ACGME Program Requirements for Graduate Medical Education in Child Neurology

Common Program Requirements are in BOLD

Effective: July 1, 2007

[Note: This material constitutes the program requirements for residency education in child neurology. The reader should refer as well to the Program Requirements for Residency Education in Neurology for information on requirements for core programs, to which programs in child neurology must be attached. The reader is also referred to the Institutional Requirements of the Essentials of Accredited Residencies in Graduate Medical Education and to other publications of the Accreditation Council for Graduate Medical Education (ACGME), which outline the composition and function of all Review Committees; indicate the actions that any Review Committee may take, as well as the actions that the ACGME may take; and describe the appeals procedure, types of programs, and the relationships among the Review Committees, their parent organizations, and the ACGME.

Requests to have a program accredited to train residents in child neurology (or related inquiries regarding residency programs) should be addressed to Executive Director, Review Committee for Neurology, 515 N State St, Suite 2000, Chicago, IL 60610. All inquiries concerning prerequisite training or whether a physician is qualified to be examined for certification in neurology with special qualification in child neurology should be addressed to Executive Vice President, American Board of Psychiatry and Neurology (ABPN), 500 Lake Cook Rd, Ste 335, Deerfield, IL 60015.]

Introduction

A. Duration and Scope of Training

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

B. Prerequisite Training

Residents may gain prerequisite training in one of three options:

1. Two years of residency training in pediatrics, accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States or the Royal College of Physicians and Surgeons in Canada;
2. One PG-1 year (as described in the Program Requirements for Residency Education in Neurology, Section I.A.1) and one year of residency training in pediatrics; or,

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

C. Goals and Objectives for Residency Training

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

D. Relation to Core Programs

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

E. Leave and Vacation Policy

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

I. Institutions

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.

B. Participating Sites

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:

a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

c) specify the duration and content of the educational experience; and,

d) state the policies and procedures that will govern resident education during the assignment.

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).

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

II. Program Personnel and Resources

A. Program Director

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.

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.

3. Qualifications of the program director must include:

   a) requisite specialty expertise and documented educational and administrative experience acceptable to
the Review Committee;

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

c) current medical licensure and appropriate medical staff appointment.

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:

a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

b) approve a local director at each participating site who is accountable for resident education;

c) approve the selection of program faculty as appropriate;

d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

e) monitor resident supervision at all participating sites;

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;

g) provide each resident with documented semiannual evaluation of performance with feedback;

h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

i) provide verification of residency education for all residents, including those who leave the program prior to completion;

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:

(1) distribute these policies and procedures to the residents and faculty;

(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

k) monitor the need for and ensure the provision of backup support systems when patient care responsibilities are unusually difficult or prolonged;

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;

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

n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

(1) all applications for ACGME accreditation of new programs;

(2) changes in resident complement;

(3) major changes in program structure or length of training;

(4) progress reports requested by the Review
Committee;

(5) responses to all proposed adverse actions;

(6) requests for increases or any change to resident duty hours;

(7) voluntary withdrawals of ACGME-accredited programs;

(8) requests for appeal of an adverse action;

(9) appeal presentations to a Board of Appeal or the ACGME; and,

(10) proposals to ACGME for approval of innovative educational approaches.

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:

(1) program citations, and/or

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

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

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

r) develop criteria to use in the assessment of the extent to which the program’s goals and objectives are met; and,

s) prepare, at the conclusion of the resident’s period of training in the program, a detailed, written evaluation of the
resident’s performance in relation to the program’s learning and performance objectives, and discuss this evaluation with the resident.

B. Faculty

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:

   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

   b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

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

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

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

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

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

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

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

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

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

      (1) peer-reviewed funding;

      (2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

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

      (4) participation in national committees or educational organizations.

   c) Faculty should encourage and support residents in scholarly activities.

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

   e) The program must have a sufficient number of qualified staff teaching residents at each site in the program.
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.

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.

1. Patient Population

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

2. Facilities

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

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

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

A. Eligibility Criteria

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

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.

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.

C. Resident Transfers

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.

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

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

A. The curriculum must contain the following educational components:

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

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;

3. Regularly scheduled didactic sessions;

4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

5. ACGME Competencies

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

   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:

      (1) must have an optimal educational experience consistent with the best medical care that balances patient care and education. Patient care responsibilities must include inpatient, outpatient, and consultation experiences;

      (2) must have at least 12 months (full-time equivalent) of clinical child neurology with management responsibility for patient care. This must include at least four months (full-time equivalent) of outpatient experience in clinical child neurology. The outpatient experience also must include a resident longitudinal/continuity clinic with attendance by each
resident at least one-half day weekly throughout the program. The resident may be excused from this clinic when a rotation site is more than one hour travel time from the clinic site;

(3) must have clinical teaching rounds that are supervised and directed by the faculty of the child neurology department or division. They must occur at least five days per week. The resident in child neurology must present cases and their diagnostic and therapeutic plans;

(4) must have instruction and practical experience in obtaining an orderly and detailed history from the patient, in conducting a thorough general and neurological examination, and in organizing and recording data. The training must include the indications for neurodiagnostic tests and their interpretation. The resident 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;

(5) must participate in the evaluation of and decision making for patients with disorders of the nervous system requiring surgical management. This experience must be part of the clinical child neurology experience. The existence of a neurosurgical service with close interaction with the neurology service is essential;

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

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

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:

must learn the basic principles of rehabilitation for neurological disorders, including pediatric neurological disorders;

must receive instruction in the principles of bioethics and in the provision of appropriate and cost-effective evaluation and treatment for children with neurologic disorders;

must receive instruction in appropriate and compassionate methods of terminal palliative care, including adequate pain relief, and psychosocial support and counseling for patients and family members about these issues;

must learn the basic sciences on which clinical child neurology is founded, including neuroanatomy, neural and behavioral development, neuropathology, neurophysiology, neuroimaging, neuropsychology, neurochemistry, neuropharmacology, molecular biology, genetics, immunology, and epidemiology and
statistics. Concentrated training in one or more of these areas, accomplished with a full-time equivalent experience of at least two months total, is required for each resident. Specific goals and objectives must be developed for this experience;

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

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

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

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:

(1) identify strengths, deficiencies, and limits in one’s knowledge and expertise;

(2) set learning and improvement goals;
identify and perform appropriate learning activities;

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

incorporate formative evaluation feedback into daily practice;

locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;

use information technology to optimize learning; and,

participate in the education of patients, families, students, residents and other health professionals.

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:

communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

communicate effectively with physicians, other health professionals, and health related agencies;

work effectively as a member or leader of a health care team or other professional group;

act in a consultative role to other physicians and health professionals; and,

maintain comprehensive, timely, and legible medical records, if applicable.
e) Professionalism

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

(1) compassion, integrity, and respect for others;
(2) responsiveness to patient needs that supersedes self-interest;
(3) respect for patient privacy and autonomy;
(4) accountability to patients, society and the profession; and,
(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.

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:

(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
(2) coordinate patient care within the health care system relevant to their clinical specialty;
(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
(4) advocate for quality patient care and optimal patient care systems;
(5) work in interprofessional teams to enhance patient safety and improve patient care quality;
and,

(6) participate in identifying system errors and implementing potential systems solutions.

B. Residents’ Scholarly Activities

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.

2. Residents should participate in scholarly activity.

3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

   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.

   b) The program must:

      (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;

      (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

      (3) document progressive resident performance improvement appropriate to educational level; and,

      (4) provide each resident with documented semiannual evaluation of performance with
feedback.

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

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

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

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

g) Each resident's permanent record must include the written evaluations completed for each defined educational experience, the written records from the semiannual reviews, results of formal assessments, and the resident's final evaluation. Written descriptions of any deficiencies and problem areas, plans for correcting the deficiencies, disciplinary actions, and commendations, where appropriate, should be included.

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:
a) document the resident’s performance during the final period of education, and

b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

B. Faculty Evaluation

1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

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.

3. This evaluation must include at least annual written confidential evaluations by the residents.

C. Program Evaluation and Improvement

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:

   a) resident performance;

   b) faculty development;

   c) graduate performance, including performance of program graduates on the certification examination; and,

   d) program quality. Specifically:

      (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

      (2) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.
(3) Evaluations of residents' attainment of the program's learning and performance objectives must be used as the basis for program evaluation. Comparisons of these data against the program's own criteria, performance criteria set by the Review Committee, and attainment levels of residents at comparable levels of training should be performed as a primary means of assessing attainment of goals and objectives.

2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

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.

2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

3. Didactic and clinical education must have priority in the allotment of residents' time and energy.

4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

B. Supervision of Residents

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

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.
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.

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

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.

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.

E. On-call Activities

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

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.

3. No new patients may be accepted after 24 hours of continuous duty.

4. At-home call (or pager call)

   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.

   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.
period.

c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

F. Moonlighting

1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

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

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.

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.

2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.

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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