Case Log Information for Neurological Surgery Programs

Background

The ACGME-I Case Log System is a data depository to support programs in complying with Advanced Specialty Requirements and to enable program directors to monitor each resident's clinical experience by capturing and categorizing resident cases.

The Surgical/Hospital-based Review Committee-International examines cases completed by graduating residents to determine a program's compliance with clinical experience requirements, judge if educational resources are sufficient for the program's accredited complement of residents, and evaluate the breadth and depth of resident experiences. The Committee understands that achievement of the minimum number for each listed procedure does not signify achievement of competence in any procedure, nor do the cases that must be logged represent the totality of clinical competency needed in any given specialty. Most importantly, meeting the minimum requirements for procedures does not replace or negate the requirement that, upon a resident's completion of the program, the program director must verify that he or she has demonstrated sufficient competence to enter practice without direct supervision.

Residents have a responsibility to enter cases accurately and in a timely manner. It is recommended that residents log cases daily or at least weekly. Residents must continue to log cases throughout the duration of their program, even if the minimum requirements have been met.

Program directors have the responsibility to regularly review and analyze each resident's completed cases. It is recommended that program directors review the Case Minimums Report at least quarterly to ensure each resident is making appropriate progress toward meeting the required minimum numbers.

The Accreditation Data System (ADS) Case Log tab includes general references on entering and retrieving information. Each specialty's page on the ACGME-I website contains additional Case Log references, including a *Resident Quick Guide* with definitions and case entry requirements particular to the specialty and a *Faculty and Staff Quick Guide* to assist program directors and faculty members choose and evaluate Case Log reports. Residents are encouraged to review these resources prior to their first case entries and to continue to refer to them as needed. Program directors can use information from the reports in ADS to review resident progress toward meeting clinical experience requirements, to set and evaluate curriculum, and to inform clinical faculty members about residents' clinical experience needs.

FREQUENTLY ASKED QUESTIONS

1. **Why are minimum numbers used?**
   The Surgical/Hospital-based Review Committee-International determined that minimum numbers for key procedures would provide information on clinical resources without detracting from the latitude that the program director must have to manage the clinical curriculum.

2. **How were case and procedure categories and minimum numbers identified?**
   The ACGME-I uses the same case and procedure categories and minimum numbers that are used for residency training in the United States. In the US, some specialties determined minimum case numbers after the specialty Review Committee analyzed national data for graduating residents. Some specialties worked with their respective boards to determine case and procedural categories and minimum numbers.

   The Review Committee-International felt that adhering to the same numbers as in the US provided a baseline to begin monitoring ACGME-I-accredited programs. Minimum numbers have been in place in the US for a number of years. In addition to the information obtained from block diagrams and ACGME-I Resident and Faculty Survey results, Case Logs for graduating residents are recognized as one important data point for judging resident clinical experience. The Review Committee-International will continue to monitor Case Log reports for graduating residents to determine if the use of US minimum numbers will need modification for the international community.

3. **How do residents enter cases?**
   The ACGME-I Case Log System uses descriptors to identify and log cases. The Review Committee-International will evaluate graduate resident cases based on descriptions of the procedures including the type of procedure and the area where the procedure was performed.

4. **If the institution uses an electronic system to track cases, duty hours, resident evaluations, etc., can the Case Log data from this system be uploaded into ADS?**
   No. At present there is no mechanism to electronically transfer cases from another system into ADS. The program director has ultimate responsibility to ensure that all data reported in ADS is accurate and complete, and should encourage residents to enter their case data daily in the Case Log System in ADS.

   Note that if your institution's electronic system has the capability, it may be possible to download ADS case log data into your system. Please contact technical support at ads@acgme.org to obtain technical assistance for this function.

5. **Will residents have access to their Case Logs after graduation?**
   Yes. Residents can access their Case Log reports after completion of the program to use for hospital credentialing, apply for fellowship training, etc. Residents are not able to add cases after completing the program.

6. **How can a resident use information from their Case Logs?**
   During the residency, Case Logs are useful to help residents determine the breadth and depth of their procedural experience. Case Logs can be used to inform revision of rotations to allow for more experience in a procedure or prevent too much experience with one type of patient or procedure at the expense of broader educational goals. After residency, Case Logs provide a record of experiences when applying for fellowship training or for hospital credentialing.

7. **How can a program director use information from resident Case Logs?**
   Program directors can apply filters for several of the reports available on the Case Log tab in ADS to determine how individual rotations, participating sites, or supervising faculty members are contributing to the residents' experiences. Program directors can also review when and how residents are recording their cases. For example, if a program requires residents to enter cases each week, the Resident Activity Report can be run weekly, and it can be quickly determined if a resident has not logged any cases.

8. **How does the Review Committee use Case Log data?**
   The Review Committee-International will review minimum case reports for those residents that have graduated from the program to determine how many residents met required minimums and which procedures were deficient. The Committee will also review the data to determine if residents are completing large numbers of certain procedures while not meeting minimums in all procedures. These analyses will allow the Committee to determine the breadth and depth of experiences provided by a program and to judge the residents' service obligations. Citations will result if minimums are not consistently met, if the Committee judges that residents are performing certain procedures as excessive service over education, and if resident reporting is inconsistent or lacking.

9. **What are the minimum case numbers for neurological surgery?**
   The following table summarizes minimum requirements for graduating residents in neurological surgery.

Operative procedures	**Minimum number**
Adult Cranial	
Craniotomy for brain tumor	60
Craniotomy for trauma	40
Total vascular lesion	50
Craniotomy for intracranial vascular lesion	*Must be reported*
Endovascular therapy for tumor or vascular lesion	*Must be reported*
Craniotomy for pain	5
Transsphenoidal sellar/parasellar tumors (endoscopic and microsurgical)	15
Extracranial vascular procedures	5
Radiosurgery	10
Functional procedures	10
VP shunt	10
Total adult cranial	205

Operative procedures	Minimum number
Adult spinal	
Anterior cervical approaches for decompression/stabilization	25
Posterior cervical approaches for decompression/stabilization	15
Lumbar discectomy	25
Thoracic/lumbar instrumentation fusion	20
Peripheral nerve procedures	10
Total adult spinal	**95**
Craniotomy for brain tumor	5
Craniotomy for trauma	10
Spinal procedures	5
VP shunt	10
Total pediatric	**30**
Adult and pediatric epilepsy	10

Critical care procedures	Minimum number
ICP monitor placement	5
External ventricular drain	10
VP shunt tap/programming	10
Cervical spine traction	5
CVP line placement	10
Airway management	10
Arterial line placement	10
Total critical care procedures	**60**
Total all defined cases	**400**

Reportable but Non-tracked Categories
Arteriography
Stereotactic frame placement