of cases for each index case category that must be available per resident in the program has been established by the Review Committee and is based on the number of institutional cases reported by programs surveyed in the past four years. These numbers are used to evaluate the resources of new programs applying for accreditation, as well as requests for changes in resident complement and participating sites.</p> <p>http://www.acgme.org/acWebsite/RRC_160/160_Neurological_Surgery_Guidelines_for_Case_Numbers.pdf</p>
<p>What are the Review Committee's expectations regarding the participation of residents in the pre- and post- operative continuum of care?</p> <p><i>[Program Requirement: V.A.5.a).(12)]</i></p>	<p>Residents are expected to have sufficient experience following the same patients through all phases of care to demonstrate competence in providing a continuum of care, including preoperative, operative and post-operative care. Each program should describe in the narrative section of the PIF how residents are provided with continuity of care experiences. How this experience is structured will be determined by each program.</p>
<p>Can residents participate in additional months of research and advanced education?</p> <p><i>[Program Requirement: Int.C.1]</i></p>	<p>Program requirements define the minimum level of education. Accordingly, so long as all program requirements are met, residents may participate in more than 12 months of research or advanced education.</p>
Duty Hours	
<p>Are there any situations in which residents may be supervised by non-neurosurgical licensed</p>	<p>In certain learning environments such as the neuro-intensive care unit (ICU), a properly credentialed and privileged critical care physician may supervise a resident. In the operating room environment, a properly credentialed and privileged anesthesiologist may supervise</p>

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<p>independent practitioners?</p> <p><i>[Program Requirement: VI.D.1.]</i></p>	<p>certain procedures, such as central line placement, arterial line placement, and endotracheal intubations.</p>
<p>What must a PGY-1 resident demonstrate in order to progress to being supervised indirectly with direct supervision available?</p> <p><i>[Program Requirement: VI.D.5.a).(1)]</i></p>	<p>Programs must document that residents have had structured education in the procedures listed below equivalent to that available through the boot camps offered by the Society of Neurological Surgeons. Program directors must ensure that a resident has demonstrated competence in each listed procedure and patient management competency to the satisfaction of the supervising faculty member before he or she can be supervised indirectly with direct supervision available for that procedure or patient management competency.</p> <p>Approved procedures and patient management competencies that PGY-1 residents can perform under indirect supervision with direct supervision available are:</p> <p><u>Patient Management Competencies</u></p> <ol style="list-style-type: none"> 1. evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests 2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests 3. evaluation and management of post-operative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medications, fluid therapy, and nutrition therapy 4. transfer of patients between hospital units or hospitals 5. discharge of patients from hospital 6. interpretation of laboratory results <p><u>Procedural Competencies</u></p> <ol style="list-style-type: none"> 1. carry-out of basic venous access procedures, including establishing intravenous access 2. placement and removal of nasogastric tubes and Foley catheters 3. arterial puncture for blood gases <p>During the early months of the PGY-1, residents must be educated in, directly observed, and assessed in the following:</p> <p><u>Patient Management Competencies</u></p>

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	<ol style="list-style-type: none"> 1. initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required) 2. evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes 3. evaluation and management of critically-ill patients, either immediately post-operatively or in the ICU, including monitoring, ventilator management, specification of necessary tests, and orders for medications, fluid therapy, and enteral/parenteral nutrition therapy 4. management of patients in cardiac arrest (ACLS required) <p><u>Procedural Competencies</u></p> <ol style="list-style-type: none"> 1. carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation 2. repair of surgical incisions of the skin and soft tissues 3. repair of skin and soft tissue lacerations 4. excision of lesions of the skin and subcutaneous tissues 5. tube thoracostomy 6. paracentesis 7. joint aspiration 8. advanced airway management <ol style="list-style-type: none"> a. endotracheal intubation b. tracheostomy
<p>What is an appropriate patient load for residents?</p> <p><i>[Program Requirement: VI.E]</i></p>	<p>The program director must make an assessment of the learning environment with input from faculty members and residents. Minimum patient loads should usually be five on the general inpatient unit and four while on clinical neurological surgery services. However, there may be situations in which lower patient loads may be acceptable. Programs will need to justify lower patient loads with evidence such as severity of illness indicators or other factors.</p>
<p>What would an appropriate patient load be for a chief resident, or a resident in the final transition-to-practice year?</p> <p><i>[Program Requirement: VI.E]</i></p>	<p>The program director must make an assessment of the learning environment with input from faculty members and residents. Residents in the final year of education generally take on more patient care responsibilities than earlier in residency education. Minimum patient loads should usually be 10 on the general inpatient unit, and three in the intensive care unit.</p>

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<p><i>Who should be included in the interprofessional teams?</i></p> <p><i>[Program Requirement: VI.F.]</i></p>	<p>Advanced practice providers, audiologists, certified registered nurse anesthetists (CRNAs), child-life specialists, nurses, nutritionists, operating room technicians, pharmacists, physical and occupational therapists, physician assistants, psychologists, radiology technicians, respiratory therapists, social workers, and speech and language pathologists are examples of professional personnel who may be part of the interprofessional teams.</p>
<p>Must every interprofessional team include representation from every professional listed above?</p> <p><i>[Program Requirement: VI.F.]</i></p>	<p>No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee's intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case/care environment.</p>
<p>What roles must residents have in the interprofessional health care team?</p> <p><i>[Program Requirement: VI.F.]</i></p>	<p>As members of the interprofessional health care team, residents must have key roles in diagnostic work-up, operative procedures, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty members and referring sources.</p>
<p>Why are PGY-2 residents defined as intermediate-level residents?</p> <p><i>[Program Requirement: VI.G.5.b)]</i></p>	<p>All residents enter the program as interns having participated in the Neurological Surgery Boot Camp offered through the Society of Neurological Surgeons. Boot camp provides intense training and assessment of fundamental professionalism, communication, and procedural skills, which are directly observed and evaluated during the early months of the PGY-1. By the time residents enter the PGY-2, they have had considerable experience as members of operative teams and in other teams providing patient care. Because neurological surgery programs are relatively small (one to three residents per PGY level), residents will assume continuously increasing progressive responsibilities. By the PGY-2, these residents are often the most senior residents on certain rotations (i.e., a pediatric service in a children's hospital), and in such a role will function as a leader of the team with the attendings. Although neurological surgery programs are long, PGY-2 residents are as prepared to assume the responsibilities of an intermediate resident as are PGY-2 residents in shorter programs in primary care specialties, such as internal medicine or pediatrics. The additional years of neurological surgery education are needed to refine operative skills, not to develop advanced skills in the other competency domains.</p>
<p>What responsibilities should residents at the PGY-3 level or beyond have in order to prepare them to enter</p>	<p>It is very important that senior and chief neurological surgical residents have semi-continuous responsibility for groups of patients as part of a team led by an attending surgeon. This type of experience is very similar to the conditions of independent practice which residents at this level will enter soon after graduating, and often occurs in the context of 'home call', where the</p>

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<p>unsupervised practice of medicine?</p> <p><i>[Program Requirement: VI.G.5.c)]</i></p>	<p>requirement for a 10-hour respite does not apply. Whether during at-home call or during scheduled duty periods, it is important that these residents have this kind of experience.</p>
<p>Why are residents at the PGY-3 level and beyond considered to be in the final years of education?</p> <p><i>[Program Requirement: VI.G.5.c)]</i></p>	<p>Neurological surgery programs are designed such that excellent educational experiences occur when residents are given the responsibility to lead a team of more junior residents under the supervision of an attending whose practice is focused in a specific clinical area. Because most neurological surgery programs have relatively few residents, it is desirable that a resident at the PGY-3 level or beyond assume such a leadership role. For example, if a PGY-3 resident is the senior-most resident working on a dedicated spine service and the operative case runs until 10:30 p.m., the resident should be able to return to lead the service hospital rounds at 6:00 a.m. the following morning. The educational value of this type of leadership experience is important for a resident's maturation as a clinician and surgeon. NOTE: such experiences must occur in the context of the 80-hour limit and the one-day-off in seven requirements.</p>
<p>What are some specific examples of circumstances when residents at the PGY-3 level or beyond may stay on duty or return to the hospital with fewer than eight hours free of duty?</p> <p><i>[Program Requirement: VI.G.5.c).(1)]</i></p>	<ol style="list-style-type: none"> 1. to optimize continuity of care for patients, such as a: <ol style="list-style-type: none"> a) patient on whom the resident operated/intervened that day and needs to return to the Operating Room (OR) b) patient on whom the resident operated/intervened that day and who requires transfer to the Intensive Care Unit (ICU) from a lower level of care; c) patient on whom the resident operated/intervened that day in the ICU and who is critically unstable; d) patient on whom the resident operated/intervened during that hospital admission and who needs to return to the OR due to a matter related to a procedure previously performed by the resident; e) patient and/or patient's family with whom the resident needs to discuss the limitations of treatment/DNR/DNI orders for a critically ill patient on whom the resident operated 2. to participate in a declared emergency or disaster when residents are included in the disaster plan 3. to perform important, low-frequency procedures necessary for competence in the field 4. when functioning in a leadership role as the senior-most resident on a team of other residents and attendings where the resident's presence at rounds or another important surgical procedure is necessary for continuity of team leadership (most often in the context of a "home call" arrangement.)

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Other	
How do I get answers to other questions?	<p>Updates and clarifications to ACGME policies and procedures can be found in the semiannual RRC newsletter. These are announced in the ACGME e-Communication as they are published. Current and past newsletters are available on the RRC website under the heading “Updates from the RRC” http://www.acgme.org/acWebsite/navPages/nav_160.asp</p> <p>In addition, you may call or email a member of the RRC staff. Contact information is available at: http://www.acgme.org/acWebsite/RRC_160/NeuroSurgeryStaffContactsbySubject.doc</p>

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