

ACGME Program Requirements for Graduate Medical Education in Neuromuscular Medicine

One-year Common Program Requirements are in BOLD

Effective: February, 2005

Introduction

Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s and fellow’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Definition and Scope of the Subspecialty

Int.B.1. Neuromuscular medicine is a subspecialty of neurology and physical medicine and rehabilitation that includes abnormalities of the motor neuron, nerve roots, peripheral nerves, neuromuscular junction, and muscle, including disorders that affect adults and children. Specialists in neuromuscular medicine possess specialized knowledge in the science, clinical evaluation, and management of these disorders. This encompasses the knowledge of the pathology, diagnosis, and treatment of these disorders at a level that is significantly beyond the training and knowledge expected of a general neurologist, pediatric neurologist, or physiatrist.

Int.B.2. Neuromuscular medicine includes the evaluation and treatment of a wide range of diseases, including:

Int.B.2.a) motor neuron disease;

- Int.B.2.b) myopathy/neuromuscular transmission disorders;
- Int.B.2.c) peripheral neuropathy;
- Int.B.2.d) cranial/spinal single and multiple mononeuropathies;
- Int.B.2.e) polyneuropathy: infectious/inflammatory;
- Int.B.2.f) inherited neuropathy;
- Int.B.2.g) polyneuropathy: ischemia/physical agents/toxins; and,
- Int.B.2.h) polyneuropathy/systemic disease.

Int.C. Duration and Scope of Education

Int.C.1. The minimum duration of fellowship education in neuromuscular medicine is 12 months, which must include the equivalent of at least six full-time equivalent (FTE) months of patient care in neuromuscular medicine, including inpatient and outpatient care. The remaining time must include additional experience in the care of patients with neuromuscular diseases, electromyography and nerve conduction studies, autonomic function testing, nerve and muscle pathology, chemodenervation, and neuromuscular rehabilitation. Elective time for fellows to pursue individual interests must be provided.

Int.C.2. Fellowship education in neuromuscular medicine must include opportunities to observe, evaluate, and manage patients with a wide variety of disorders of the muscle, neuromuscular junction, nerve, and motor neuron. It must provide clinical experiences to allow the fellow to develop:

- Int.C.2.a) skills in interviewing and examining patients with neuromuscular diseases;
- Int.C.2.b) knowledge of differential diagnosis for the various clinical presentations of neuromuscular problems;
- Int.C.2.c) knowledge of the appropriate investigations for diagnosis of neuromuscular disorders, including laboratory, pathologic, radiologic, and electrodiagnostic/neurophysiologic testing; and,
- Int.C.2.d) knowledge and skills to manage inpatients and outpatients with neuromuscular diseases.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the

program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.A.1. The program must take place in a center in which there is an ACGME-accredited residency program in neurology or physical medicine and rehabilitation, and with the written approval and support of the program director of the residency program at that institution.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;

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

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

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

I.B.3. Participation by an institution that provides two or more months of fellow education 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 GMC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

- II.A.2. Qualifications of the program director must include:**
- II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
 - II.A.2.b) current certification in the subspecialty by the American Board of Psychiatry and Neurology or the American Board of Physical Medicine and Rehabilitation, or specialty qualifications that are acceptable to the Review Committee; and,**
 - II.A.2.c) current medical licensure and appropriate medical staff appointment.**
 - II.A.2.c).(1) The program director must possess current medical licensure in the state in which the sponsoring institution is located.**
- II.A.3. The program director must administer and maintain an educational environment conducive to education the fellows in each of the ACGME competency areas. The program director must:**
- II.A.3.a) prepare and submit all information required and requested by the ACGME;**
 - II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
 - II.A.3.c) obtain review and approval of the sponsoring institution's GMC/DIO before submitting to the ACGME information or requests for the following:**
 - II.A.3.c).(1) all applications for ACGME accreditation of new programs;**
 - II.A.3.c).(2) changes in fellow complement;**
 - II.A.3.c).(3) major changes in program structure or length of training;**
 - II.A.3.c).(4) progress reports requested by the Review Committee;**
 - II.A.3.c).(5) responses to all proposed adverse actions;**
 - II.A.3.c).(6) requests for increases or any change to fellow duty hours;**
 - II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;**

- II.A.3.c).(8) requests for appeal of an adverse action; and,
- II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.
- II.A.3.d) 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.3.d).(1) program citations, and/or
 - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.
- II.A.3.e) prepare a written statement outlining the educational goals of the program with respect to knowledge, skills, and other attributes of fellows at each level of training and for each major rotation or other program assignment;
 - II.A.3.e).(1) This statement must be distributed to fellows and members of the teaching faculty, and should be readily available for review.
- II.A.3.f) select fellows for appointment to the program in accordance with institutional and departmental policies and procedures;
- II.A.3.g) select and supervise the teaching faculty and other program personnel at each site participating in the program; and,
- II.A.3.h) supervise fellows through explicit written descriptions of supervisory lines of responsibility for the care of patients.
 - II.A.3.h).(1) Such guidelines must be communicated to all members of the program faculty and staff.
 - II.A.3.h).(2) Fellows must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.
- II.A.4. The program director, with participation of members of the teaching staff, shall advance fellows to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth.
- II.B. Faculty
- II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

- II.B.1.a) In addition to the program director, there must be at least one additional full-time faculty member who is Board-certified in neuromuscular medicine, or possesses appropriate educational qualifications as judged by the Review Committee.
- II.B.1.b) There should be a sufficient number of faculty members with diverse interests and skills to make the breadth of training appropriate to a program meeting these special requirements, to ensure adequate clinical experience of fellows, and to provide continued interaction among fellows and faculty through, for example, seminars, conferences, and clinical supervision.
- II.B.1.c) Faculty must be available with expertise to instruct the fellows in the performance and interpretation of electromyography and nerve conduction studies, and for teaching the principles, including indications, techniques, limitations, and complications, of nerve and muscle biopsy and clinical molecular genetics.
- II.B.1.d) The fellow must be exposed to a one-on-one relationship with the faculty.
- II.B.1.e) The teaching staff members must be available during clinical care, neurophysiological studies, and the clinical correlation of the results.

II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.

II.B.3. The physician faculty must have current certification in the subspecialty by the American Board of Psychiatry and Neurology or the American Board of Physical Medicine and Rehabilitation, or possess qualifications acceptable to the Review Committee.

II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.5. A member of the teaching staff of each participating site must be designated to assume responsibility for the day-to-day activities of the program at that site, with overall coordination by the program director.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty

program requirements.

- II.D.1. The neuromuscular medicine program must be within a department or division of neurology or physical medicine and rehabilitation, and have facilities adequate for the educational program.
- II.D.2. The number of patients must be adequate to provide a sound educational program.
 - II.D.2.a) It is the program director's responsibility to ensure that the number of patients is appropriate.
 - II.D.2.b) They must be diversified as to age, sex, short-term and long-term neuromuscular problems, and inpatients and outpatients.
 - II.D.2.c) Making patients available to the neuromuscular medicine fellow must not interfere with the education of residents in the core residency program.

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.

- III.A.1. The neuromuscular medicine fellow must have successfully completed a residency program in either adult or pediatric neurology or physical medicine and rehabilitation accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada. Neuromuscular medicine training must be separate and distinct from all training required in these residencies.

III.B. Number of Fellows

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

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

IV.A.2.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,

IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.

IV.A.2.d) Interpersonal and Communication Skills

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

IV.A.2.e) Professionalism

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

IV.A.2.f)

Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

IV.A.3.

Each fellow must be required to be proficient in the technical skills determined to be necessary for a practitioner of neuromuscular medicine and any related standards relevant to neurology or physical medicine and rehabilitation.

IV.B.

Fellows' Scholarly Activities

It is recommended that the program provide fellows with the opportunity for neuromuscular research (including clinical study design, data collection and management, statistical analysis, and coordination of multiple study sites.)

IV.C.

Curriculum Organization and Fellow Experiences

IV.C.1.

Fellows must have formal instruction, clinical experience and demonstrate competence in clinical evaluation and management of patients of all ages with neuromuscular disorders in inpatient and outpatient settings, including the:

IV.C.1.a)

ability to integrate information obtained from patient history, physical examination, and diagnostic testing (including electrodiagnosis, biopsy, immunological and molecular tests), to arrive at an accurate and timely diagnosis and treatment plan;

IV.C.1.b)

use of all available treatments (e.g., immunomodulatory agents) and awareness of their side effects;

IV.C.1.c)

knowledge of the natural history, the prognosis, and the integration of knowledge garnered from a variety of testing modalities, including electromyography, nerve conduction studies, genetic testing and muscle imaging, of neuromuscular disorders; and,

IV.C.1.d)

critical appraisal of the professional and scientific literature and application of new contributions to management and care of patients.

IV.C.2.

Fellows must have formal instruction in the rehabilitation aspects of neuromuscular disorders, neuroanatomy, neurophysiology, neuropathology, safety issues related to diagnostic testing, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.

IV.C.3.

Fellows must have formal instruction in nerve conduction and EMG studies (including neuromuscular junction testing) and the pathology of

nerve and muscle biopsies.

- IV.C.3.a) An opportunity to observe nerve and muscle biopsies should be provided.
- IV.C.4. In particular, training must provide the following clinical experiences:
 - IV.C.4.a) inpatient evaluation and management of patients presenting with acute and severe neuromuscular disorders;
 - IV.C.4.b) critical care management of patients with conditions such as myasthenic crisis, and acute and severe Guillain-Barre syndrome;
 - IV.C.4.c) outpatient evaluation and diagnosis of patients with non-emergent neuromuscular disease manifestations;
 - IV.C.4.d) care of patients in different settings, including nursing homes, rehabilitation centers, and outpatient clinics;
 - IV.C.4.e) ordering and clinical interpretation of electrophysiologic studies and their role in the diagnosis and management of patients;
 - IV.C.4.f) ordering and clinical interpretation of diagnostic blood tests, including those involving molecular genetic testing; and,
 - IV.C.4.g) consulting with other medical professionals, including cardiologists, radiologists, rheumatologists, pediatricians, neurological surgeons, pathologists or neuropathologists, and physiatrists in the overall care and management of patients with neuromuscular diseases.
- IV.C.5. The program must provide fellows the opportunity to evaluate and manage pediatric and adult patients with neuromuscular diseases in various settings including subspecialty clinics and intensive care units.
- IV.C.6. The program must provide the opportunity for fellows to participate in clinical and basic research projects in neuromuscular disorders.
- IV.C.7. The program must conduct formal lectures and teaching conferences on a regular basis. Participation in clinical conferences dealing with neuromuscular medicine is of particular importance.
- IV.C.8. Fellows must be involved formally and informally in the teaching of neuromuscular medicine to other residents, medical students, nurses, and other health care personnel.
- IV.C.9. Although a wide range of clinical experience is required, the neuromuscular medicine fellows may have the opportunity to concentrate a portion of their training in one or more areas of special interest in neuromuscular medicine.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate fellow performance in a timely manner.

V.A.1.a).(1) Fellow evaluation by staff must be made at regular intervals so that areas of weakness and strength may be communicated to fellows.

V.A.1.a).(2) Records shall be maintained which document fellows' experience and performance.

V.A.1.a).(3) Periodic review of the fellows' performance is essential for planning their subsequent educational program. The evaluation will include judging the fund of knowledge, basic clinical competence, general skills in the primary specialty, and proficiency in the technical skills needed to evaluate and treat neuromuscular disorders as listed in section Int.B.2.

V.A.1.a).(4) The program director must perform regular evaluations of fellows' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

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); and,

V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.]

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

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must

become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:

- V.A.2.a) document the fellow's performance during their education, and**
- V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.**

V.A.3. This evaluation should reflect the periodic evaluation of the fellow by faculty members.

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.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) fellow performance, and

V.C.1.b) faculty development

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 approved by the teaching faculty and documented in meeting minutes.

V.C.3. The teaching staff and faculty must periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for education purposes, the evaluation and the quality of supervision of fellows.

V.C.4. The teaching staff must be organized and have regular documented meetings to review program goals and objectives, as well as program effectiveness in achieving them. At least one fellow representative must participate in these reviews.

V.C.5. One measure of the quality of a program is the proportion of its graduates who take the examination in neuromuscular medicine provided by the

American Board of Psychiatry and Neurology or the American Board of Physical Medicine and Rehabilitation, as well as their performance on those examinations.

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

- VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**
- VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**
- VI.A.4. The learning objectives of the program must:**
- VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
 - VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.**
- VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
- VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
 - VI.A.5.b) provision of patient- and family-centered care;**
 - VI.A.5.c) assurance of their fitness for duty;**
 - VI.A.5.d) management of their time before, during, and after clinical assignments;**
 - VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
 - VI.A.5.f) attention to lifelong learning;**

- VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,
- VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
- VI.B. Transitions of Care
 - VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
 - VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
 - VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.
- VI.C. Alertness Management/Fatigue Mitigation
 - VI.C.1. The program must:
 - VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
 - VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
 - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
 - VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
 - VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.
- VI.D. Supervision of Fellows

- VI.D.1.** In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
- VI.D.1.a)** This information should be available to fellows, faculty members, and patients.
- VI.D.1.b)** Fellows and faculty members should inform patients of their respective roles in each patient's care.
- VI.D.2.** The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.
- VI.D.3.** Levels of Supervision
- To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:
- VI.D.3.a)** Direct Supervision – the supervising physician is physically present with the fellow and patient.
- VI.D.3.b)** Indirect Supervision:
- VI.D.3.b).(1)** with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- VI.D.3.b).(2)** with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- VI.D.3.c)** Oversight – the supervising physician is available to provide

review of procedures/encounters with feedback provided after care is delivered.

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each fellow's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.

VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.

VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.

VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

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

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.a) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b) Fellows must not be assigned additional clinical

responsibilities after 24 hours of continuous in-house duty.

VI.G.4.c) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.c).(1) Under those circumstances, the fellow must:

VI.G.4.c).(1).(a) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.c).(1).(b) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.c).(2) The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Neuromuscular medicine fellows are considered to be in the final years of education.

VI.G.5.a).(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 fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.a).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.

VI.G.5.a).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient

with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float.

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

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

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