



**Accreditation Council for
Graduate Medical Education**

ACGME Program Requirements for Graduate Medical Education in Child Neurology

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Common Program Requirements are in BOLD

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

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 physician to assume personal responsibility for the care of individual patients. For the resident, 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 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 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. Child neurology involves the diagnosis, evaluation, and management of, and the advocacy for, infants, children, and adolescents with either primary or secondary disorders of peripheral and central nervous systems.

Int.C. The educational program in child neurology must be 36 months in length. ^{(Core)*}

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.
^(Core)

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. ^(Core)

I.A.1. The sponsoring institution must also sponsor Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs in

pediatrics and neurology. ^(Core)

I.A.2. The division of child neurology must be part of the department of pediatrics and/or the department of neurology. ^(Core)

I.A.3. At a minimum, the sponsoring institution must provide at least 20 percent full-time equivalent (FTE) time and funding support for the program director with an additional one percent per resident. ^(Core)

I.A.4. The sponsoring institution must provide financial support for a program coordinator to assist the program director in the administration of the program. ^(Core)

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. ^(Detail)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; ^(Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; ^(Detail)

I.B.1.c) specify the duration and content of the educational experience; and, ^(Detail)

I.B.1.d) state the policies and procedures that will govern resident education during the assignment. ^(Detail)

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). ^(Core)

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 GMC must approve a change in program director. ^(Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. ^(Core)

- 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. ^(Detail)
- 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; ^(Core)
- II.A.3.b)** current certification in the subspecialty by the American Board of Psychiatry and Neurology, or subspecialty qualifications that are acceptable to the Review Committee; and, ^(Core)
- II.A.3.c)** current medical licensure and appropriate medical staff appointment. ^(Core)
- 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. ^(Core)
- 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; ^(Core)
- II.A.4.b)** approve a local director at each participating site who is accountable for resident education; ^(Core)
- II.A.4.c)** approve the selection of program faculty as appropriate; ^(Core)
- II.A.4.d)** evaluate program faculty; ^(Core)
- II.A.4.e)** approve the continued participation of program faculty based on evaluation; ^(Core)
- II.A.4.f)** monitor resident supervision at all participating sites; ^(Core)
- II.A.4.g)** prepare and submit all information required and requested by the ACGME; ^(Core)
- II.A.4.g).(1)** This includes but is not limited to the program application forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)
- 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; ^(Detail)

- II.A.4.i)** provide verification of residency education for all residents, including those who leave the program prior to completion;
(Detail)
- 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,
(Core)
- and, to that end, must:
- II.A.4.j).(1)** distribute these policies and procedures to the residents and faculty;
(Detail)
- II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
(Core)
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
(Detail)
- 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.
(Detail)
- 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;
(Detail)
- 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;
(Detail)
- 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;
(Detail)
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including;
(Core)
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs;
(Detail)
- II.A.4.n).(2)** changes in resident complement;
(Detail)
- II.A.4.n).(3)** major changes in program structure or length of training;
(Detail)

- II.A.4.n).(4) **progress reports requested by the Review Committee;**
(Detail)
- II.A.4.n).(5) **responses to all proposed adverse actions;** (Detail)
- II.A.4.n).(6) **requests for increases or any change to resident duty hours;** (Detail)
- II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;** (Detail)
- II.A.4.n).(8) **requests for appeal of an adverse action;** (Detail)
- II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,** (Detail)
- II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.** (Detail)
- II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)
 - II.A.4.o).(1) **program citations, and/or,** (Detail)
 - II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)
- II.A.4.p) ensure supervision of residents through explicit written descriptions of supervisory lines of responsibility for patient care;
(Core)
 - II.A.4.p).(1) Such guidelines must be communicated to all members of the program staff. (Core)
 - II.A.4.p).(2) Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. (Core)
- II.A.4.q) develop criteria to use in assessing whether the program's goals and objectives are met; (Detail)
- II.A.4.r) monitor resident stress, including mental or emotional conditions inhibiting performance of learning, and drug- or alcohol-related dysfunction; and, (Core)
 - II.A.4.r).(1) Situations that demand excess service or that consistently produce undesirable stress on residents must be recognized and resolved. (Core)

- II.A.4.s) approve the 12 months of adult neurology education. ^(Detail)
- II.A.5. The program director should attend at least one national program director meeting per year. ^(Detail)

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. ^(Core)**

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 ^(Core)**
- II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. ^(Core)**
- II.B.2. The physician faculty must have current certification in the subspecialty by the American Board of Psychiatry and Neurology, or possess qualifications judged acceptable to the Review Committee. ^(Core)**
- II.B.2.a) There must be at least two child neurology faculty members. ^(Core)
- II.B.2.a).(1) In programs with two or more residents, a faculty-to-resident ratio of at least 1:1 must be maintained within the section of child neurology. The program director may be counted as one of the faculty members in determining the ratio. ^(Core)
- II.B.2.b) Faculty members with special expertise in the disciplines related to child neurology, including cognitive development, neuro-ophthalmology, neuromuscular disorders, critical care, clinical neurophysiology, neuroimmunology, infectious disease, neonatal neurology, neuroimaging, neurogenetics, neuro-oncology, pain management, and child and adolescent psychiatry must be available for the education of residents. ^(Detail)
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. ^(Core)**
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. ^(Core)**
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. ^(Core)**

- II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)**
- 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; ^(Detail)**
- II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; ^(Detail)**
- 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, ^(Detail)**
- II.B.5.b).(4) participation in national committees or educational organizations. ^(Detail)**
- II.B.5.c) Faculty should encourage and support residents in scholarly activities. ^(Core)**
- II.B.6. Physician faculty members must participate regularly in conferences in a manner that promotes a spirit of inquiry and scholarship, including mentoring residents in scholarly activity. ^(Core)**
- II.B.6.a) While not all members of the faculty must be investigators, the staff as a whole must demonstrate broad involvement in scholarly activity, and child neurology education must be conducted in centers where there is research in the subspecialty. ^(Detail)**
- 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. ^(Core)**
- 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. ^(Core)**
- II.D.1. The number and type of patients must be appropriate to support resident education. ^(Core)**
- II.D.1.a) The patient population must be diversified as to age and sex, short- and long-term neurologic problems, and inpatients and outpatients. ^(Core)**
- II.D.2. Facilities**

II.D.2.a) There must be adequate inpatient and outpatient facilities, examining areas, chart and record-keeping systems for use in patient treatment, conference rooms, and research laboratories. (Core)

II.D.2.b) There must be adequate space for faculty offices. (Core)

II.D.2.c) There must be space for study, chart work, and dictation. (Core)

II.D.2.d) There must be state-of-the-art clinical laboratory facilities that report rapidly the results of necessary laboratory evaluations, including clinical-pathological, electrophysiological, imaging, and other studies needed by neurological services. (Core)

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. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

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

III.A.1. Prerequisite Education

Prior to appointment in the program, residents must have successfully completed one of the following:

III.A.1.a) two years of ACGME-accredited education in pediatrics; or, (Core)

III.A.1.b) one year of ACGME-accredited education in pediatrics and one year of ACGME-accredited education in family medicine or internal medicine; or, (Core)

III.A.1.c) one year of ACGME-accredited education in pediatrics and one year of neuroscience research approved by the program director. (Core)

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the

specialty-specific requirements. ^(Core)

III.B.2. 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. ^(Detail)

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.** ^(Detail)

III.C.2. **A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion.** ^(Detail)

III.D. Appointment of Residents and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty residents, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. ^(Core)

III.D.1. **The program director must report the presence of other learners to the DIO and GMCC in accordance with sponsoring institution guidelines.** ^(Detail)

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 make available to residents and faculty;** ^(Core)

IV.A.2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form;** ^(Core)

IV.A.3. **Regularly scheduled didactic sessions;** ^(Core)

IV.A.3.a) A three-year curriculum should include teaching in the following disciplines: cerebrovascular disease, clinical neurophysiology, cognitive and behavioral development, critical care, epilepsy, ethics, general and child neurology, infectious disease, movement disorders, neurogenetics, neuroimaging, neuroimmunology, neurometabolism, neuromuscular disease, neuro-oncology, neuro-ophthalmology, neuro-otology, neuropathology,

- neuroradiology, and, pain management. ^(Detail)
- IV.A.3.b) There must be gross and microscopic pathology conferences and clinical pathological conferences. ^(Detail)
- IV.A.3.c) There must be periodic seminars, journal clubs, lectures, and didactic courses that address the major developments in both the basic and clinical sciences related to child neurology. ^(Detail)
- IV.A.3.d) There must be patient-based teaching which must include clinical teaching rounds. ^(Detail)
- IV.A.3.d).(1) Child neurology faculty members must supervise and direct clinical teaching rounds. ^(Detail)
- IV.A.3.d).(2) Clinical teaching rounds must occur at least five days per week. ^(Detail)
- 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, ^(Core)**
- IV.A.5. ACGME Competencies**
- The program must integrate the following ACGME competencies into the curriculum: ^(Core)**
- IV.A.5.a) Patient Care and Procedural Skills**
- IV.A.5.a).(1) 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: ^(Outcome)**
- IV.A.5.a).(1).(a) must demonstrate competence in obtaining an orderly and detailed history from the patient, in conducting a thorough general and neurological examination, and in organizing and recording data; ^(Outcome)
- IV.A.5.a).(1).(a).(i) This must include the indications for neurodiagnostic tests and their interpretation. ^(Outcome)
- IV.A.5.a).(1).(b) must demonstrate recognition of psychiatric disorders in children and adolescents, and must utilize the consultation and referral of mental health providers; ^(Outcome)
- IV.A.5.a).(1).(c) must demonstrate competence in management of neurological disorders interacting with psychiatric

- disorders; ^(Outcome)
- IV.A.5.a).(1).(d) must demonstrate competence in the management of pediatric patients with acute neurological disorders in an intensive care unit and an emergency department; ^(Outcome)
- IV.A.5.a).(1).(e) must demonstrate competence in formulating a differential diagnosis and management plan; ^(Outcome)
- IV.A.5.a).(1).(f) must demonstrate competence in the management of infants, children, and adolescents with neurologic disorders; ^(Outcome)
- IV.A.5.a).(1).(g) must demonstrate competence in diagnosing and managing common and complex neurologic problems, including headaches, epilepsy, pediatric stroke, and neurometabolic and neurogenetics problems; and, ^(Outcome)
- IV.A.5.a).(1).(h) must demonstrate competence in the use of appropriate and compassionate methods of terminal palliative care, including adequate pain relief. ^(Outcome)
- IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. ^(Outcome)**
- 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: ^(Outcome)**
- IV.A.5.b).(1) must demonstrate competence in their knowledge of the psychological aspects of the patient-physician relationship, and the importance of personal, social, and cultural factors in disease processes and their clinical expression;
- IV.A.5.b).(2) must demonstrate knowledge of the basic principles of psychopathology, common psychiatric diagnosis and therapies, and the indications for and common complications of psychiatry drugs;
- IV.A.5.b).(3) must demonstrate competence in their knowledge of basic principles of rehabilitation for neurological disorders, including pediatric neurological disorders; ^(Outcome)
- IV.A.5.b).(4) must demonstrate competence in the use of principles of

bioethics and in the provision of appropriate and cost-effective evaluation and treatment for children with neurologic disorders; and, ^(Outcome)

IV.A.5.b).(5)

must demonstrate knowledge of the basic sciences on which clinical child neurology is founded, through application of this knowledge in the care of their patients and by passing clinical skills examinations.

IV.A.5.b).(5).(a)

This knowledge includes: epidemiology and statistics, genetics, immunology, molecular biology, neural and behavioral development, neuroanatomy, neurochemistry, neuroimaging, neuropathology, neuropharmacology, neurophysiology, and, neuropsychology. ^(Outcome)

IV.A.5.b).(5).(a).(i)

Specific goals and objectives must be developed for this experience. ^(Detail)

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.
^(Outcome)

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; ^(Outcome)

IV.A.5.c).(2)

set learning and improvement goals; ^(Outcome)

IV.A.5.c).(3)

identify and perform appropriate learning activities;
^(Outcome)

IV.A.5.c).(4)

systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; ^(Outcome)

IV.A.5.c).(5)

incorporate formative evaluation feedback into daily practice; ^(Outcome)

IV.A.5.c).(6)

locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; ^(Outcome)

IV.A.5.c).(7)

use information technology to optimize learning;
^(Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals; and, ^(Outcome)

IV.A.5.c).(9) assume responsibility for learning about major developments in both the basic and clinical sciences relating to child neurology. ^(Detail)

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. ^(Outcome)

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; ^(Outcome)

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

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

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

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

IV.A.5.d).(6) provide psychosocial support and counseling for patients and family members about terminal palliative care. ^(Outcome)

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. ^(Outcome)

Residents are expected to demonstrate:

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

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

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

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

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.** ^(Outcome)

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. ^(Outcome)

Residents are expected to:

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

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

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

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

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

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

IV.A.6. **Curriculum Organization and Resident Experiences**

IV.A.6.a) **The program director must, with assistance from the faculty, develop and implement the academic and clinical program of resident education by:** ^(Detail)

IV.A.6.a).(1) **preparing and implementing a comprehensive, well-organized, and effective curriculum that includes the presentation of core subspecialty knowledge supplemented by the addition of current information; and,** ^(Detail)

- IV.A.6.a).(2) providing residents with direct experience in progressive responsibility for patient management. ^(Detail)
- IV.A.6.b) The curriculum must be organized to provide the following:
- IV.A.6.b).(1) at least 12 FTE months of adult neurology that do not need to be contiguous, including: ^(Core)
- IV.A.6.b).(1).(a) six months on inpatient rotations (an inpatient rotation is defined as one that requires more than 50 percent of time spent managing patients admitted to an inpatient service requiring neurologic care); ^(Detail)
- IV.A.6.b).(1).(b) three months of outpatient clinical adult neurology (an outpatient rotation is defined as any rotation that requires more than 50 percent of time spent managing patients in an outpatient clinic setting); and, ^(Core)
- IV.A.6.b).(1).(c) three months of elective adult neurology clinical experiences. Rotations on subspecialty areas of neurology, including neuroradiology, neuropathology, and neurophysiology, may be counted toward this requirement. ^(Detail)
- IV.A.6.b).(2) at least 12 FTE months of clinical child neurology; ^(Core)
- IV.A.6.b).(2).(a) This must include at least four FTE months of outpatient experience. ^(Core)
- IV.A.6.b).(3) at least a one-month FTE experience under the supervision of a qualified child and adolescent psychiatrist; ^(Core)
- IV.A.6.b).(4) a minimum of three months elective time with assignments that accommodate individual resident interests and previous education; ^(Detail)
- IV.A.6.b).(5) management responsibility for hospitalized patients with neurological disorders, including pediatric patients with acute neurological disorders, in an intensive care unit and in an emergency department; ^(Detail)
- IV.A.6.b).(6) experience in the evaluation and management of patients with disorders of the nervous system requiring surgical management; and, ^(Detail)
- IV.A.6.b).(7) assignment on a consultation service to the medical, surgical, and psychiatric services. ^(Detail)

IV.A.6.c) Residents must attend a longitudinal/continuity clinic at least one half-day weekly throughout the duration of the program. ^(Core)

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. ^(Core)

IV.B.2. Residents should participate in scholarly activity. ^(Core)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. ^(Detail)

IV.B.4. The curriculum must advance residents' knowledge of the basic principles of evidence-based medicine and research, including how research is conducted, evaluated, explained to patients, and applied to patient care. ^(Core)

IV.B.5. Residents should participate in scholarly activity under the mentorship of program faculty members. ^(Core)

IV.B.6. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. ^(Core)

IV.B.7. Residents should receive support to attend one regional, national, or international professional conference during the program. ^(Detail)

IV.B.8. Child neurology education must be conducted in centers where there is active ongoing research in both clinical and basic neuroscience fields. ^(Detail)

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. ^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)

V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. ^(Detail)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)

- V.A.2.e) Each resident must complete at least two of the required clinical examinations by the end of the R2 year, and all prior to the final month of education. ^(Detail)
- V.A.2.f) There must be a written plan to correct deficiencies, if applicable. ^(Detail)
- V.A.3. Summative Evaluation**
- V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. ^(Core)**
- V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program. ^(Core)**
- This evaluation must:**
- V.A.3.b).(1) 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; ^(Detail)**
- V.A.3.b).(2) document the resident’s performance during the final period of education; and, ^(Detail)**
- V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. ^(Detail)**
- V.B. Faculty Evaluation**
- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)**
- 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. ^(Detail)**
- V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. ^(Detail)**
- V.C. Program Evaluation and Improvement**
- V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)**
- V.C.1.a) The Program Evaluation Committee:**

- V.C.1.a).(1)** must be composed of at least two program faculty members and should include at least one resident;
(Core)
- V.C.1.a).(2)** must have a written description of its responsibilities; and,
(Core)
- V.C.1.a).(3)** should participate actively in:
- V.C.1.a).(3).(a)** planning, developing, implementing, and evaluating educational activities of the program;
(Detail)
- V.C.1.a).(3).(b)** reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
(Detail)
- V.C.1.a).(3).(c)** addressing areas of non-compliance with ACGME standards; and,
(Detail)
- V.C.1.a).(3).(d)** reviewing the program annually using evaluations of faculty, residents, and others, as specified below.
(Detail)
- V.C.2.** The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE).
(Core)
- The program must monitor and track each of the following areas:
- V.C.2.a)** resident performance;
(Core)
- V.C.2.b)** faculty development;
(Core)
- V.C.2.c)** graduate performance, including performance of program graduates on the certification examination;
(Core)
- V.C.2.c).(1)** Graduate pass-rates for the American Board of Psychiatry and Neurology (ABPN) subspecialty certifying examination must be used in evaluating the educational effectiveness of the program.
(Outcome)
- V.C.2.c).(2)** At least 80 percent of a program's eligible graduates from the preceding five years should take the ABPN certifying examination in child neurology.
(Outcome)
- V.C.2.c).(2).(a)** At least 75 percent of a program's eligible graduates from the preceding five years who take the ABPN certifying examination in child neurology for the first time should pass.
(Outcome)

- V.C.2.c).(2).(b) In those programs with fewer than five graduates over the past five years, at least 50 percent of graduates who take the ABPN certifying examination in child neurology for the first time should pass. ^(Outcome)
- V.C.2.d) program quality; and, ^(Core)
- V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and ^(Detail)
- V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. ^(Detail)
- V.C.2.e) progress on the previous year's action plan(s). ^(Core)
- V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)
- V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)

VI. Resident 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 residents 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. ^(Core)
- VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. ^(Core)
- VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. ^(Core)
- 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, ^(Core)
- VI.A.4.b) not be compromised by excessive reliance on residents to

fulfill non-physician service obligations. ^(Core)

- VI.A.5.** The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. ^(Core)
- VI.A.6.** Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.6.a)** assurance of the safety and welfare of patients entrusted to their care; ^(Outcome)
 - VI.A.6.b)** provision of patient- and family-centered care; ^(Outcome)
 - VI.A.6.c)** assurance of their fitness for duty; ^(Outcome)
 - VI.A.6.d)** management of their time before, during, and after clinical assignments; ^(Outcome)
 - VI.A.6.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers; ^(Outcome)
 - VI.A.6.f)** attention to lifelong learning; ^(Outcome)
 - VI.A.6.g)** the monitoring of their patient care performance improvement indicators; and, ^(Outcome)
 - VI.A.6.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. ^(Outcome)
- VI.A.7.** All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They 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. ^(Outcome)
- VI.B. Transitions of Care**
- VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care. ^(Core)
 - 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. ^(Core)
 - VI.B.3.** Programs must ensure that residents are competent in communicating with team members in the hand-over process. ^(Outcome)
 - 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 residents currently responsible for each patient's care. ^(Detail)

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; ^(Core)

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, ^(Core)

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. ^(Detail)

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

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

VI.D. Supervision of Residents

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. ^(Core)

VI.D.1.a) This information should be available to residents, faculty members, and patients. ^(Detail)

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care. ^(Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. ^(Core)

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 resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care

with feedback as to the appropriateness of that care. ^(Detail)

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision: ^(Core)

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient. ^(Core)**
- 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. ^(Core)**
 - 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. ^(Core)**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. ^(Core)**
 - VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. ^(Core)**
 - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. ^(Detail)**
 - 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. ^(Detail)**
- VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. ^(Core)**

- VI.D.5.a)** Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. ^(Outcome)
- VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.] ^(Core)
- VI.D.6.** Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility. ^(Detail)
- VI.E. Clinical Responsibilities**
- The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. ^(Core)
- VI.E.1.** The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident. ^(Detail)
- VI.F. Teamwork**
- Residents 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. ^(Core)
- VI.G. Resident 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. ^(Core)
- 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. ^(Detail)
- The Review Committee for Neurology will not consider requests for exceptions to the 80-hour limit to the residents' 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. (Detail)
- 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. (Detail)
- VI.G.2.** **Moonlighting**
- VI.G.2.a)** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. (Core)
- VI.G.2.b)** Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)
- VI.G.2.c)** PGY-1 residents are not permitted to moonlight. (Core)
- VI.G.3.** **Mandatory Time Free of Duty**
- Residents 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. (Core)
- VI.G.4.** **Maximum Duty Period Length**
- VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in duration. (Core)
- 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. (Core)
- VI.G.4.b).(1)** Programs must encourage residents 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. (Detail)
- VI.G.4.b).(2)** It is essential for patient safety and resident education that effective transitions in care occur. Residents 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. (Core)
- VI.G.4.b).(3)** Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house

duty. ^(Core)

VI.G.4.b).(4) In unusual circumstances, residents, 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. ^(Detail)

VI.G.4.b).(4).(a) Under those circumstances, the resident must:

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

VI.G.4.b).(4).(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. ^(Detail)

VI.G.4.b).(4).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty. ^(Detail)

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. ^(Core)

VI.G.5.b) Intermediate-level residents [as defined by the Review Committee] 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. ^(Core)

R1 residents are considered to be at the intermediate level.

VI.G.5.c) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. ^(Outcome)

R2 and R3 residents 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 [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. ^(Detail)

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. ^(Detail)

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 resident 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

Residents must not be scheduled for more than six consecutive nights of night float. ^(Core)

VI.G.6.a)

Residents should not have more than two consecutive weeks of night float, and no more than six weeks of night float per year. ^(Detail)

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). ^(Core)

VI.G.8.

At-Home Call

VI.G.8.a)

Time spent in the hospital by residents 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. ^(Core)

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 resident. ^(Core)

VI.G.8.b)

Residents 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”. (Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or residents at key stages of their graduate medical education.