

# ACGME Program Requirements for Graduate Medical Education in Neurology

*Common Program Requirements are in BOLD*

*Effective: July 1, 2007*

## Introduction

### Int.A. Definition

Neurology is a medical specialty concerned with the diagnosis and treatment of all categories of disease involving the central, peripheral, and autonomic nervous systems, including their coverings, blood vessels, and all effector tissue, such as muscle. For these diseases, the neurologist is often the principal care physician, and may render all levels of care commensurate with his or her training.

### Int.B. Duration and Scope of Training

A complete neurology residency requires 48 months of training. Approved residencies in neurology must provide at least 36 months of this education. The program meeting these requirements may be of two types:

Int.B.1. Those that provide four years of residency training, the first year of which training, accredited by the Accreditation Council of Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada must include a broad clinical experience in general internal medicine. This year must include at least one of the following:

Int.B.1.a) eight months in internal medicine with primary responsibility in patient care, or

Int.B.1.b) six months in internal medicine with primary responsibility in patient care and a period of at least two months time comprising one or more months of pediatrics, emergency medicine, internal medicine, or family medicine. Residents must spend no more than two months in neurology during this year.

Int.B.2. Those that provide three years of residency training but accept only residents who have had an initial first year of graduate training in the United States or Canada. This first year must meet the minimum requirements as noted in B.1. above.

### Int.C. Goals and Objectives for Residency Education

The purpose of the training program is to prepare the physician for the independent practice of clinical 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.D. Program Design

- Int.D.1 All educational components of a residency program must be related to program goals. The program design and structure must be approved by the Review Committee for Neurology as part of the regular review process.
- Int.D.2. Programs that cosponsor combined training in neurology and another specialty must inform the Review Committee. Residents in such training must be informed of the necessary requirements of the specialty boards in question.

## 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 resident 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 residents;**
- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, 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 resident 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 residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
- I.B.2.a) Assignments at participating sites must be of sufficient length to ensure a quality educational experience, and should provide**

sufficient opportunity for continuity of care. Although the number of participating sites may vary with the various specialties' needs, all participating sites must demonstrate the ability to promote the program goals as well as educational and peer activities. Exceptions must be justified and approved in advance by the Review Committee.

- I.B.2.b) Participation by any site providing six months or more of training in a program of three or more years must be approved by the Review Committee.

## **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 and faculty are responsible for the general administration of the program and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for the program director and faculty are essential to maintaining such an environment.
- II.A.1.b) Notification of a change in the program directorship must include a copy of the new director's curriculum vitae, including details of his or her experience and qualifications in graduate medical education.
- 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, 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 residents 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 resident 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 resident 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 resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
- II.A.4.g) provide each resident 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 residents, 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 resident 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 residents and faculty;**
  - II.A.4.j).(2) monitor resident 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 residents, disciplinary action, and supervision of residents;
- 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 resident 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 resident 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) report changes in administrative structure, such as a change in the hierarchical status of the program and/or department within the institution;
- II.A.4.q) monitor residents' well-being. Program directors must monitor stress and impairment and ensure that appropriate confidential help is available.
- II.A.4.r) ensure that the program has an equitable leave and vacation policy for residents, in accordance with overall institutional policy;
- II.A.4.s) with assistance from the faculty, is responsible for developing and implementing the academic and clinical program of resident education by:
  - II.A.4.s).(1) preparing and implementing a comprehensive, well-organized, and effective curriculum, both academic and clinical, which includes the presentation of core specialty knowledge supplemented by the addition of current information, and
  - II.A.4.s).(2) providing residents with direct experience in progressive responsibility for patient management.
- II.A.4.t) ensure that a formal curriculum exists for bioethics, cost-effective care, and palliative care, including adequate pain relief as well as psychosocial support and counseling for patients and families. If formal lectures are not provided by the site, they must be provided by the program.
- II.A.4.t).(1) The program director should keep in mind that resident assignments need not be identical for each resident, and elective time should accommodate an individual resident's interests and previous training. Elective time should be a minimum of three months.

**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 residents 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 residents, and**

- II.B.1.b) administer and maintain an educational environment conducive to educating residents 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, or possess qualifications acceptable to the Review Committee.**
- II.B.2.a) The faculty must include a program director, a child neurologist, and a minimum of four neurology faculty who provide clinical service and teaching and who devote sufficient time to the program to ensure basic and clinical education for residents. A faculty to resident ratio of 1:1 must be maintained. The program director may be counted as one of the faculty in determining the ratio. All faculty teaching in the subspecialties of neurology should have certification in neurology and a subspecialty.
- II.B.2.a).(1) Faculty must have diverse interests and skills in an appropriate range of teaching and research. Faculty must ensure adequate clinical opportunities for residents and provide continued instruction through seminars, conferences, and teaching rounds.
- II.B.2.a).(2) Faculty with special expertise in all the disciplines related to neurology, including neuro-ophthalmology, neuromuscular disease, cerebrovascular disease, epilepsy, movement disorders, critical care, clinical neurophysiology, behavioral neurology, neuroimmunology, infectious disease, neuro-otology, neuroimaging, neuro-oncology, pain management, neurogenetics, child neurology, the neurology of aging, sleep disorders, and psychiatry must be available on a regular basis to neurology residents.
- II.B.2.b) The faculty must demonstrate competence in both clinical care and teaching abilities.
- II.B.2.c) The teaching staff must periodically evaluate the use of the resources available to the program, the contribution of each site participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.
- 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 residents in scholarly activities.**
- II.B.5.d) Faculty must demonstrate commitment to their own continuing medical education by participating in scholarly activities.**

**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 resident education, as defined in the specialty program requirements.**

**II.D.1. Patient Population**

It is the program director's responsibility to ensure that the number of patients is appropriate. Patients must be from a range of age groups, of both sexes, from in-patient and out-patient settings, and represent the full range of short-term and long-term neurological problems.

**II.D.2. Facilities**

There must be adequate inpatient and outpatient facilities, examining areas, conference rooms, and research laboratories. There must also be adequate space for faculty offices. Space for study, chart work, and dictation must be available for the residents. 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**

**Residents 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. Resident Appointments**

### **III.A. Eligibility Criteria**

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

### **III.B. Number of Residents**

**The program director may not appoint more residents 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 residents appointed to the program.**

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

III.B.2. The program director will establish the maximum number of resident positions that can be supported by the educational resources for the program, subject to the approval of the Review Committee. The program director must report any increase or decrease in the resident complement (at the beginning of the academic year), and any resulting change in the structure of the program, to the Review Committee. A permanent change in resident complement must be approved in advance by the Review Committee. Programs that fail to recruit any new residents for two consecutive years may be subject to adverse action because of inactivity in the educational program.

### **III.C. Resident Transfers**

**III.C.1. Before accepting a resident 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 resident.**

**III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents 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, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' 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 residents and faculty annually;**

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

**IV.A.3. Regularly scheduled didactic sessions;**

**IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents 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**

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

**IV.A.5.a).(1) will have a combination of patient care, teaching, and research in their training program. Patient care responsibilities must ensure a balance between patient care and education that achieves for the trainee an optimal educational experience consistent with the best medical care. Patient care responsibilities must include inpatient, outpatient, and consultation experiences;**

- IV.A.5.a).(2) must have six months of inpatient experience in adult neurology; residents must also have outpatient experience which must include a resident longitudinal/continuity clinic with attendance by each resident one half day weekly throughout the program. The continuity clinic may be counted toward the required six months of outpatient experience, assuming that one half day clinic assignment per week for three years is equal to 3.6 months. All clinics may be credited toward the six month outpatient requirement. Residents may be excused from this clinic when a rotation site is more than one hour's travel time from the clinic site;
- IV.A.5.a).(3) must have experience with neurological disorders in children under the supervision of a child neurologist with ABPN certification or suitable equivalent qualifications. This must consist of a minimum of three months FTE in clinical child neurology with management responsibility;
- IV.A.5.a).(4) must have clinical teaching rounds supervised by faculty. These rounds must occur at least five days per week. Residents must present cases and their diagnostic and therapeutic plans;
- IV.A.5.a).(5) 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 and limitations of clinical neurodiagnostic tests and their interpretation. Residents 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).(6) must participate in the evaluation of and decision-making for patients with disorders of the nervous system requiring surgical management. The existence of a neurosurgical service with close interaction with the neurology service is essential;
- IV.A.5.a).(7) must participate in the management of patients with psychiatric disorders. The program must include at least one month full-time equivalent experience in clinical psychiatry, including cognition and behavior. The experience should take place under the supervision of a psychiatrist certified by the American Board of Psychiatry and Neurology, or who possesses qualifications acceptable to the Review Committee. 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. Residents must learn the principles of psychopathology, psychiatric diagnosis, and therapy and the indications for and complications of drugs used in psychiatry;

- IV.A.5.a).(8) must learn the basic principles of rehabilitation for neurological disorders;
- IV.A.5.a).(9) must participate in the management of patients with acute neurological disorders in an intensive care unit and an emergency department;
- IV.A.5.a).(10) must have experience in neuroimaging that ensures a familiarity with and knowledge of all relevant diagnostic and interventional studies necessary to correlate findings with other clinical information for the care of patients. At a minimum this must include magnetic resonance imaging, computerized tomography and neurosonology;
- IV.A.5.a).(11) must receive instruction in appropriate and compassionate methods of end-of-life palliative care, including adequate pain relief and psychosocial support and counseling for patients and family members about these issues; and,
- IV.A.5.a).(12) must received instruction on recognition and management of physical, sexual, and emotional abuse.
- IV.A.5.a).(13) must have opportunities for increasing responsibility and professional maturation. Early clinical assignments must be based on direct patient responsibility for a limited number of patients. Subsequent assignments must place residents in a position of taking increased responsibility for patients. Night call is essential in accomplishing these goals. Adequate faculty supervision is essential throughout the program. Neurological training must include assignment on a consultation service to the medical, surgical, obstetric and gynecologic, pediatric, rehabilitation medicine, and psychiatry services.
- IV.A.5.a).(14) must have management responsibility for patients with neurological disorders. Neurology residents must be involved in the management of patients with neurological disorders who require emergency and intensive care.

#### **IV.A.5.b)**

#### **Medical Knowledge**

**Residents 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. Residents:**

- IV.A.5.b).(1) must regularly attend seminars and conferences in the following disciplines: neuropathology, neuroradiology, neuro-ophthalmology, neuromuscular disease, cerebrovascular disease, epilepsy, movement disorders, critical care, clinical neurophysiology, behavioral neurology, neuroimmunology, infectious disease, neuro-otology, neuroimaging, neuro-oncology, sleep disorders, pain management, neurogenetics, rehabilitation, child neurology, the neurology of aging, and general neurology. There must be gross and microscopic pathology conferences and clinical pathological conferences. Residents must have increasing responsibility for the planning and supervision of the conferences. Residents must learn about major developments in both the basic and clinical sciences relating to neurology. Residents must attend periodic seminars, journal clubs, lectures in basic science, didactic courses, and meetings of local and national neurological societies;
- IV.A.5.b).(2) must learn the basic sciences on which clinical neurology is founded, including neuroanatomy, neuropathology, neurophysiology, neuroimaging, neuropsychology, neural development, neurochemistry, neuropharmacology, molecular biology, genetics, immunology, epidemiology, and statistics. The didactic curriculum developed to satisfy this requirement must cover basic science and must be organized and complete; and,
- IV.A.5.b).(3) must receive instruction in the principles of bioethics and in the provision of appropriate and cost-effective evaluation and treatment for patients with neurological disorders.

**IV.A.5.c)**

**Practice-based Learning and Improvement**

**Residents 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. Residents 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, residents and other health professionals.
- IV.A.5.c).(9) teach other residents, medical students, nurses, and other health care personnel, formally and informally.

#### **IV.A.5.d)**

#### **Interpersonal and Communication Skills**

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

**Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents 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**

**Residents 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. Residents 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. Residents' Scholarly Activities**

- IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
- IV.B.2. Residents should participate in scholarly activity.
- IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

## **V. Evaluation**

### **V.A. Resident Evaluation**

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

**V.A.1.a)** The faculty must evaluate resident 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 resident performance improvement appropriate to educational level; and,

**V.A.1.b).(4)** provide each resident with documented semiannual evaluation of performance with feedback.

**V.A.1.c)** The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

**V.A.1.d)** Examples of formative evaluation tools are the resident in-service examination (RITE) and objective skills assessment tools.

#### **V.A.2. Summative Evaluation**

**The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:**

**V.A.2.a)** document the resident's performance during the final period of education, and

**V.A.2.b)** verify that the resident 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 residents.**

**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) resident 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) Residents 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 residents' assessments of the program together with other program evaluation results to improve the program.**

**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.**

**V.C.3. A program will be judged deficient by the Review Committee if, during the most recent five-year period, fewer than 60% of its graduates who take the examinations pass either the written (Part I) or oral (Part II) examination.**

**VI. Resident Duty Hours in the Learning and Working Environment**

**VI.A. Principles**

**VI.A.1. The program must be committed to and be responsible for**

**promoting patient safety and resident well-being and to providing a supportive educational environment.**

- VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
- VI.A.3. Didactic and clinical education must have priority in the allotment of residents' time and energy.**
- VI.A.4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

**VI.B. Supervision of Residents**

**The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.**

- VI.B.1. There must be explicit and current written supervisory lines of supervision circulated to all members of the program staff.**

**VI.C. Fatigue**

**Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.**

**VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)**

**Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.**

- VI.D.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- VI.D.2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
- VI.D.3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

**VI.E. On-call Activities**

- VI.E.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.**

- VI.E.1.a) Residents must provide on-call duty in the hospital.
- VI.E.1.b) In-house call is required to provide the experience of primary coverage for already-hospitalized inpatients and initial evaluation and treatment of urgent admissions to neurology or consultation patients. In most instances, practicality and optimal quality of care will necessitate that residents sleep in the hospital when providing such care. Under some conditions, it may be permissible for this call to be taken from home. If at-home call causes frequent interruption or significant deprivation of sleep, it should be considered equivalent to in-house call with respect to duty hours; that is, the entire night must be included in the calculation of total on-duty hours per week, and the 10 hour rest period and the 24+6 rule must be triggered. It will be the program director's responsibility in consultation with residents and other faculty to establish rules to ensure that the spirit of the duty hours is respected, regardless of the nature of call.
- VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
- VI.E.3. No new patients may be accepted after 24 hours of continuous duty.**
- VI.E.3.a) A new patient is defined as any patient for whom the resident has not previously provided care.
- VI.E.4. At-home call (or pager call)**
- VI.E.4.a) **The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.**
- VI.E.4.b) **Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
- VI.E.4.c) **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**
- VI.F. Moonlighting**
- VI.F.1. **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

**VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

**VI.G. Duty Hours 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. 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.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.3. The Review Committee for Neurology will not consider requests for exceptions to the limit to 80 hours per week, averaged over a four week period.**

**VII. Experimentation and Innovation**

**Requests for experimentation or 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 Experimentation or 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 residents for the duration of such a project.**

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