

MILLER SCHOOL OF MEDICINE/UNIVERSITY OF
MIAMI

JACKSON MEMORIAL MEDICAL CENTER

DEPARTMENT OF PHYSICAL MEDICINE &
REHABILITATION

RESIDENCY PROGRAM

RESIDENT'S HANDBOOK

2006-2007



TABLE OF CONTENTS

TABLE OF CONTENTS	1
FOREWARD	3
INTRODUCTION TO PHYSICAL MEDICINE AND REHABILITATION	5
PROGRAM DESCRIPTION	6
EDUCATIONAL OBJECTIVES	7
OVERALL PROGRAM OBJECTIVES	8
GLOBAL LEARNING OBJECTIVES OF THE PMR RESIDENCY PROGRAM	8
ROTATION-SPECIFIC OBJECTIVES	17
ACQUIRED BRAIN INJURY	17
COMPREHENSIVE INPATIENT	18
MIAMI VA MEDICAL CENTER (PGY 2)	18
CONSULTATION SERVICE	19
NEUROLOGICAL REHABILITATION	19
SPINAL CORD INJURY INPATIENT	20
EMG/NEUROMUSCULAR DISEASE	261
SPORTS MEDICINE/ORTHOPEDIC/MUSCULOSKELETAL	272
MVAMC (PGY 3) ROTATION	273
PAIN MANAGEMENT	24
ELECTIVE ROTATION	24
JMH SENIOR CHIEF ROTATION	24
SENIOR ELECTRODIAGNOSTIC/NEUROMUSCULAR DISEASE	25
JMH PEDIATRIC REHABILITATION	26
GENERAL GUIDELINES	28
RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS	28
RESIDENT SUPERVISION	288
GUIDELINES BASED ON LEVEL OF TRAINING	28
PGY-II and PGY-III REHABILITATION MEDICINE RESIDENTS	29
PGY-IV REHABILITATION MEDICINE RESIDENTS	29
CHIEF RESIDENT	29
CLINICS	29
ACUTE IN-PATIENT/CONSULTATIONS	29
PROFESSIONAL BEHAVIOR AND DEMEANOR	30
WORK HOURS AND PUNCTUALITY	31
CONFIDENTIALITY OF INFORMATION	32
TELEPHONE ADVICE	32
PRESCRIPTION RENEWAL	32
BEEPER	32
SEXUAL HARASSMENT	31a
EMERGENCIES ON IN-PATIENT REHAB	33
PATIENT CARE	33
ON CALL RESPONSIBILITIES	34
MORNING REPORT	35
CLINICS	36
CLINIC ATTENDINGS	36
DEPARTMENTAL CONFERENCES	36

TEAM EVALUATION CONFERENCE.....	375
FAMILY MEETINGS.....	37
PROGRAM DIRECTOR ROUNDS	37
GRAND ROUNDS	36
JOURNAL CLUB.....	37
DIDACTIC LECTURE SERIES.....	39
INTERDEPARTAMENTAL CONFERENCES	39
OTHER LEARNING RESOURCES.....	399
DEPARTAMENTAL LIBRARY.....	40
HOSPITAL LIBRARY	40
RESEARCH	40
RESIDENT SCHEDULING	41
HOSPITAL HOLIDAYS.....	41
SICK DAYS.....	41
VACATION DAYS.....	41
SCHEDULE CHANGES.....	41
ROTATION CHANGE POLICY.....	41
ABSENTEEISM.....	42
POLICY FOR RESIDENT SELECTION, EVALUATION, PROMOTION AND DISMISSAL.....	42a
MISCELLANEA	43
RESIDENT STRESS.....	42
GRIEVANCES	44
MALPRACTICE INSURANCE.....	46
SOCIETY MEMBERSHIP.....	46
NON-DISCRIMINATION POLICY.....	46
POST RESIDENCY PLACEMENT.....	46
RESIDENT PERFORMANCE.....	46
RESIDENT CONTRACTS.....	47
CORRECTIVE ACTION, DISCIPLINE AND APPEAL PROCEDURES.....	47
MOONLIGHTING.....	51
MEDICAL RECORDS.....	51
SITE AFFILIATIONS	52
MSMC, VA.....	52
DISCHARGE SUMMARY.....	53
SAMPLE DISCHARGE SUMMARY	54
INCOMPLETE MEDICAL RECORDS.....	606
JOURNALS AND PERIODICALS FOR USE AT JOURNAL CLUB	607
DEPARTAMENTAL TELEPHONE NUMBERS.....	60
EMERGENCY NUMBERS.....	61
DEPARTMENT ADMINISTRATION	620
REHABILITATION THERAPY DEPARTMENTS	60
JMH NURSING STATION TELEPHONE NUMBERS.....	620
LIST OF PROCEDURES TO BE OBSERVED WHILE IN PM&R RESIDENCY	62
RESIDENT LIBRARY LIST.....	63
APPENDICES	
RESIDENTS' ROTATION SCHEDULE	
RESIDENTS' LECTURE SCHEDULE	
FOREWARD	

Welcome.

The entire Department of Rehabilitation team Medicine at the Leonard M. Miller School of Medicine University of Miami welcomes you to our program. Each one of us will do our best to facilitate your training in your chosen specialty and may your stay with us be rewarding and worthwhile.

This manual contains guidelines for the PMR Residency Training Program in the Department of Rehabilitation at Jackson Memorial Hospital. We ask that you read this carefully and familiarize yourself with its content. Many of the requirements you will need to fulfill are listed in this handbook. We hope this handbook will add clarity that will facilitate and enhance the performance of your duties.

Our task goes well beyond learning skills or acquiring knowledge. We have been entrusted with the care of the sick and disabled. We must work together to serve them in the most comprehensive and compassionate manner possible.

Your suggestions and constructive criticisms are welcome to ensure that you enjoy a high quality educational and personal growth experience over the next three years. For the next three years, you will become part of the “face” that this Department of Rehabilitation assumes among our colleagues in the hospital and medical school. Therefore, we only ask that as long as you also assume part of the responsibility in implementing those making changes that you suggest to improve the quality of the educational program and the reputation that this department enjoys among the other medical and surgical specialties at the University of Miami. . Dr. Sherman and the Rehabilitation team will be available anytime you wish to share your thoughts with them.

Once again, welcome to our program. We look forward to working with you.

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INTRODUCTION TO PHYSICAL MEDICINE AND REHABILITATION

The specialty of Physical Medicine and Rehabilitation is concerned with diagnosis, evaluation and treatment of patients with limited function as a consequence of diseases and injuries that lead to physical and emotional impairments that result in disabilities. Emphasis is placed on maximal restoration of the physical, psychological, social, and vocational functions of the person. Additionally, you are charged with providing for prevention of secondary complications of disability; maintenance of medical stability, and on alleviation of pain in your patients. Physiatrists have special training in therapeutic exercise and physical modalities; management of musculoskeletal injuries; prosthetics, orthotics, and the use of other durable medical equipment; gait analysis; diagnosis and therapeutic injections; electrodiagnostics studies; and rehabilitation management.

Rehabilitation management of chronically ill and disabled individuals, with major emphasis on the maintenance and restoration of their functional integrity, can often prevent, reduce, or postpone disability. Goals include improvement, restoration, or maintenance in functioning with or without change in underlying disease process and creation and supervision of a program of restoration. At first you may find that your input in the patient management is limited as you learn the basics of rehabilitation management and find the multidisciplinary team functions quite well on these established units. However, as you gain confidence, you will find yourself given more responsibility and ultimately become the leader of the treatment team and in charge of your patient's welfare.

As you progress through your training years, emphasis will switch from primary management of rehabilitation inpatients to outpatient care, musculoskeletal care, electrodiagnosis, and pain management. The ability to function as an independent physician in the outpatient setting is crucial to becoming an excellent physical medicine physician.

The practice of rehabilitation medicine stresses interdisciplinary team work under medical supervision. Physiatrists are trained to direct and lead a team of health related professionals that includes physical therapists, occupational therapists, speech and hearing therapists, clinical psychologists, rehabilitation counselors, nurses, social workers, group and community workers. All of these professionals collaborate with their medical colleagues in order to fulfill the goals of comprehensive medical care. Mobilization of essential family and community resources is emphasized. Planning and implementation of continuity of restorative care bridges the gap between intensive treatment and social re-integration.

The residency training program is designed to fulfill these goals.

PROGRAM DESCRIPTION

The residency program in rehabilitation medicine at Jackson Memorial Hospital is a three year program of postgraduate training in physical medicine and rehabilitation that leads to eligibility for certification by the American Board of Physical Medicine and Rehabilitation. In July 2004 our program was granted a two-year provisional approval, as a newly launched program, by the Rehabilitation Residency Committee (RRC) under the Accreditation Council for Graduate Medical Education (ACGME). The program trains physicians beginning at the second postgraduate year and requires a preliminary year that includes at least six months of training in one of the following areas: internal medicine, general surgery, pediatrics and/or family practice. Residents must have passed part II of the USMLE/COMLEX to begin the residency and must complete USMLE III with a passing score to move onto the R3 year.

The objectives of the program are to provide a post-doctoral specialty training in Physical Medicine and Rehabilitation and to enable the trainee, upon completion, to undertake state-of-the-art clinical practice, perform research, and/or pursue an academic career. Towards that end, the program is structured to expose the trainee to all areas essential to the attainment of competency and expertise in the profession.

Here at Jackson Memorial Medical Center we have inpatient units that consist of the following number beds for each. Spinal cord injury/comprehensive rehabilitation has 26 beds, neuro-rehabilitation has 28 beds, and pediatric rehabilitation has 12. These patients are admitted to this service by Jackson Memorial Hospital physicians only. The mix of patients is heterogeneous, proportionately reflecting disability seen in the general population. Each resident rotates through the inpatient service twelve - fifteen months. During these rotations the resident will be responsible for the comprehensive primary medical and rehabilitative care of their patients. Residents will be given a list of comprehensive objectives for which they must show competency to pass the rotation.

The rehabilitation medicine consultation service receives over 2500 annual consultations for patients on other services. One resident will rotate through the service, performing all consultations and then presenting them to the attending physician on service. One resident each month will be assigned to the Electrodiagnostic Medicine service, jointly managed by Rehabilitation Medicine and Neurology alternating with the Orthopedic service where clinics are attended. Two months minimum of the resident's experience will be devoted to pediatric rehabilitation, including evaluation and psychiatric management of inpatients at the Jackson Memorial Hospital, consultations in the neonatal intensive care unit at Jackson Memorial Hospital, Miami Children's Hospital, and the pediatric rehabilitation in-patient wards, and outpatient exposure in the pediatric rehabilitation clinics.

Didactic course series include lectures in: prosthetics/orthotics, electrodiagnostics, anatomy and kinesiology (including cadaver dissection laboratory), physical examination, therapeutic modalities, orthopedic rehabilitation, principles of neurologic, cardiopulmonary, and musculoskeletal rehabilitation, manual medicine, neurotrauma, and pediatric rehabilitation. Regularly scheduled academic discussions and activities include: monthly journal clubs, case presentation rounds both on the inpatient unit and consultative services, program director case conferences, board review club, formal research training, and grand rounds. Interdisciplinary conferences include: spine conference, neuroradiology conference, rheumatology conferences, anatomy course with dissection laboratory, neurology grand rounds, geriatric grand rounds, and orthopedic grand rounds.

The department supports the philosophy of adult learning. A major goal of the residency is the development of sound educational habits that result in a self-generated study and continuous learning. Although the program provides an extensive variety of didactic educational tools, each resident is ultimately responsible for his/her own professional education and is expected to devote substantial time at regular intervals to reading and enhancement of his/her knowledge.

Resident evaluations occur every month and include formal written evaluations of the resident and face to face presentation of the evaluation. Additionally individual discussion with the Program Director occurs twice per year. All residents participate in the annual Self Assessment Examination administered nationally by the American Academy of Physical Medicine and Rehabilitation. Residents are expected to score no lower than the 25 percentile nationally on this examination. The residents also receive a written evaluation upon completion of each rotation. Conversely, residents evaluate the program and the attending physicians annually, in addition to monthly rotation evaluations. The Chairperson and Program Director use this evaluation process to optimize the resident's learning experience.

Resident assessment is based on ACGME guidelines for residency programs (see Appendix).

Residents are required to develop and participate in original research that will culminate in a presentation, during or at the end of the residency. Each resident must seek a mentor with whom the resident may use the basic tools acquired in the research lectures to produce original work. The results and methods of the research must be presented in oral presentation at the end of the residency on the designated research day program. Additionally, all residents are required to submit an abstract for poster or platform presentation to be presented at the National Academy of PM&R meeting during their PGY 4 year. Residents who submit an acceptable abstract (reviewed by the program director) will have expenses related to that meeting paid for by the department.

EDUCATIONAL OBJECTIVES

OVERALL PROGRAM OBJECTIVES

- To provide an educational experience to enable our graduates to attain competencies necessary for entry level independent of Physical Medicine and Rehabilitation. This is accomplished through intensive study in diagnosis, pathogenesis, treatment, prevention, and rehabilitation of neuromusculoskeletal, cardiovascular, pulmonary, and other system disorders common to the specialty.
- To develop the attitudes and psychomotor skills required to:
 - Modify history taking technique to include data pertinent to functional abilities, and impairments that affect those abilities.
 - Perform physiatric examinations and procedures common to the practice of physical medicine and rehabilitation.
 - Make sound clinical judgments.
 - Design and monitor rehabilitation treatment programs to minimize and prevent impairment and maximize functional ability.
- To coordinate, lead, and manage an interdisciplinary team of allied rehabilitation professionals through:
 - Knowledge of each provider's role.
 - Writing of detailed, goal-based physiatric prescriptions.
 - Development of leadership and management skills.

The above concepts will be taught within the framework of the six key areas of residency teaching:

Resident must achieve competence in six key areas of physician training:

1. Patient Care
2. Medical Knowledge
3. Professionalism
4. Systems Based Practice
5. Interpersonal and Communication Skills
6. Practice Based Learning

It is expected that by achieving competence in each of the six areas, that this program will graduate complete PMR physicians who are competent to practice in this field of PMR and can effectively compete with other physiatrists equally in an academic or private practice setting.

The global objectives that you are expected to achieve while in the PMR program are listed below:

GLOBAL LEARNING OBJECTIVES OF THE PMR RESIDENCY PROGRAM

The PMR residency program at Jackson Memorial Hospital and the University of Miami School of Medicine requires our residents to attain competency in the six areas identified by the ACGME. These are: patient care, medical knowledge, practice-based learning and improvement, communication and interpersonal skills, professionalism, and systems-based practice.

Residents will be expected to progress through the PGY 2, 3, and 4 years and improve their levels of competence to achieve independence in PMR medicine. Educational programs and clinical experience provide our residents with the skills to achieve competency in these areas. The program directors have put in place assessment tools to measure residents' competency in each area, and continue to work on expanding our methods of assessment.

An outline of the six competencies, current objectives, and methods of assessment are discussed below.

Patient care:

Residents must provide compassionate, comprehensive care to all patients. To make diagnostic and therapeutic decisions based on best available evidence, sound judgment, and patient preferences. Residents must possess comprehensive history and physical examination skills, and competence in procedural skills.

Education:

1. Structured inpatient and outpatient experiences provide the opportunity for residents to assess and provide care to patients with widely varying clinical problems. In the PGY-2 year, residents will see new patients in inpatient and ambulatory settings at both JMH and the VA, and have very close and comprehensive mentoring and supervision from both more senior residents and attending level faculty.
2. In these settings, residents will strengthen their ability to gather accurate data, and learn to synthesize this data to develop a comprehensive plan of assessment, differential diagnosis and treatment.
3. Residents are supervised in the performance of procedural skills by more senior residents or faculty, and document each procedure on-line.
4. Faculty serves as role models for the provision of comprehensive, compassionate care. Dedicated PMR faculty is assigned to both the inpatient rehabilitation service and the ambulatory settings, where they review the assessment and care plan for each patient with the resident.

Areas of Competence (Objectives) that must be achieved:

PGY-2

- 1.1a Perform an expanded psychiatric history, including aphasic patients.
- 1.2a Perform basic neurological, musculoskeletal, and medical physical exam that includes all aspects of the psychiatric exam.
- 1.3a Perform the expanded functional exam unique to the psychiatric assessment.
- 1.4a Perform the ASIA SCI examination.
- 1.5a Perform in depth musculoskeletal and neurologic system examination.

- 1.6a Learn basic procedural skills including peripheral joint injection, foley catheter placement, refill Baclofen pumps.
- 1.7a Begin to learn to perform EMG/NCV studies and Botox injections.
- 1.8a Learn how to document properly in the care of the patients with competent progress notes, discharge summaries, and team evaluation summaries.
- 1.9a Identify normal and common abnormalities on:
 - i. Brain CT, MRI
 - ii. Spine X-ray, CT, MRI
 - iii. Bone Scan
 - iv. KUB X-ray

PGY-3

- 1.1b Perform an expanded psychiatric history, including aphasic patients in the setting of the acute care consultation.
- 1.2b Perform and orthopedic examination on specific areas of the body:
 - i. Shoulder
 - ii. Knee
 - iii. Spine
 - iv. Elbow
 - v. Wrist and hand
 - vi. Ankle
- 1.3b Perform an expanded history and physical exam targeted to patients with chronic pain disorders and a history of Military Service
- 1.4b Perform the necessary neurological exam that will allow for the EMG/NCS testing
- 1.5b Perform a basic NCV and EMG exam.
- 1.6b Perform joint injections in the areas of the body mentioned above.
- 1.7b Order diagnostic tests appropriately to evaluate patients with musculoskeletal and neurological disorders.
- 1.8b Show improved abilities to read and interpret:
 - vii. Brain CT, MRI
 - viii. Spine X-ray, CT, MRI
 - ix. Bone Scan
 - x. EMG/NCS reports

PGY-4

- 1.1c Perform and document an expert comprehensive psychiatric history, physical examination, and function examination in a manner that conveys compassion, caring, and respect for the patient.
- 1.2c Based upon comprehensive assessment, create an appropriate rehabilitation diagnosis, treatment plan, and goal for functional outcome.
- 1.3c Perform a comprehensive psychiatric consultation on patients in the acute hospital.
- 1.4c On patients on whom consultation is performed, decide on the need for inpatient vs outpatient rehabilitation.
- 1.5c On patients needing inpatient rehabilitation, choose appropriate treatment modalities and set goals for treatment.

- 1.6c Order appropriately and interpret diagnostic tests in the setting of musculoskeletal and neurologic diseases.
- 1.7c Identify detailed normal anatomy as it pertains to the nervous and musculoskeletal system on CT, MRI, myelography, bone scan, and X-ray.
- 1.8c Demonstrate the ability to reference and utilize electronic systems to access relevant medical, scientific and patient information.

Assessment:

1. Residents document each procedure performed on-line.
2. Mini-CEX (clinical-evaluation exercises) exams are performed throughout each inpatient and outpatient rotation, and are reviewed with the resident by the faculty. The results of these are further reviewed with each resident at the time of each semi-annual review with the program director or associate program director.
3. Monthly evaluations are completed by the resident's attending physician, co-resident, intern and medical students and are reviewed with the resident by both his attending and program director(s).
4. Evaluations of residents in continuity clinic are completed semi-annually by their assigned attendings.

Medical Knowledge:

Residents must demonstrate knowledge of basic and clinical sciences and apply this knowledge to decisions regarding patient care. They will have comprehensive understanding of mechanisms of disease, and possess desire for lifelong learning.

Education:

1. Resident inpatient rounds with senior residents and attending staff are held at both JMH and the VA four or five days weekly.
2. The core curriculum lecture series provides comprehensive didactics throughout the academic year, and is presented at JMH with a 18 month cycle.
3. An introductory lecture series is held daily for the first month of each academic year, required for all PGY-1s, and attended by many junior and senior residents as well, to provide comprehensive education regarding emergencies in clinical medicine.
4. Journal Club is held once per month.
5. Clinical case conference is held with the program director two Fridays per month.
6. Monthly M & M, Journal club or Performance-Improvement conferences are held and required for all residents.
7. Monthly PMR grand rounds are given.
8. A 20 hour anatomy course is given each year by anatomy staff each year.
9. Prosthetic and Orthotics staff gives lecture series on a 1 ½ year cycle.
10. Courses will be provided in Botox injection and joint injection.

Areas of Competence (Objectives) that must be achieved:

PGY 2

- 2.1a Learn the basic pathophysiology, evaluation, treatment, and inpatient rehabilitation management of the core problems of:

- a. TBI
 - b. Stroke
 - c. SCI
 - d. Amputee
 - e. Chronic pain
 - f. Total Joint replacement
 - g. Post cardiac surgery
 - h. Debility
 - i. Inflammatory joint disease
 - j. Burn
- 2.2b Learn to prevent and then identify common and uncommon medical complications that occur in patients with disabling injuries in the inpatient rehabilitation setting including but not limited to
- k. Decubiti
 - l. MI
 - m. Respiratory incident
 - n. Autonomic dysreflexia
 - o. Hydrocephalus
 - p. Heterotopic Ossification
- 2.3c Begin to learn the pathophysiology, evaluation, treatment, and rehabilitation management of common and some uncommon problems seen in the outpatient setting including but not limited to
- q. Shoulder disorders
 - r. Knee disorders
 - s. Spine disorders
 - t. Chronic pain disorders
 - u. Post polio
 - v. Follow up SCI, TBI, Stroke, Amputee, Total joint
- 2.4a Learn the anatomy of the musculoskeletal, spine, and neurological system
- 2.5a Learn physical examination maneuvers that test the anatomy when pathology is present.

PGY-4

- 2.1d Demonstrate comprehensive knowledge of common and uncommon neurologic disorders including considerations relating to age, gender, race, ethnicity, genetics, and sociocultural factors.
- 2.2d Demonstrate comprehensive knowledge of common and uncommon musculoskeletal disorders including considerations relating to age, gender, race, ethnicity, genetics, and sociocultural factors.
- 2.3d Demonstrate comprehensive knowledge of common and uncommon painful disorders including considerations relating to age, gender, race, ethnicity, genetics, and sociocultural factors.
- 2.4d Demonstrate comprehensive knowledge in psychiatric disorders and how they impact patients with chronic disease, pain, and disability.
- 2.5d Demonstrate knowledge of healthcare delivery systems.

- 2.6d Demonstrate knowledge of the anatomy and pathophysiology of all of the common and uncommon neurological, musculoskeletal, medical, and painful disorders that a physiatrist would be expected to encounter.
- 2.7d Demonstrate the ability to competently treat all of the common and uncommon neurological, musculoskeletal, medical, and painful disorders that a physiatrist would be expected to encounter.
- 2.8d Demonstrate specific knowledge of the neurophysiology of EMG/NCS/SSEP
- 2.9d Demonstrate the knowledge of peripheral joint injection.
- 2.10d Assess a patient with amputation or limb weakness and prescribe an appropriate orthotic or prosthetic device.

Assessment:

1. Residents at all three PGY levels are required to take the standardized in-training examination annually.

Results are reviewed in detail at the time of the semi-annual reviews.

- 2. After a “block” of lectures, an exam will be given.
- 2. Evaluations of medical knowledge are completed as part of the comprehensive monthly evaluation at the end of each rotation by the attending, physicians.
- 3. Residents actively participate in case conference in the presence of the chairman, program director, and other key faculty.

Practice-based learning and improvement:

Residents must demonstrate competency in the investigation and self-evaluation of patient care, use of technology and appraisal of scientific evidence, apply evidence-based medicine to improve patient care, and other methods of self-improvement in the provision of outstanding patient care. The Basic Objectives are shared among PGY2, 3, and 4 levels but the level of competence expected will be expected to be higher in the more experienced resident.

Education:

- 1. Residents attend a comprehensive didactic lectures in evidence-based medicine and research methodology.
- 2. Journal club, held at least monthly, is presented by one resident and discussed by another resident and supervised by a faculty member that serves as preceptor. Discussions of sound medical evidence and application to patient care are emphasized.
- 3. M & M conferences, and performance-improvement conferences stress methods of identifying areas for potential improvement and the open discussion of medical errors.
- 4. A grand rounds on prevention of medical errors is held annually.
- 5. All deaths and complications are reviewed during M&M report at both JMH and the VA.

Areas of Competence (Objectives) that must be achieved:

PGY-2,3,4

- 3.1 Employ principles of quality improvement in practice.
- 3.2 Demonstrate awareness of limitation in one’s own knowledge base and clinical skills
- 3.3 Demonstrate effective methods for lifelong learning

- 3.4 Demonstrate the ability to obtain, review, and critically evaluate up-to-date information from scientific and practice literature and other sources (internet based searches, literature databases such as PubMed, drug information databases) to assist in patient care.
- 3.5 Evaluate caseload and practice experience in a systematic manner.
- 3.6 Participate in the learning of students and other health care professionals.
- 3.7 Employ a strategy to identify medical errors in practice and initiate improvements to eliminate or reduce errors.

Assessment:

1. Monthly evaluations are completed by the resident's attending, regarding competency in practice-based learning and improvement.
2. Case presentations during rounds and at conferences are encouraged to include current literature reviews. Problem-based learning objectives are identified and discussed at follow-up conferences.

Communication and interpersonal skills:

Residents must demonstrate competency in effective listening and communication skills, and in the ability to develop strong therapeutic relationships with patients, nurses, rehabilitation multidisciplinary team and the families. They must be able to obtain and provide information in clearly understandable ways, and educate and counsel patients effectively. They must demonstrate the ability to work well with others as part of an interdisciplinary health care team.

Education:

1. Throughout all aspects of residency training, residents are exposed to faculty who are effective and active role models for becoming competent in communication and interpersonal skills. These interactions occur daily in both inpatient and outpatient settings.
2. Specifically, in the inpatient setting, residents are exposed to faculty role models and also actively participate in family conferences with patients and families regarding issues of rehabilitation goals, discharge planning, medical and functional prognosis, and psychological issues.
3. Specific didactic sessions, including during medical grand rounds, are dedicated to discussion of communication and interpersonal skills.

Areas of Competence (Objectives) that must be achieved:

- 4.1 Demonstrate the ability to communicate effectively with patients, caregivers, physicians, and other health professionals.
- 4.2 Demonstrate the ability to collaborate with patients, caregivers, physicians and other health professionals.
- 4.3 Communicate effectively with consulting physicians and other health professionals, and outline clear and specific recommendations.
- 4.4 Maintain up-to-date medical records that respect patient privacy and document essential information
- 4.5 Demonstrate the ability to work effectively as a member of a multidisciplinary treatment team.
- 4.6 Demonstrate the ability to work effectively as a member of a multidisciplinary team

- 4.7 Demonstrate the ability to effectively lead a multidisciplinary treatment team on the inpatient rehabilitation service and in the outpatient setting.
- 4.8 Partner with the patient and his/her family to develop a mutually agreeable healthcare management plan, discuss risks of proposed treatment, and discuss benefits, complications and alternative treatments.
- 4.9 Provide preventative education
- 4.10 Educate patients and their families about the medical, psychological, and behavioral issues of their disability.
- 4.11 Demonstrate the ability to obtain proper informed consent including explanation of risks, benefits, and alternative treatments.
- 4.12 Communicate effectively with medical consultants.
- 4.13 Communicate the advice of consultants effectively to patients and families.
- 4.14 Maintain up-to-date medical records that respect patient privacy and reflect the treatment that is being offered and given. Such records must be understandable to non-rehab physicians, other caregivers, non-physicians, attorneys, and the patient and family.
- 4.15 Write legible and accurate prescriptions.
- 4.16 Develop a therapeutic relationship with patients by instilling a sense of trust, honesty, openness, rapport, and comfort.

Assessment:

1. Peer-to-peer evaluations are completed anonymously in the form of a 360 degree evaluation once per rotation. These are anonymous and immediately available for each resident to review. These are discussed during the semi-annual evaluations with a program director.
2. Monthly evaluations are completed by the resident's attending physician.
3. The Mini-CEX exams address a resident's ability to effectively communicate and interact with patients.

Professionalism:

Residents must enhance their awareness of one's sensitivity and respect towards patients and co-workers, strengthen their degree of responsibility and accountability, and demonstrate responsiveness to the culture, gender and socioeconomic background of patients. Residents must foster an atmosphere of respect and compassion at all times. Interest and enthusiasm for teaching must be consistently evident in a resident's behaviors.

Education:

1. Professionalism is consistently stressed as a critically important part of a resident's life throughout all aspects of the residency program.
2. Faculty role models are expected to exhibit a high level of professionalism at all times.
3. Medical ethics and professionalism are discussed during resident case conferences and during other interactive sessions with residents.
4. Didactics have been presented specifically addressing professionalism.
5. Videos that address this topic are presented and discussed with attending staff.

The Basic Objectives are shared among PGY2, 3, and 4 levels but the level of competence expected will be expected to be higher in the more experienced resident.

- 5.1 Demonstrate responsible behavior in the care of patients, including timely response to communications from patients and health professionals and coordination of patient care.
- 5.2 Demonstrate confidentiality in the delivery of care.
- 5.3 Demonstrate ethical behavior, professionalism, integrity, honesty, and compassion in both spoken and written communications, including matters of informed consent, professional conduct, and conflict of interest.
- 5.4 Demonstrate respect for patients, caregivers, and professional colleagues.
- 5.5 Communicate verbally and non-verbally
- 5.6 Demonstrate respect for patients, caregivers, and professional colleagues in regard to different ages, cultural beliefs, religious beliefs, genders, disabilities, socioeconomic backgrounds, political leanings, and sexual orientation.
- 5.7 Demonstrate sensitivity regarding end-of-life care issues.
- 5.8 Participate in the review of professional conduct of colleagues.
- 5.9 with patients, caregivers, and the rehab medical team in an ethical and appropriate manner.

Assessment:

- 1. Monthly evaluations completed by attendings address this competency, and are reviewed with the resident both immediately after each rotation and during the semi-annual reviews.
- 2. Peer-to-peer evaluations are completed anonymously in the form of a 360 degree evaluation once per rotation. These are anonymous and immediately available for each resident to review. These are discussed during the semi-annual evaluations with a program director.
- 3. An award is presented annually to the resident in our program who has best demonstrated the ideals of professionalism.

Systems-based practice:

Residents must demonstrate competency in negotiating the system in which they work to ensure optimal patient care, and to apply knowledge of systems to improve patient care. They must be able to use systematic approaches to reduce errors and improve care, as well as effectively access and utilize outside resources to benefit their patients.

Education:

- 1. Close interaction with social workers, case managers, clinical pharmacists, nursing staff, physical and occupational therapists, nutritionists, and other members of the rehabilitation multidisciplinary team provide residents with opportunities to utilize resources for the benefit of their patients.
- 2. Social workers and case managers are assigned to specific patient care units and interact daily with residents.
- 3. Dedicated time with the Geriatric service at the VA is required for all PGY-4 residents. During this rotation, residents are exposed to methods of providing comprehensive care to this population, including the interaction of social workers, geriatric case managers, nurses and physicians to optimize the level of care.
- 4. Residents will interact with insurance medical directors to obtain increased inpatient rehabilitation days.

The Basic Objectives are shared among PGY2, 3, and 4 levels but the level of competence expected will be expected to be higher in the more experienced resident.

- 6.1 Demonstrate the ability to use the diverse systems involved in treating patients, as part of a comprehensive, individualized treatment plan.
- 6.2 Utilize community systems of care and assist patients to access appropriate care and other support services.
- 6.3 Demonstrate effective utilization of managed health systems
- 6.4 Practice cost-effective health care and resource allocation that does not compromise quality of care.
- 6.5 Lead the multidisciplinary team in the provision of comprehensive rehabilitation treatment.
- 6.6 Demonstrate effective time management skills
- 6.7 Utilize systems of care appropriately including rehab placement, nursing home placement, home care, and hospice.
- 6.8 Act as an advocate for patients so that they can receive medical care regardless of their sociocultural or financial situation.
- 6.9 Behave in a manner that shows awareness of medical-legal and financial aspects of patient care and risk management.
- 6.10 Participate effectively in utilization review communications and meetings and advocate for quality of care when appropriate.
- 6.11 Practice cost-effective health care that does not compromise patient care.

Assessment:

1. Monthly evaluations completed by attending physicians and reviewed with the resident upon completion of the rotation and at the semi-annual evaluations.
2. Discussion of issues of systems-based practice at rounds regularly.
3. Peer-to-peer evaluations are completed anonymously in the form of a 360 degree evaluation once per rotation. These are anonymous and immediately available for each resident to review. These are discussed during the semi-annual evaluations with a program director.

ROTATION OBJECTIVES AND AFFILIATIONS

JMH-UM ROTATIONS

ACQUIRED BRAIN INJURY ROTATION OBJECTIVES

The faculty member (s), will be reporting to the rotation director about the progress and performance of each resident through the course of the rotation. Although the resident will be directly reporting to a faculty member, he/she may also be reporting to the rotation director as needed.

The resident may take care of as many as but usually no more than 14 patients at any given time. On average, a minimum of 8 patients will be on the teaching service. Teaching will occur during bedside rounds to expand the resident's medical knowledge base. In addition, the resident will be exposed to didactic sessions throughout the rotation on topics appropriate to the care of the psychiatric patient. These will be assigned and adjusted according to the clinical load at any given time.

The resident will be expected to:

- Show reliability, punctuality, integrity, and honesty.
- Accept responsibility for any actions and decisions made.
- Demonstrate and exemplify caring and respectful behaviors, present material clearly and accurately, and establish trust and maintain rapport with patients and family members.
- Collaborate and work effectively with other health professionals and maintain appropriate behaviors.
- Effectively communicate verbally and in writing patient needs to all staff involved with the rehabilitation patient.
- Contribute to discussions on the care of the rehabilitation patient with other health care professionals by attending and participating in conferences and rounds in order to facilitate such discussions.
- Complete all chart notes and dictations in a timely and legible manner. This includes daily progress notes on all patients, discharge summaries completed within 24 hours of discharge barring unforeseen circumstances, team rounds summaries, and accurate medication and therapy orders.
- Present 2 conferences for teaching purposes during each 3-month rotation.
- Senior residents will have a topic assigned for teaching purposes weekly.
- Furnish a brief summary or notes taken during the various didactic sessions that are not directly supervised by a faculty member, as evidence of attendance.
- Keep a log of any procedures done during the rotation (i.e. intrathecal drug therapy trials, chemodenervating procedures, pump refills/programming, and the like).

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

COMPREHENSIVE INPATIENT ROTATION

The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner. Specifically the resident will be expected to:

- Demonstrate caring and respectfully behaviors (verbal and non-verbal) with patients.’
- Elicit information using effective questioning and listening skills.
- Diagnose physical, cognitive, and psychosocial impairments in rehabilitation patients with acute and chronic medical problems, musculoskeletal injuries, and disabilities.
- Admit and perform as the primary care provider under attending supervision of all acute and some chronic SCI inpatients. Residents are responsible for all administrative care related to their patient including but not limited to:
 - Daily progress notes, discharge summaries, team rounds summaries, daily patient medication orders, comprehensive therapy orders, family conference summaries
 - Perform a full comprehensive neuromuscular examination on selected patients.
 - Perform comprehensive internal medical exam on selected patients.
 - Perform comprehensive rehabilitation consultations on selected patients.
 - Create a differential diagnosis appropriate to the physical findings.
 - Recommend appropriate inpatient and outpatient rehabilitation patients based upon their known or suspected diagnosis.
 - Learn to interpret the findings of the ordered tests.
 - Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

VAMC R2 combined inpatient and then outpatient Rotation with Consultation Responsibilities

GENERAL REHABILITATION OBJECTIVES FOR THE IN-PATIENT ROTATION

At the end of the rotation, it is expected that the resident will be able to:

- Cite and apply outcome-based criteria for determination of candidacy for admission to acute inpatient unit
- Apply current knowledge in rehabilitation medicine to the design and implementation of goal-based, therapeutic protocols for inpatients.
- Write detailed, comprehensive prescriptions for durable medical equipment, including ambulatory assistive devices, prosthetics, orthotics, and wheelchairs.
- Cite and apply objective tools of measurement for patients with disability to measure changes in functional status.

- Apply current knowledge in general medicine to the care and improvement of health of rehabilitation inpatients and outpatients with coexisting medical conditions.
- Attain competency and expertise in the management of emergent, complicating conditions affecting inpatients on the rehabilitation unit.
- Cite alternative methods and systems for delivery of rehabilitative services, i.e., sub-acute-short-term, long-term, home care, etc.
- Attain competency and expertise in diagnostic evaluation of patients with neuromuscular, musculoskeletal, cardiopulmonary, rheumatologic, or other disabling conditions.
- Apply appropriate managerial principles toward direction and leadership of the interdisciplinary team.

OBJECTIVES OF THE CONSULTATION SERVICE

At the end of the rotation, it is expected that the resident will demonstrate competency and expertise as a consultant in rehabilitation medicine, including:

- Performance of appropriate history and physical examination focusing on impairment, disability, and other functional aspects of the patient.
- Development of skills required to manage a large consultative service in a tertiary care hospital setting.
- Development and implementation of appropriate therapeutic protocols and plans, including interdisciplinary care, durable medical equipment, and further diagnostic and therapeutic options as indicated.
- Demonstration of ability to present cogent case histories to the attending physician in charge of the consult service
- Application of appropriate selection and screening criteria to determine appropriate level of rehabilitative care and familiarity with all options.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

NEUROLOGICAL REHABILITATION ROTATION

Goal: To provide a comprehensive Neurological Rehabilitation training for PM&R residents over a 10 weeks period.

Objectives: Residents will be required to have knowledge of the following disorders:

1. Multiple Trauma and Traumatic Brain Injury
2. Cerebrovascular Disorders
3. Demyelinating Disorders
4. Degenerative Disorders of the Central and Peripheral Nervous System
5. Primary and Secondary Tumors of the Central and Peripheral Nervous System.
6. Metabolic Disorders affecting the Central and Peripheral Nervous System
7. Transplant
8. Metabolic Disorders causing disabilities.

Residents will be required to achieve the following milestones of learning on the disorders listed above:

1. To be able to perform a comprehensive Neurological Rehabilitation Exam
2. To be understand differential diagnosis and describe the pathophysiology of on Neurological and related disorders in a organized format
3. To be able to do workup and treat the disorders listed above
4. To be able to determine the prognosis of Neurological disorders
5. To be able to develop and recommend rehabilitation programs for patients with Neurological and related disorders
6. To be able to relate structural with functional in the management of the listed disorders
7. To be able to utilize various Neuropharmacologic agents in the management of Neurological disorders and related complications
8. To access safety and risk factors in the Neurological Rehabilitation patients
9. To understand the medical legal aspects of the disabled patient.

Skills to master:

1. Lumbar Puncture
2. Management of Spasticity disorders with rehabilitation intervention, oral agents, Botox and Baclofen Pumps
3. Conducting team conferences
4. Conducting family conferences
5. Communicating with therapies, consulting physicians, insurance companies, case managers and discharge planners and families
6. Management of patients in the out-patient setting
7. Offering consultative services on patients in the acute care services when transfer is contemplated to rehab or who are involved in discharge planning
8. Write up of consults, admission notes and orders
9. Attend sessions involving medical-legal testimony.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

SCI INPATIENT ROTATION

Each resident will be under the supervision of Department of Rehabilitation Medicine faculty members specialized in spinal cord medicine throughout this clinical rotation. The faculty members will supervise the resident during examinations on the inpatient rehabilitation unit to assure clinical competency and attainment of objectives including but not limited to those described below. The supervising physicians will constantly evaluate the resident to assure the resident obtains patient care competency as expected for a new practitioner. Additionally, the resident will undergo evaluation by a 360 degree type review of all members of the multidisciplinary rehabilitation team.

Specifically the resident will be expected to:

- Admit and perform as the primary care provider under attending supervision of all acute and some chronic SCI inpatients. Residents are responsible for all administrative care related to their patient including but not limited to:
 - Daily progress notes, discharge summaries, team rounds summaries, daily patient medication orders, comprehensive therapy orders, family conference summaries
 - Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients.
 - Elicit information using effective questioning and listening skills.
 - Diagnose physical, cognitive, and psychosocial impairments in rehabilitation patients with Spinal cord injuries.
 - Perform a full comprehensive neuromuscular examination and ASIA examination on selected patients.
 - Perform comprehensive physiatric examinations on patients admitted to their service.
 - Perform daily examinations on SCI inpatients to prevent medical complications.
 - Create a differential diagnosis appropriate to the physical findings.
 - Recommend appropriate inpatient and outpatient rehabilitation plans based upon the level of spinal cord injury and co-morbid conditions or suspected diagnosis.
 - Learn to order appropriate diagnostics and interpret the findings of the ordered tests.
 - Create organized, coherent, and comprehensive reports that can be easily interpreted by other physicians and allied health personnel.
 - Demonstrate caring with the patients who are going through chronic illness and disability.
 - Lead a multidisciplinary team in the care of SCI patients.
 - Show such leadership in weekly team meetings
 - Show leadership and become proficient at organizing and leading a family meeting.
 - Perform appropriate comprehensive examinations on SCI inpatients daily and on rounds with attending physicians.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

EMG / NEUROMUSCULAR DISEASE ROTATION

Each resident will be under the supervision of multiple physiatry and neurology faculty members throughout this clinical rotation. The faculty members will supervise the resident during examinations in the clinics, spine institute, and private outpatient offices to assure clinical competency and attainment of objectives including but not limited to those described below. Additionally, residents will be expected to acquire the psychomotor skills essential to performing electrophysiological examinations. CD ROMS are available for review to assist learning. The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner.

Specifically the resident will be expected to:

- Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients.
- Elicit information using effective questioning and listening skills.

- Diagnose physical, cognitive, and psychosocial impairments in patients with neuromuscular injuries and diseases.
- Perform a full comprehensive neuromuscular examination on patients with neuromuscular complaints.
- Create a differential diagnosis appropriate to the physical findings.
- Learn what electrophysiologic tests are appropriate based upon the differential diagnosis.
- Obtain appropriate informed consent for the procedure.
- Respect that the patient is going through an uncomfortable procedure.
- Learn to interpret the findings on electrophysiologic exam.
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians.
- Demonstrate caring with the patients who are undergoing a largely unpleasant study.
- Integrate the findings to recommend rehabilitation treatment based upon the electrodiagnostic findings.
- Learn how an intraoperative monitoring procedure is performed.
- Learn how to interpret and perform somatosensory evoked potential exams.

Residents will be expected to gradually increase their knowledge in electrodiagnostic medicine and neuromuscular disease. They will receive opportunities to learn from their attending via bedside teaching but will also be expected to investigate medical topics via journal articles and specialized textbooks. Each of these will be made available by the supervising attending in the rotation. A didactic course dedicated to both electrophysiologic testing and neuromuscular disease will be taught. Evaluation will occur by direct one-on-one feedback throughout the rotation, through a formal written evaluation at the middle and end of the rotation. The didactic course will offer written exams and an SAE exam will be offered.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

SPORTS MEDICINE/ORTHOPEDIC/MUSCULOSKELETAL

One PGY-3 resident will be assigned to rotate through the Orthopaedic Musculoskeletal Clinic at Jackson Memorial Hospital. The rotation will be overseen by Dr. Alejandro Posada. The resident may also accompany Dr. Posada to the operating room to observe surgical management of orthopedic patients.

- Demonstrate competency and expertise in evaluation and management of outpatients with common orthopedic and musculoskeletal conditions and their resultant disability.
 - Shoulder injuries and illness
 - Spine injury
 - Knee pain and injury
 - Elbow injuries
 - Foot and ankle injuries
- Cite and apply knowledge of sports orthoses and indications for usage.

- Demonstrate knowledge of common operative interventions and management of postoperative orthopedic rehabilitation protocols.
- Demonstrate proficiency in assessment of the athlete of all ages both pre-participation and during participation. Cite and apply criteria for determination of withdrawal from sports related activity.
- Cite and apply limitations to office-based practice imposed by in the system of health care delivery. Develop strategies and management skills for conduct of independent physiatric practice.
- Apply managerial strategies for direction of office personnel and interdisciplinary care with in- office allied health care providers.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

VA R3 Rotation – Outpatient clinic service and Consultation service

Each resident will be under the supervision of multiple psychiatry faculty members employed by the VAMC and who have voluntary faculty appointments with the University of Miami Department of Rehab Medicine throughout this clinical rotation. The faculty members will supervise the resident during examinations on the inpatient rehabilitation unit to assure clinical competency and attainment of objectives including but not limited to those described below. The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner.

Specifically the resident will be expected to:

- Demonstrate caring and respectfully behaviors (verbal and non-verbal) with patients.’
- Elicit information using effective questioning and listening skills.
- Diagnose physical, cognitive, and psychosocial impairments in rehabilitation patients with acute and chronic medical problems, musculoskeletal injuries, and disabilities.
- In the outpatient clinics resident will write comprehensive progress notes and patient medication and therapy orders,
- Perform a full comprehensive neuromuscular examination on selected outpatients.
- Perform comprehensive internal medical exam on selected patients.
- Perform comprehensive rehabilitation consultations on selected patients.
- Create a differential diagnosis appropriate to the physical findings.
- Recommend appropriate inpatient and outpatient rehabilitation patients based upon their known or suspected diagnosis.
- Learn to interpret the findings of the ordered tests.
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians.
- Demonstrate caring with the patients who are going through chronic illness and disability.
- Integrate the findings to recommend rehabilitation treatment based upon the examination findings.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

PAIN MANAGEMENT

Senior residents are assigned to rotate through the UM-JMH pain management service. The resident will be an active participant in the management and follow up of in-patients and out-patients. The resident will also assist in the interventional procedures performed by the pain service and help the service with consultations. The resident will be trained to do the following:

- Cite methods for evaluation and treatment of patients with chronic pain.
- Cite indications, contraindications, risks and benefits of interventional treatment for the management of chronic pain.
- Develop methods for evaluating patients with chronic pain and selection of patients for invasive procedures.
- Devise a comprehensive multidisciplinary approach to the chronic pain patient.
- Cite indications, uses, and contraindications of noninvasive pharmacological agents for chronic pain.
- Explain the role of behavioral scientists in the evaluation and management of chronic pain patients.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

ELECTIVE ROTATION

Senior residents have one month, at the Chairperson discretion, of elective rotation. The rotations are arranged during the private office or pain rotation months and have to be approved by the Chairperson. The elective rotation will be taken as a PGY-4. Since the experiences will be so different depending on the experience, it will be up to the RESIDENT to write the rotation objectives. These will be reviewed by the program director and if acceptable then the elective will be approved.

JMH Senior Chief rotation

- Apply current knowledge in rehabilitation medicine to the design and implementation of goal-based, therapeutic protocols for inpatients.
- Demonstrate proficiency in the evaluation and management of patients with cardiovascular disability.
- Knowledge of application and use of exercise testing, including indications and contraindications.
- Design and implementation of therapeutic exercise programs.

- Impact of cardiovascular morbidity on functional ability.
- Assessment and management of postoperative cardiovascular conditions.
- Discuss pathophysiology of pulmonary disease as it impacts on functional status and rehabilitation potential.
- Demonstrate proficiency in evaluation and management of patients with disability due to primary and secondary pulmonary function impairment.
- Demonstrate proficiency in the management of emergent, complicating conditions affecting inpatients on the rehabilitation unit.
- Effectively teach junior residents.
- Perform as a senior resident on the TR-4 service
- Assist with some administrative functions for the residency such as schedule making, call coverage, quality meetings, hospital medical director meetings.
- Perform accurate senior level consultations on inpatients on the acuter medical surgical services

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

SENIOR ELECTRODIAGNOSTIC SERVICE/Neuromuscular disease

Each resident will be under the supervision of multiple physiatry and neurology faculty members throughout this clinical rotation. The faculty members will supervise the resident during examinations in the clinics, spine institute, and private outpatient offices to assure clinical competency and attainment of objectives including but not limited to those described below. Additionally, residents will be expected to acquire the psychomotor skills essential to performing electrophysiological examinations. CD ROMS are available for review to assist learning. The resident will be constantly evaluated by the supervising physicians to assure the resident obtains patient care competency as expected for a new practitioner.

Specifically the resident will be expected to:

- Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients.
- Elicit information using effective questioning and listening skills.
- Diagnose physical, cognitive, and psychosocial impairments in patients with neuromuscular injuries and diseases.
- Perform a full comprehensive neuromuscular examination on patients with neuromuscular complaints.
- Create a differential diagnosis appropriate to the physical findings.
- Learn what electrophysiologic tests are appropriate based upon the differential diagnosis.
- Obtain appropriate informed consent for the procedure.
- Respect that the patient is going through an uncomfortable procedure.
- Learn to interpret the findings on electrophysiologic exam.
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians.
- Demonstrate caring with the patients who are undergoing a largely unpleasant study.
- Integrate the findings to recommend rehabilitation treatment based upon the electrodiagnostic findings.

- Learn how an intraoperative monitoring procedure is performed.
- Learn how to interpret and perform somatosensory evoked potential exams.
- Teach junior residents to perform electrodiagnostic testing.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

JMH PEDIATRIC REHABILITATION

- Demonstration of knowledge of normal pediatric development, milestones, and age-appropriate behavior, including learning ability and play skills.
- Demonstration of knowledge of pediatric disorders that creates functional disability, whether congenital or acquired, including presentation, natural history, prognosis, and functional implications.
- Demonstration of ability to perform pediatric development examination.
- Demonstration of ability to devise and implement multidisciplinary plan of rehabilitative care, write appropriate orders, and initiate appropriate modifications in plan as indicated.
- Cite and apply tools for screening normal or at-risk populations for developmental disabilities.

A full set of objectives divided out into each of the six key competency areas will be given out at the beginning of the rotation. This will list responsibilities and competencies that must be achieved to pass the rotation. (See appendix)

GENERAL GUIDELINES

RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS

GENERAL GUIDELINES

RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS

An important part of residency training is gaining the ability to assume primary responsibility for patient care. However, the desire to create independent practitioners must be balanced with realization that even as a senior resident, an adequate amount of supervision by experienced attending level physician on staff must be available at all times. The amount of responsibility a resident will be given will depend on the knowledge, skill, and judgment they are able to demonstrate. The degree of responsibility will increase as the attending physician feels comfortable with the competence of the resident. The resident must also show a willingness to assume that responsibility.

The resident on the inpatient unit will be supervised only by a licensed attending physician who has been granted clinical hospital rehabilitation privileges through the medical staff process. The attending physician is ultimately legally and ethically responsible for the welfare of the patients assigned to them and the resident. Therefore it is made clear to the residents that regardless of PGY level, they residents are to notify the attending physician with any significant change in medical or mental status, unscheduled admission, death of a patient, new onset medical problem (minor or major), or severe illness requiring evaluation for transfer off the rehabilitation unit. Residents will never be criticized for calling the attending physician, regardless of the hour but are reprimanded if a failure to notify the attending physician results in an unfavorable outcome for the patient.

Clinical experience should allow for progressive responsibility with lesser degrees of supervision as the resident advances and demonstrates additional competency. All clinical activities attended by residents in the first year of training (PGY-1) are supervised by attendings and residents in the second and third year of training. This supervision includes direct clinical observation, teaching, review, and critical appraisal of the resident's work. Residents in the second year of training may be supervised and instructed by attending physicians, SCIM fellows (PGY-5), and senior residents. Residents in the third year of training shall receive supervision and teaching from attending physicians and residents in the final year of training.

PGY-II and PGY-III REHABILITATION MEDICINE RESIDENTS

The role of PGY-II and PGY-III residents involves primarily the care of patients admitted to the Rehabilitation Service or patients evaluated in outpatient rehabilitation clinics. The responsibilities of the inpatient resident include but are not limited to performing admission history and physical, formulating a rehabilitation and medical treatment plan, writing a proper rehabilitation prescription with short and long term goals, providing consultation requests to other services, and leading team conferences with respective attendings. The PGY-II and PGY-III residents also are responsible for management of patients in clinics to which they are assigned.

The PGY-III resident who is assigned to floor duty to fill in for a vacationing resident at JMH or VAMC may provide leadership and loose supervision of the other PGY-2 resident on the service. In the outpatient clinics, it is expected that all core residents who evaluate a new patient will be able to present this case to an attending level supervising physician. In some of the sports medicine clinics, the chief orthopedic resident often serves as an attending physician like figure and can teach the resident to handle non-operative orthopedic problems independently.

Typically, the PGY III electrodiagnostic rotation will be taught one on one by the attending physician but may also involve teaching by a senior resident or a neuromuscular fellow from the department of Neurology.

PGY-IV REHABILITATION MEDICINE RESIDENTS

Residents in their third year of training in rehabilitation medicine (PGY-4) spend the year in rotations through mainly outpatient rotations including an administrative chief/JMH clinic rotation, electrodiagnostic service, pediatric rehabilitation, and outpatient pain, musculoskeletal, and elective rotations. It is expected that as a PGY4 in this program, the resident will be able to function in a more independent fashion to take good care of patients at this institution. However, the pediatric rotation will present unique challenges to the PGY-4 resident who has taken care of adults only. Therefore there is one area where attending level supervision is critical to providing competent patient care. During clinic rotations where junior residents are present, the PGY-4 will be expected to teach the junior residents on the problems the patient presents. Typically patients with non-operative spine, musculoskeletal, and neuromuscular problems are seen most often. Again, in each rotation, the responsible attending physician will need to make a determination as to how much autonomy to grant each individual resident.

CHIEF RESIDENT

The Chairman and the faculty choose one PGY-4 resident to serve as chief resident for the entire academic year. The selection is based on their performance the previous two years and reflects their leadership skills, diligence, scholarship and dependability. The chief is the liaison between administration/faculty and the residents and assists the faculty to coordinate and enact the program's objectives. The chief resident reports directly to the program director and chairman.

The Chief Resident's responsibilities include, but are not limited to:

1. Coordination of resident scheduling for rotation and on-call duties.
2. Direct supervision of junior and senior residents.
3. Direct teaching of junior residents through didactic and clinical methods.
4. Leader of Team Evaluation conferences on the inpatient rehabilitation unit.
5. Screen potential admissions for the inpatient rehabilitation unit.
6. Organize and enact orientation program for new residents.
7. Participate in resident recruitment and interviews.
8. Participate in department Total Quality Management team.
9. Coverage of resident activities during times of manpower shortage.
10. Attend education committee meetings and retreat.
11. Attend GME committee meetings

In addition to the chosen chief resident, all PGY-4 residents will be given the opportunity to rotate as a "chief" at JMH. This rotation will assign administrative and educational responsibilities to the resident that are both supplemental to, and in addition to, the named chief resident. These responsibilities include:

1. Attend Jackson Rehabilitation Quality meetings
2. Attend GME committee meetings
3. Provide lectures and educational teaching for junior residents that include weekly teaching rounds.
4. Coordinate M&M conferences at JMH

CLINICS

PMR core residents will evaluate patients many different types of clinics. Residents will be supervised at all times regardless of the clinic. At JMH and the Miami VAMC, residents will have more autonomy to make treatment decisions but an attending physician will be on site for assistance at all times. Some clinics will have chief residents or fellows as the most senior member of the physician team on site but an attending physician will always be available by phone for advice and will physically come down to that clinic to examine complex patients. At Mount Sinai, and University of Miami Health Clinics/Bascolm Palmer Eye Institute, the attending physician will physically see every patient after the resident performs a thorough history and physical examination and formulates a differential diagnosis and treatment plan.

ACUTE INPATIENT CONSULTATIONS

Residents will be expected to independently perform a history and physical examination. The attending physician of record will be expected to discuss every consultation with the resident. In most cases, the attending physician will teach at the bedside and re-evaluate each consultation to provide the resident with proper feedback on their treatment decision making skills.

The resident will be responsible for communicating their findings to the rehabilitation office to allow for admission planning, funding approval, and bed placement. Residents may need to

intervene with insurance companies and medical directors to gain admission approval. Ultimately the resident will re-screen the patient on the date of transfer in order to make sure that they are medically stable.

PROFESSIONAL BEHAVIOR AND DEMEANOR

Rehabilitation patients are disabled, physically ill, often in pain, and sometimes mentally depressed. The resident is taught by the attending physician that these patients are placing their trust in them. Residents are made to understand that by accepting the career in medicine they are accepting the serious responsibility of acting on their behalf of those who can no longer care for themselves. While at times the responsibility can be overwhelming, the program makes sure that attending physicians are accessible and accountable for providing the proper supervision and professional mentoring to ensure that residents will achieve competence in all of the six competency areas outlined by the ACGME.

WORK HOURS AND PUNCTUALITY

All residents perform the dual roles of physician and student, caring for patients while learning, advancing in experience and knowledge. This double set of constraints on the resident's time demands dedication to a broad range of challenging –and potentially conflicting- academic and clinical responsibilities. Residents are required to attend all didactic sessions and arrive on time. **Only true patient or personal emergencies are considered adequate excuse for a resident's absence or tardiness. Absences or late arrival at teaching sessions for any other reason is unacceptable and may result in disciplinary action against the resident.** Any resident who anticipates being absent or tardy must inform the program director/residency coordinator in advance and justify good cause. The program director/residency coordinator has the authority to approve or deny the request.

Residents are not allowed to work more than 80 hours per week, on average of four weeks.. Residents will have at least 10 hours between scheduled shifts. When on call, the resident will be completed with patient care duties the next day such that they are not on duty more than 30 hours. Residents are allowed to perform a limited amount of duties that morning after 24 hours as they approach 30 hours. Those duties include attending didactics, performing paperwork such as progress notes or discharge summaries, participating in teaching conferences, and clinical care to provide continuity of care. They Residents will have at least 10 hours between scheduled shifts. In addition residents will have on average one full day out of every seven days off and one full weekend off per month. The resident will not be on-call more than every third night.

As professionals, residents are expected to be on the hospital grounds, with their beeper on, by 7:00a.m. on most days unless cleared by the supervising attending physician. This time may vary at times based on the individual supervising attending physician's schedule. Typically residents will remain at work until all of the patients are sufficiently cared for. Experience has shown that residents will typically be able to finish their workload between 4:30 p.m. and 6:30 p.m. *Even in the absence of scheduled academic or clinical activity*, residents are to be available in the hospital during his time to tend to clinical and/or administrative duties. If free/down time becomes available during the work day, the resident is to spend that time usefully in pursuit of educational advancement: studying in the library, attending optional lectures, in-services or activities within or outside of the department

and investigating/exploring research possibilities, preparing presentations, or reading. Except as described above, **under no conditions is the resident to sign out his/her beeper to another fellow or resident and leave the hospital vicinity without permission from the supervising attending physician.** Similar rules apply to residents on affiliate rotations, however, demands on the resident's time will be dictated by the needs of the affiliate rotation.

Weekend days are free from clinical duties when not on call at JMH. Residents rotating While at the VAMC will be asked to come in, Residents may be asked to work a half day every third Saturday with no clinical duties on Sunday. Residents will have then still average of 5 full days off per month at both sites.

CONFIDENTIALITY OF INFORMATION

It is imperative to maintain the confidentiality of all patient information. No information of any kind may be released to any person without the written permission of the patient or his/her legal designee/proxy. This includes relatives, friends, other physicians, lawyers and the press. If you have any questions, check with your attending and hospital counsel for guidance. Please familiarize yourself with all HIPPA guidelines. You will receive training in this area during your orientation weeks.

Discussion of patients or their status in public areas, such as elevators is strictly prohibited. This is considered a breach of patient confidentiality.

TELEPHONE ADVICE

Patients who you speak to on the telephone, with medical questions or problems should be given the most conservative advice possible. It is always better to instruct the patient to go to the nearest emergency room where they can be examined. Whenever possible the reason for the call and advice given should be documented in the patient's chart.

PRESCRIPTION RENEWAL

Patients once discharged may not be given prescription for renewal of their medications. Appointments should be made for them to receive these at the appropriate clinics. Please call your supervising attending with any patient prescription requests. If no attending is available, you may call in 72 hours worth of medication to allow the patient to continue their medication until they can find an alternative source for their renewals.

BEEPER

Each resident is responsible for his/her own beeper. The resident must pay out of his/her pocket for beepers lost, under any condition.

EMERGENCIES ON IN-PATIENT REHAB

Any emergencies occurring on the in-patient rehab unit should be reported to the admitting attending on call. Emergencies occurring on private patients should be reported to the Rehabilitation Medicine attending on call as quickly as possible. First priority is to stabilize the patient. AT JMH, a medical house officer (MOD) is available 24 hours per day for assistance. Often in acute situations, a nurse not involved in the activity can age the attending of record while the clinical care to stabilize the patient continues.

PATIENT CARE

Patients may be admitted to the Rehabilitation Unit from various sources: other services at Jackson Memorial Hospital, direct admissions arranged by private attendings, from clinics, from the emergency room and other hospitals. All residents who have responsibility of transferring or admitting a patient to the rehabilitation service should be thoroughly familiar with rehabilitation unit admission guidelines. If in question, the program director should be consulted. All private transfers and admissions are cleared by private attendings regarding suitability. If the resident has any question, they should contact the private attending.

If the rehabilitation unit has no available beds, emergency admissions to other units of the hospital may be arranged. Patients 'boarding' on other units are treated exactly as if they were on the rehabilitation unit, including daily rounds and progress notes by the resident, daily delivery of therapeutic services and primary management by the rehabilitation team.

At JMH the assigned resident is responsible for completion of the history and physical examination form and initial rehabilitation orders on all new admissions to their service. Typically admissions will be completed by 5:30 p.m. The resident-on-call may assist with the initial history and physical examination after 5:30 p.m. If the patient is admitted overnight by the on call resident then the primary resident must perform their own history and physical the next morning to familiarize themselves with the patient. However, a full admission note does not have to be re-done and the partial note can serve as the progress note the next day. If the patient cannot give reliable history, the family or primary caregiver(s) must be interviewed. Information should be sought from prior physicians, other hospitals, friends or neighbors, etc. whenever appropriate.

At the VAMC, the history and physical examination form available in the nurses' station is to be completed and placed in the chart within 24 hours of the patient's admission via computer. If the patient cannot give reliable history, the family or primary caregiver(s) must be interviewed. Information should be sought from prior physicians, other hospitals, friends or neighbors, etc. whenever appropriate.

All rehabilitation orders on inpatients must be updated and reviewed *every two weeks* by the resident. The resident is responsible for writing a meaningful, complete, **rehabilitation-oriented** daily progress note on every patient under his/her care. Opioid orders must be renewed every 3 days. The note must reflect a thorough assessment of the day's subjective, objective findings, and summation of the problem list and plan(s) of action. These notes and the total plan of care are to be reviewed

with the attending physician. Charts are to be kept on the ward and should be maintained in a complete, up-to-date and legible fashion. Your charts are scientific and legal documents. Your meaningful and legible notes should reflect your thinking and care of the patient.

Bedside teaching rounds occur daily on the inpatient rehabilitation unit and are conducted by the attending physician. A resident may be assigned to patients of more than one attending physician. Each attending will round with the residents on all of his/her patients regularly to assure that the entire team is cohesive and is working toward similar goals for their patients. Consultations from other services may be necessary based on the severity of the patient's condition, and the expertise and comfort level of the attending physiatrist. Do not wait until the problem has reached dangerous proportions before calling a consultation. If in doubt, consult with the attending physiatrist on the case.

Charts should be signed out promptly so that discharge summaries are quickly available for follow-up care. All charts must have a complete diagnosis written on the face sheet before the patient can be discharged.

All discharge summaries must be dictated the day the patient is discharged and notes in the progress report are to reflect this. A sample of the format of a discharge summary may be found in this manual. Please remember that discharge summary should reflect the rehabilitation status of the patient along with the short and long term goals and whether or not these were achieved. For a resident on vacation, covering residents may dictate summaries on those patients being discharged but the ultimate responsibility for those summaries being completed lies with the resident who was the primary caregiver for the patient. Any outstanding discharge summaries will be dictated by the primary resident.

ON CALL RESPONSIBILITIES

Patients admitted to the rehabilitation medicine service remain under the care of the department of rehabilitation medicine 24 hours per day, seven days per week. All residents will participate in the call schedule. The individual dates may vary but on average, an individual resident will be on call overnight at Jackson Memorial Hospital one night every two weeks. Residents who are on call will be able to be free from clinical duties by 12:00 the next day but will stay in the hospital until 1:30 to participate in didactic activities, if there are any. An attending physician will be on call with each resident from home and available by beeper and cell phone for advice. If needed, the attending physician will come into the hospital to assist with acute patient emergencies. The resident is responsible for all after-hours and weekend/holiday hospital requests for urgent psychiatric consultation, evaluation and patient management, and respond to the needs of all patients admitted to the rehabilitation service.

All residents shall have the opportunity to spend at least one full day, out of every seven, free of inpatient and outpatient care responsibilities. Schedules will be assembled monthly by the program director or his/her designee. The resident must remain in/around the hospital grounds and will be provided with access to an on-call room. The following are the on-call guidelines:

On-Call Guidelines in Rehabilitation

1. Residents in PM&R are required to do in-house call.

2. The residents carry both a central on-call beeper and will carry an on-call cell phone to minimize any confusion with communication.
3. Residents will be supervised at all times by a qualified attending physician who will also provide backup coverage and come into the hospital if necessary for difficult management issues.
4. Weeknight call - The resident will be released from all patient duties the next day 30 hours after the start of their shift. Residents will be supplied with a suitable on-call sleeping quarters. The quarters are supplied by the hospital. If the quarters are not suitable then the resident will notify the program director immediately and the program director will request an intervention from the hospital.
5. On weekends, the resident on call will arrive at 7 AM after which the previous resident will give report and then leave the hospital.
6. The resident will be the first physician to be notified for any regular issues during the call period (up to 7 AM of the following day). If there is any urgency or emergency, the nursing staff is to contact **BOTH THE RESIDENT AND THE ATTENDING ON-CALL**, who will provide backup while the resident is en route to the hospital.
7. For any patient that becomes unresponsive (with or without pulse or respirations), the nurse will call a code immediately, followed by calling the resident and attending on-call. This will assure immediate physician response, while our team is en route to assess the patient.
8. In the event the resident or attending physician cannot be reached through their pagers, the nursing staff is to resort to the secondary contact numbers (either cell phones or home phone numbers). A list of these numbers is available to the nurse supervisors on each unit and it is their responsibility to make it available to the nursing staff while maintaining its confidentiality.
9. The following conditions will require personal attendance of the patient by the on-call resident:
 1. hematemesis
 2. bright red blood per rectum,
 3. NEW ONSET chest pain or chest pain in a cardiac patient that otherwise had resolved angina
 4. NEW ONSET change in mental status or neurologic deficit
 5. any changes in clinical status associated with hypotension and/or tachycardia, that might signify evolving shock
 6. acute respiratory distress
 7. seizures
 8. falls that have resulted in trauma and or pain
9. Any other issues arising during the call time will be addressed by the resident to the best of their judgment. Nevertheless, the nursing staff has the responsibility of contacting the on-call attending in cases where that judgment is within question.

MORNING REPORT

On Saturdays and Sundays, a report is given to the resident coming in. The resident-on-call the previous night may not leave the premises until the resident on call for that day has reported for duty. A similar sign-out session is held at the end of each day to alert the resident-on-call of any developments that may require his/her attention.

CLINICS

All assigned residents must report to the clinics on time. They may not leave the clinic area without informing the attending physician. If the assigned a resident is unable to come to the clinic on time for any reason, the program director must be informed immediately so that a substitute can be assigned to the clinic. See Appendix for Clinic Schedules.

CLINIC ATTENDINGS

1. General Rehabilitation Clinic:
 - ✓ Jose Restrepo, M.D.
2. Prosthetic/Orthotic Clinic:
 - ✓ Jose Restrepo, M.D.
3. Wheelchair, Botulinum Toxic Injection:
 - ✓ Zoraya Parrilla, M.D.
4. Traumatic Brain Injury Clinic
 - ✓ Zoraya Parrilla, M.D.
5. Spinal Cord Injury
 - ✓ Kresimir Banovac, M.D.
5. JMH musculoskeletal
 - ✓ Ron Tolchin, DO
6. UMHC musculoskeletal
 - ✓ Andrew Sherman, MD
 - ✓ Fernando Branco, MD
 - ✓

DEPARTMENTAL CONFERENCES

TEAM EVALUATION CONFERENCE

Team evaluation conferences discuss patients on the inpatient rehabilitation service. They are held weekly with the attending physicians at scheduled times. All residents are expected to know their patient's comprehensive medical rehabilitation status. Team conference discussions are recorded by the resident on the team evaluation sheet in the patient's chart. This is a JCAHO and Florida State requirement. Rehabilitation orders are to be updated every 2 weeks on all patients, based on the goals established in the team meeting.

Formal bedside rounds with private attending physicians will occur regularly. The resident will consult with each attending to determine the time rounds will be made.

FAMILY MEETINGS

Time slots are available for family meetings with the rehabilitation team members. These meetings are to be scheduled as necessary by the rehabilitation attending staff. If for any reason the attending physician is unable to be present, the resident should be prepared to conduct the family/team meeting.

Initially, the attending physician will run the meetings. But as the rotation progresses then the resident is expected to be able to eventually function as the team leader. If they are successful, then the resident will eventually lead the team conference.

PROGRAM DIRECTOR ROUNDS

The Program Director will meet weekly with the residents to present both didactic and clinical material including, but not limited to, formal lecture, case conference, and associated relevant literature. Topics may include basic or clinical science, modalities, other topics of interest. All residents rotating within JMH-UM must attend.

GRAND ROUNDS

The departmental grand rounds are held once per month, on Friday from 8am – 9 am dates will be listed on the weekly schedule. Prominent guest speakers present state-of-the-art information pertaining to the practice of rehabilitation medicine. Residents may also be scheduled for presentation and are expected to present well-researched rehabilitation related topics. The discussion should be case-oriented, followed by general discussion of the topic, review of the pertinent literature and involve the attendant audience by discussing problem-related issues relevant either to the case presented or the topic in general. The resident should choose a mentor and prepare his presentation under the supervision of an attending. Topics for discussion should include interesting and unusual case reports, research and new developments in rehabilitation medicine. Residents are strongly discouraged from presenting reviewed topics in which no direct clinical case correlation or presentation is made or in which the resident does not have significant, personal clinical or research experience.

JOURNAL CLUB

Once per month – inter-institutional combined journal club. The date is the second Monday of the month at 12:30 PM-1:30 pm. An individual attending physician may change the time up or back and hour depending on their clinical responsibilities with 2 weeks notice.

When a Jackson attending is supervising, the site will be at Jackson. When the VA attending supervises, the site is at the VA.

At FORMAL journal club, the resident will be expected to prepare a presentation on their chosen journal article that will include:

- 1- A summary of the article – May or may not be in power point format (15 min maximum).

- 2- Present the inclusion and exclusion criteria for subject enrollment and analyze the rationale behind these.
- 3- Present a flow diagram or a relevant table illustrating what happens to the enrollees from enrollment to the end of the study.
- 4- A handout including the abstract and significant tables and figures (ideally fitting in one page, 2-sided)

The resident will choose an article that is original research, prospective, preferably blinded and placebo controlled and performed within the last 1 year.

A list of journals would include:

Journal of Spinal Cord Medicine
 American Journal of PM&R (Blue)
 Archives of PM&R (White)
 Muscle and nerve
 American Journal of Sports Med
 Journal of head trauma and rehabilitation
 Brain injury
 American journal of neurology
 JAMA
 NEJM

Others can be added if necessary

The attending assigned will do the same for their article. The attending chosen article is expected to be more of a “classic” PM&R article.

One good place to find a list of such articles is on the AAP website “physiatry.org”

The entire discussion, presentation of each article is not to exceed 30 minutes.

The journal club schedule is as follows:

<u>Dates</u>	<u>Time (tentative)</u>	<u>Resident</u>	<u>Attending</u>
July 10	12:00 pm	Vrable	Sherman
August 14	12:00 pm	Lucinda	Cardenas
September 11	12:00 pm	Sigler	Branco Kushner
October 9	12:00 pm	Lenchig	Restrepo
November 13	12:00 pm	Berliner	Saber
December 11	12:00 pm	Massa	Kushner
January 8	12:00 pm	Abad	Parrilla
February 12	12:00 pm	Suzanne	Tolchin
March 12	12:00 pm	TBA	TBA
April 9	12:00 pm	Vrable	Sherman
May 14	12:00 pm	Lucinda	Tabaro/Ward
June 11	12:00 pm	Sigler	Kushner

In addition, each site director is expected to have their own “mini journal club” either every week or every other week on a patient relevant issue.

DIDACTIC LECTURE SERIES (See appendix for schedule)

Each Friday morning the time from 8:00 AM to 12:00 p.m. has been set aside for the didactic teaching program. Lectures or Grand Rounds will occur from 8-10 AM (Occasionally to 11AM). The lectures will cover comprehensively all of the subspecialty and general subjects of the field of Physical Medicine and Rehabilitation. Lectures will be referenced to the textbooks edited by Cucurrillo or Braddom. The lecture cycle will be 18 months for most lectures in order that each resident will be exposed to the material twice before they graduate. Some lectures such as the general psychiatric principle lectures will be given yearly to the PGY 2 group and taught by the PGY 3 and PGY 4 group. Anatomy also will be presented yearly by the anatomy department to the PGY2 group. EMG and neuromuscular medicine is taught to the PGY 3 level and combines the neurology department and residents with the PMR residents for this. The PMR service also presents a monthly journal club presented by a resident and attending physician who is paired for this purpose.

In addition to the PMR core didactic program, PMR residents can take advantage of didactic programs put on by other departments. Residents are encouraged and often mandated to attend the Orthopedics department or the Neurosurgery departments' weekly Grand Rounds. The Miami Project to Cure Paralysis puts on a weekly morning lecture and monthly grand rounds lecture that the PMR residents are encouraged to attend to gain research experience.

All physicians involved in the residency will participate in the didactic and journal club program.

INTERDEPARTAMENTAL CONFERENCES

- 1. RHEUMATOLOGY/REHABILITATION CONFERENCE**
- 2. COMBINED ORTHOPEDICS/NEUROSUGERY/REHABILITATION SPINE CONFERENCE**
- 3. NEUROLOGY GRAND ROUNDS**
- 4. GERIATRIC GRAND ROUNDS**
- 5. ORTHOPEDIC GRAND ROUNDS**
- 6. MIAMI PROJECT GRAND ROUNDS**

In addition to the above, other departments have frequent conference announcements and these are posted in the residents' room or on bulletin boards and signs throughout the hospital. All residents are encouraged to attend these conferences as time permits and avail themselves to this tremendous opportunity to learn.

OTHER LEARNING RESOURCES

DEPARTMENTAL LIBRARY

A departmental library is maintained in the residents' room, the office of the chairman, and the program director's office. New books and journals are added to the library regularly. A list of books available in the department is enclosed. Any resident wishing to borrow a book should sign it out with the program director or residency coordinator.

HOSPITAL LIBRARY

The Medical Library at Jackson Memorial Hospital-Miller School of Medicine University of Miami carries a wide array of textbooks and journals in all the major subspecialties. A list of rehabilitation-related journal available in the hospital library is enclosed. Any articles or journals not available in the library can be requested through interlibrary loan.

In addition to hard copy material, the library has computer terminals linked through a local area network to the OVID medical literature search program. Each resident will have the opportunity to be trained in the use of the computers. These linked PC's also have word processing capability, and several educational programs. Through a dedicated high-speed line, the hospital library system is linked to the wide-area network at Miller School of Medicine-University of Miami, where medical search and database facilities are available to the resident, as well as connection to selected Internet sites.

RESEARCH

Each resident will be required to develop a research interest and project. An original research project must be undertaken. The results of the research will be presented the last month of the PGY 4 year in a seminar. Research helps stimulate critical thinking, allows for deep analysis and study of a given field of interest, and gives the individual a chance to contribute meaningfully to the current body of scientific work. One attending physician will be chosen, by each resident, to work as a mentor.

Didactic sessions will be held throughout the year to help residents grasp the fundamentals of research, including critical analysis, statistics, etc. The faculty will keep track of the resident's progress and advise accordingly through regular meetings and academic sessions.

Additionally, an abstract for poster or platform presentation must be submitted to the Annual Scientific Program of the American Academy of Physical Medicine and Rehabilitation for their PGY 4 year. Typically, this means submission of the abstract must occur by March of the PGY 3 year. The two more common formats include: 10-minute oral presentation and poster presentation. This abstract may consist of original research or simple case report. These presentations help the resident develop cogent writing, organization, and presentation skills, as well as allowing for in-depth study in the desired field of physical medicine and rehabilitation.

RESIDENT SCHEDULING

Coretha Davis the residency coordinator will monitor the call schedule and resident duty hours. Beginning in July 2006, an online electronic residency management system will be put in place. Into this system, residents will input their work hours and days off to make certain the PMR program adheres to all ACGME work hour laws and guidelines.

HOSPITAL HOLIDAYS

New Year's Day
Martin Luther King, Jr's Birthday
President's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day & Friday after
Christmas Day

Special consideration will be given to requests for time off Christmas Eve and New Year's Eve. Coverage for these holidays will be divided as fairly as possible among the residents to allow residents time with their families for at least one of the major holidays. Requests to be off on particular holidays will be taken into consideration if requested early enough.

VA holidays will allow the resident rotating at the VAMC to be free from clinical duties for that day. However, the resident is still considered working and therefore it is expected that the resident will perform research, attend any lectures or conferences, and perform call if on duty.

SICK DAYS

Each resident is permitted a total of 14 sick days. If more than 14 sick days are used, the additional days may be added onto the end of the residency in order to fulfill the 36-month requirement of the American Board of Physical Medicine and Rehabilitation. These additional days could alternatively be made up as unspent vacation days. If there is reasonable evidence that sick days, especially on-call days, have been used, that resident may be asked to make up the on-call days. The resident must call the program director/residency coordinator at 8a.m. every day that he/she is out sick, to inform of the absence. The affected resident is expected to be at home to answer any questions about patient care.

If the resident is taking prolonged sick leave, the program director has the authority to order a medical or psychiatric evaluation with a physician scheduled and approved by the Public Health Trust. If sick leave is exhausted, the program director may grant paid or unpaid leave based upon the situation and the previous competence and performance of the resident. The decision on whether to grant leave will be based on the physician's competence more so than the illness suffered. To that end, a marginal or incompetent resident still may be dismissed while on sick leave for poor performance.

VACATION DAYS

Each resident is entitled to 28 paid vacation days. The resident's vacation will consist of 5 consecutive work days (Monday through Friday) plus the attached two day weekend. Residents are to take vacation only in one week blocks. **IT IS REQUIRED THAT EACH PGY 2 RESIDENT TAKE ONE WEEK VACATION PER ROTATION.** Requests for more than one week vacation must be granted by the supervising attending physician – then from the program director. If a signed document from the supervising attending physician is obtained then the vacation may be granted. There can be no more than two people on vacation at a time. Consideration will be given to residents who may need more than one week at any particular time. No vacation may be taken by PGY-II residents in July, December 26th through 31st, or June. Due to critical manpower needs, vacation time must be approved in advance by the program director, who will make the schedule for the entire academic year. Vacation requests for the entire year are to be submitted to the program coordinator by July 30th. Changes in vacation are strongly discouraged and must be approved, in writing, by the program director, subject to the needs of the Program. Failure to abide by this policy may result in forfeiture of unused vacation time.

SCHEDULE CHANGES

Changes in schedule arranged between the residents are permitted as long as the supervising attending physician and then, the program director approves. Whenever a change is made, the resident must notify the residency coordinator, page operator, in-patient nursing stations, and the emergency room at the start of the on-call.

ROTATION CHANGE POLICY

Unless circumstances strongly warrant, changes in the rotation schedule are strongly discouraged. *No changes or exchanges are to be made without the written approval of the Program Director.* The following procedure will be in effect:

1. A resident desiring a change in a scheduled rotation shall, no later than sixty (60) days prior to date of desired change, complete and sign the rotation change request form (residency coordinator will have these) stating desired change and reason.
2. The resident must then secure the approval and signature on the form of all other residents whose schedules are affected by such a change.
3. The form is then submitted to the program director for approval and signature. If approved it should then be taken to Coretha Davis, Residency Program Coordinator, for final administrative approval. After which the change becomes official, Ms. Davis will notify all affiliates of the approved scheduled changes.

Requests compliant with the above policy will be processed in a timely manner.

ABSENTEEISM

Absenteeism without notification of the Department will not be tolerated and is grounds for disciplinary action.

MISCELLANEA

RESIDENT STRESS

(Information also found in the CIR manual)

Section 2: Physical and Psychological Impairment

A Chief of Service or his/her authorized representative shall have the authority to require employees that have been determined, through reasonable suspicion, to possibly suffer from a physical, psychological, or psychiatric impairment, which may prevent the employee from satisfactorily performing the complete duties and responsibilities of their positions, to submit to a physical, medical, psychological, or psychiatric examination deemed necessary for purposes of determining the employee's fitness to perform the complete duties and responsibilities of their position.

Such examinations will be performed by a physician approved and appointed by the Public Health Trust. The results of such examination(s) shall be promptly furnished to the concerned Chief of Service or their authorized representative.

The result of the applicable information submitted by the examining physician to the Public Health Trust should be limited to information that is pertinent to the issues of the employee's ability to perform the duties and responsibilities of their position.

Based upon the results of such examinations and other relevant information, the Chief of Service may place the employee on either paid or unpaid compulsory leave in accordance with the provisions of the leave manual until such time as the Trust is satisfied that the employee can return to work. The Trust may require the employee or attending physician to furnish additional pertinent medical reports or information deemed necessary while the employee is on compulsory leave.

Should the condition be corrected and so certified by the attending physician or psychologist, the employee may petition the Trust for reinstatement. If the employee's petition for reinstatement is denied by the Chief of Service, disciplinary action must be initiated by the Chief of Service in accordance with the Trust rules. Nothing in the provision of this Article shall prevent the Trust from administering appropriate disciplinary action in accordance with the Trust rules and this collective bargaining agreement.

GRIEVANCES

(Information also found in the CIR manual) **Article 11**

Grievance and Arbitration Procedures

Section 1:

In a mutual effort to provide harmonious working relationships between the parties to this Agreement, it is agreed to and understood by both parties that the following shall be the sole procedure for the resolution of grievances arising between the parties as to the interpretation of and application of the provisions of this Agreement.

The parties further agree that other disputes shall be reviewable and appealable as set forth in other parts of this Agreement and that the union-management committee may address concerns not falling under the grievance/arbitration or other appeal procedures.

Section 2:

Except as otherwise provided in this Agreement, the term "grievance" shall mean:

- A. A dispute concerning the application or interpretation of the terms of this collective bargaining agreement;
- B. A claimed violation, misinterpretation, or misapplication of the rules, regulations, authorized existing policy, practice, or orders of the Trust affecting housestaff.

The following shall not be considered grievances: a formal or informal counseling, disputes over progress in the educational program, discharge of clinical responsibilities, the timely decision to renew the appointment of a housestaff officer, advancement decisions, a program termination, and any matters for which other appeal procedures are provided for in this Agreement (or otherwise specifically made available to this bargaining unit).

Section 3:

A class grievance (general grievance) shall be defined as any dispute which concerns two or more employees within the bargaining unit. Class grievances should attempt to name all employees or classifications covered in a grievance; however, the absence of a housestaff officer's name shall not exclude him/her from any final decision or award.

Class grievances, at the option of the union, may be submitted at Step 2.

Section 4:

Each written grievance, when filed, shall contain a brief statement of the facts of the violation claimed (including the date, or approximate date, upon which the violation occurred), together with the article(s) of the contract violated, and the remedy sought.

Section 5:

Grievances shall be processed in accordance with the following procedure:

A grievance may be brought no later than fourteen (14) calendar days after the date on which the grievance arose (or was reasonably likely to have become known) by an individual housestaff officer and CIR, or by CIR alone, and shall be undertaken pursuant to a two (2) step grievance procedure as follows:

Step 1. The aggrieved employee, and/or the union, shall discuss the grievance with the concerned Chief of Service or designee. The Chief of Service or designee shall respond to the grievance within (14)_fourteen calendar days. Grievances of an administrative nature not directly under the control of the Program Director may be filed with the Director of Physician Services.

Step 2. If the grievance has not been satisfactorily resolved in Step 1 thereof, the aggrieved employee and/or the union may appeal to the Senior Vice-President for Medical Affairs within (14)_fourteen calendar days. The Senior Vice-President for Medical Affairs may conduct a meeting and shall respond to the employee with a copy to the union within (14) fourteen calendar days of the appeal.

Section 6:

Failure by the employee or the union to observe the time limits for submission of a grievance at any step will automatically result in the grievance being considered abandoned. Failure by the Public Health Trust to respond to a grievance within the prescribed time limits will automatically move the grievance to the next step.

Section 7:

Each party shall be allowed one (1) extension of time, not to exceed seven (7) calendar days. This extension can be used only once during the grievance. The other party must be notified of the requested extension. Additional extensions may be granted in good faith settlement discussions or by mutual agreement.

Section 8:

The parties acknowledge that as principle of interpretation, employees are obligated to work as directed while grievances are pending. This does not limit the rights an employee may have under federal, state, or local laws where the employee is faced with an immediate physical danger at work.

Section 9:

Individual grievants and a representative of the grievant class will be permitted to attend any grievance meeting scheduled by the Trust. Meetings will be scheduled at times mutually convenient to the persons involved.

Section 10: Employer Responses

All responses required in Step 1 and Step 2 above shall be directed to the aggrieved employee with a copy furnished to the union. In class grievances, copies will be directed to the union only. A rejection of a grievance at any step of the procedure must contain a statement of the reasons for the rejection.

Section 11: Arbitration

A. If the union is not satisfied with the reply in Step 2 of the grievance procedure, the union shall have thirty (30) days to file a request for arbitration to Federal Mediation and Conciliation Service (FMCS) or American Arbitration Association (AAA) and provide a copy to the Trust.

B. The union shall request a list of seven (7) arbitrators from Federal Mediation and Conciliation Service (FMCS) or American Arbitration Association (AAA). The parties shall each strike from said list, alternately, three (3) names, after determining the first strike by lot, and the remaining name shall be the arbitrator. Nothing herein shall prohibit the parties from agreeing on an impartial arbitrator outside the above procedure.

C. The arbitrator shall promptly conduct the hearing on the grievance at which both parties shall be permitted to present their evidence and arguments pursuant to the Voluntary Labor Arbitration Rules of the American Arbitration Association. The decision of the arbitrator shall be rendered in writing with copies of the award promptly furnished to both parties, no later than thirty (30) calendar days after the conclusion of the hearing, and such decision shall be final and binding.

D. Each party will pay its own expenses and will share equally in expenses incurred mutually in arbitration. Employees required to testify will be made available without loss of pay; however, whenever possible, they shall be placed on call to minimize time lost from work and, unless directly required to assist the principal union representative in the presentation of the case, they shall return to work upon completion of their testimony. The intent of the parties is to minimize time lost from work and disruption of patient care.

E. The arbitrator shall limit his/her opinion to the interpretation or application of this Agreement and shall have no power to amend, modify, nullify, ignore, or add to the provisions of this Agreement.

Grievances, as defined, may be submitted regarding the matters contained in the Agreement or arising from conditions of employment. Matters excluded from the grievance procedure are not arbitrable

MALPRACTICE INSURANCE

The hospital provides residents with malpractice insurance. This insurance, however, covers you only for duties ascribed directly to the training program.

SOCIETY MEMBERSHIP

All residents should apply to the American Academy of Physical Medicine and Rehabilitation for junior membership. This membership includes the subscription to the journal ARCHIVES. Also the Southern Medical Association offers complementary membership for residents & fellows.

NON-DISCRIMINATION POLICY

The department of rehabilitation medicine follows and adheres in every way to the non-discriminatory policy of Jackson Memorial Medical Center-University of Miami. The hospital maintains full compliance with the Americans with Disability Act.

POST-RESIDENCY PLACEMENT

The department will make every effort to assist residents in finding placement at the completion of their training. Announcement of job openings are regularly posted in the rehabilitation residents room. Members of the faculty will be glad to advise the senior residents in this all-important step.

RESIDENT PERFORMANCE

Resident promotion decisions will occur typically at the end of the third rotation – 9 months into the year.

The factors taken into account:

- 1) Rotation evaluations
- 2) Lecture performance
- 3) Attendance to work, professionalism, attitudes.

A board of 5 department members will serve as the disciplinary committee:

- 1- Andrew Sherman, MD Program Director
- 2- Fernando Branco, MD Associate Program Director
- 3- Andres Restrepo, MD Associate Program Director
- 4- Site Director VAMC Ronald Tolchin D.O.
- 5-One at large member voted on by the department.

The disciplinary committee will meet only if called upon by one of two issues:

- 1- Resident non-performance
- 2- Attending non-performance.

If one of the attending MD on the list of is being discussed, they will not attend the initial meeting and will be replaced by an alternate.

Rotation evaluations:

- Residents are evaluated on 6 competencies.
- They will be evaluated monthly by the site director and attending MD's who have close contact with the resident.

Scores will be on a 1-9 level. Anything under 4 (1-3) is a failing grade.

If the first evaluation has any 3's or less or averages less than 5, the resident will be placed upon unofficial watch. Both the site director and the resident will check in WEEKLY with the Program director who will monitor progress. The goal will be to identify the limiting performance factors, enhance performance, and turn around unsatisfactory behaviors.

A follow up evaluation will be presented after 2-3 weeks.

If one rotation is failed with an average of 2-3. Then the resident will not be given credit for the rotation. The board will meet with the resident and the site director individually. The resident will be placed upon official probation. The site director will present a plan to the resident on what work will need to be accomplished to earn a passing grade. In some cases, passing the rest of the year may suffice to improve to a passing score. Other suggestions will include remedial testing, written project, or extra time added onto the end of the residency. (Unclear how this would work with financial constraints)

If the resident fails one rotation, and then receives a failing grade in the next or subsequent rotation, they will not be renewed for the following year.

In certain cases, when it is unclear that the resident is entirely at fault, expectations are unclear, structure is necessary, the resident may be switched to a different rotation.

RESIDENT CONTRACTS

Contracts are issued for period of one year and are not automatically renewable. A new application form and approval by the program director is required for each successive year.

CORRECTIVE ACTION, DISCIPLINE, AND APPEAL PROCEDURES

(Information also found in the CIR manual) Article 13

Section 1:

The Chief of Service (hereafter "Chief" or "Chief of Service") or his/her designee shall periodically consult with the housestaff officer about his/her progress in the residency program and discharge of clinical responsibilities. The Chief of Service shall give notice of any deficiencies, improvement required, and plan to accomplish such, and time within which the improvement must be made.

Continued deficiencies in performance after counseling may result in non-renewal or non-advancement/non-certification, reprimands, or disciplinary action, as below.

The housestaff officer shall regularly be given photocopies of his/her evaluations. The fact and date of counseling shall be documented.

Discipline by the employer or Chief of Service may include relief of the housestaff officer from clinical duties and/or reassignment to other duties, suspension with or without pay, termination for unsatisfactory performance and/or conduct in discharging clinical responsibilities, for conduct unbecoming an employee, or for excessive tardiness or absenteeism.

Section 2:

Any housestaff officer covered by this collective bargaining agreement shall not be discharged or disciplined without just cause. The employer or Chief will follow progressive disciplinary procedures, whenever appropriate, and in all instances will have the burden of proving just cause for disciplinary action.

Whenever it is alleged that a housestaff officer's discharge of clinical responsibilities is unsatisfactory or that he/she has violated any law, rule, regulation, or policy, that housestaff officer shall be so notified and informed of the areas deemed unsatisfactory, or law, rule, regulation, or policy allegedly violated.

The employer or Chief shall initiate an investigation prior to notification to the housestaff officer of a pending disciplinary action. The employer or chief shall conduct the necessary investigation to include full consideration of any documentation submitted by the housestaff officer prior to making a final decision.

The employer or Chief agrees to inform the housestaff officer and union of their right to representation in the disciplinary process. The employer or Chief will give the housestaff officer 48-hours written notice providing date, time, and place that a disciplinary/counseling session is scheduled. This notice will include the law, rules, regulation, or policy allegedly violated and the nature of the alleged violation.

Disciplinary action determinations will not be rendered until the completion of the presentation and rebuttal meetings where the employer or Chief of Service and the housestaff officer, together with his/her representative, through use of documents and witnesses, have opportunity to present their respective cases. Rebuttal meetings should be scheduled within fourteen (14) calendar days, unless time is extended by mutual agreement. The Chief of Service or the employer shall render a written decision within seven (7) calendar days after the rebuttal meeting. The Union and the housestaff officer shall receive a copy of the rebuttal decision.

The housestaff officer may request, within fourteen (14) calendar days, that the Senior Vice-President for Medical Affairs or his designee meet to review or rescind the proposed discipline. The disciplinary action will take effect unless the housestaff officer makes a timely request for review. Unless the Senior Vice-President rescinds the proposed action, it will become effective following his/her review and decision. The Union and the housestaff officer shall receive a copy of the Senior Vice-President's decision within (7) seven calendar days.

Section 3: Emergency Situations

Where the Chief of Service, Senior Vice-President for Medical Affairs, or their designee makes a tentative determination that a housestaff officer's discharge of his/her clinical responsibilities is so unsatisfactory that to allow him/her to continue in his/her assignment would expose patients to unnecessary medical risks and the hospital to unnecessary liability, he/she may, prior to a hearing, temporarily reassign the housestaff officer to duties other than his/her clinical responsibilities.

Section 4:

In the case of a suspension without pay or termination, the President of the Public Health Trust may withhold the housestaff officer's compensation when the action becomes effective, as in Section 2 above, while further appeal process and any subsequent grievance or arbitration is being pursued.

Section 5:

A disciplinary action of a suspension without pay or dismissal may be appealed by the housestaff officer disciplined or the union by petitioning the President of the Public Health Trust for an appeal hearing within fourteen (14) calendar days of receiving notice of the Senior Vice-President's decision. Any such disciplinary action that is not timely appealed shall be considered final as of the date of receipt of the decision.

Upon receipt of a petition, the President shall direct the Senior Vice President for Medical Affairs to appoint a Peer Review Committee, which shall consist of two housestaff officers and two members of the medical staff. The two medical staff members shall be selected by the Senior Vice-President and the two housestaff officers by the union. The appointment of the committee shall be within seven (7) calendar days of the receipt of the petition. The committee shall meet within five (5) calendar days of their appointment to agree upon a fifth committee member as chairperson (an attending physician other than a housestaff officer) to conduct a hearing regarding discipline. The panel shall conduct a hearing within ten (10) calendar days after the selection of the fifth committee member. The housestaff officer may bring and be assisted by a union representative or counsel of his/her choosing, may present evidence, and may otherwise fully participate in the proceedings.

After a hearing or hearings, the chairperson shall promptly submit a report regarding the Committee's findings and recommendations within fourteen (14) calendar days to the President of the Trust and the union for a final determination regarding the disposition of the disciplinary action under appeal. The President shall issue a written decision to the housestaff officer and the union within thirty (30) calendar days of receipt of the committee's report.

Section 6:

housestaff officer shall also terminate any reappointment of the housestaff officer to any subsequent year of training that may have occurred by the terms of this Agreement or otherwise.

Section 7:

If the determination of the President is adverse to the housestaff officer, the Union may request arbitration in accordance with Article 11 (B).

Section 8:

Arbitration hereunder shall determine whether just cause or basis exist for the disciplinary action. The arbitrator shall be authorized to accept, reject, or modify the charge or disciplinary action. The arbitrator shall not have the authority to substitute his or her judgment for clinical or academic evaluations, but may issue decisions and create remedies that include impartial evaluation procedures.

Section 9:

Representation and Information: Housestaff officers shall have the right of representation by the union in investigatory meetings and/or hearings. The housestaff officer and his/her representative shall have the right, prior to all hearings, to receive and review all statements and other documents on which the proposed charges are based, along with other appropriate materials.

At formal hearings (the Peer Review Committee hearing or in arbitration), the housestaff officer shall have the right to confront and question all witnesses, under oath where appropriate, and shall have the full and unimpaired right to present such evidence as the housestaff officer and union may deem necessary.

Section 10:

All written notices required to be sent to the housestaff officer and union pursuant to this article shall be by certified mail or personal delivery by the Chief of Service, Senior Vice-President, or designees. The date of receipt shall be documented.

Section 11: Reprimands

Reprimands may be appealed by the employee through the grievance procedure up to and including Step 2, but shall not be further appealable to either an arbitrator or to the Peer Review Committee. Within thirty (30) calendar days of the receipt of the Trust's reply to such a grievance at any step of the grievance procedure, the housestaff officer and/or the union shall have the right to file a written response to the written reprimand and have said response inserted in the housestaff officer's personnel folder.

Section 12:

Written reprimands and records of counseling, together with any reference to such reprimands and records of counseling, excluding performance evaluations, shall cease to be of any force or effect for employment purposes after a two-year period from receipt of the record of counseling or written reprimand in which the housestaff officer has received no further disciplinary action or records of counseling.

Section 13: Rescinded Disciplinary Actions

Documents reflecting disciplines that have subsequently been rescinded shall be appropriately noted as either "no longer in effect" or "rescinded," in accordance with the requirements of the Florida Public Records A

MOONLIGHTING

A. A housestaff officer wishing to engage in limited employment in addition to his/her regularly assigned duties must first file a written request with the Chief of the appropriate service and obtain in writing the Chief's approval. Such approval will not be unreasonably denied. The Chief of Service may request a reduction in hours or total abolishment of such additional employment, when, in the Chief's judgment, the educational progress or clinical service requirements of said housestaff officer is being compromised.

B. A housestaff officer may engage in limited employment during his/her vacation period(s) with prior written notice and the approval of the Chief of Service. Such approval will not be unreasonably denied.

It is department policy that PGY 2 residents are not permitted to moonlight. Further details are in the attached JMH moonlight policy and procedure.

MEDICAL RECORDS

Residents are expected to visit the medical records department **AT LEAST ONCE A WEEK** to complete the charts. Substantial numbers of uncompleted charts or excessive delays in completing charts may result in disciplinary action.

SITE AFFILIATIONS

MOUNT SINAI MEDICAL CENTER

- A. Attain competency and expertise in the evaluation and management of ambulatory patients with neuromusculoskeletal impairments and their attendant disabilities.
- B. Attain proficiency in the planning and technical execution of electrodiagnostic evaluation of patients with neuromuscular disorders.
- C. Attain proficiency in designing and prescribing prosthetics and orthotics.
- D. Establish competency in designing goal-based therapeutic programs and in accurately prescribing them.
- E. Cite and apply techniques of treatment of wounds and chronic ulcers.

MIAMI VA MEDICAL CENTER

DISCHARGE SUMMARY

The discharge summary should reflect the following:

- ✓ Discharge Diagnosis
- ✓ Present Illness
- ✓ Past Medical History
- ✓ Previous Operations
- ✓ Review of Systems
- ✓ Social and Living Arrangements
- ✓ Physical Examination
- ✓ Laboratory Data, EKG, X-rays
- ✓ Hospital Course: Medical
- ✓ Rehabilitation –P.T., O.T., Speech, ADL
- ✓ Family Meetings
- ✓ Social Service Intervention
- ✓ Psychology
- ✓ Goals-Established at time of admission to Rehab, and whether these were achieved. If not, why?
- ✓ Re-establishment of Goals.
- ✓ Discharge Diet
- ✓ Discharge Level of Activity
- ✓ Follow-up: Medical
 Rehab -M.D.
 Therapy
- ✓ Medications
- ✓ Condition on Discharge

SAMPLE DISCHARGE SUMMARY

JACKSON MEMORIAL MEDICAL CENTER - UNIVERSITY OF MIAMI

Name: SAMPLE
Adm.
Disch.
Chart#

This was the second inpatient admission of this 42 year old white male with the admitting diagnosis of juvenile rheumatoid arthritis; quadriparesis secondary to arthritis in the cervical spine; status post recent cervical laminectomy; status post insertion of bilateral total hip prostheses; old history of pancreatitis; mature cataract left eye.

PRESENT ILLNESS: A review of the patient's first admission reveals that at age 4 he was diagnosed as having juvenile rheumatoid arthritis. In 1959 he had a left prosthetic hip inserted and this was replaced in 1965. He states that he was able to walk until 1968 when he underwent a total replacement of the right hip in Boston. At that time, he was told that the left hip prosthesis would eventually need replacement and was advised to walk on crutches to extend the period of time until such replacement would be necessary. In 1978 he had a total replacement of the left hip in Boston. He states that following this surgery he became a "total wreck" with psychological and multiple physical problems. In January 1979 he was discharged to his home and received physical therapy at home. Beginning in March 1979 he began to develop numbness in both lower extremities and also noted increasing numbness in both hands. X-rays were taken of the cervical spine and thoracic spine and myelogram was advised which the patient refused. In August 1979, however, because of progressive symptoms, he returned to Boston and a myelogram was done which was negative. The diagnosis was made there of paraparesis secondary to vasculitis but this was not confirmed by biopsy.

The patient was seen for an initial evaluation at _____ on 4/21/79 by Dr. _____ and admission was recommended.

The patient was first admitted to _____ on 5/14/80. A modest improvement in independence had occurred by the time of his discharge on 7/10/80. The patient felt that he had improved considerably. By August 1989 the patient noted decreasing function and in November 1980 he was hospitalized at _____ Hospital in _____. Workup there revealed increasing symptoms attributable to the disease of the cervical spine and recommendation was made for laminectomy. The patient decided to return to _____ Hospital in Boston where, on December 7, 1980, he underwent cervical laminectomy. Halo was applied and removed on March 5, 1981. He was discharged on March 16, 1981 to his home while awaiting admission here. According to the patient, improvement has been noted, particularly in the right arm, post operatively compared to his stated in November 1980. There were no complications of his stay in Boston.

The patient was admitted to _____ for a period of evaluation and therapy.

PAST MEDICAL HISTORY: There are no known allergies. The patient had a severe attack of pancreatitis 18 years ago.

PREVIOUS OPERATIONS: See above.

REVIEW OF SYSTEMS: Head: Negative. EENT: Patient has been told he has a cataract in the left eye.

Cardiopulmonary: Negative.

Gastrointestinal: Negative.

Genitourinary: Negative.

MARITAL: Patient has been married for 25 years. Patient's wife and two children are living and well.

PHYSICAL EXAMINATION: The patient is well developed, thin, white male who is alert, oriented and cooperative. Blood Pressure: 110/64. Pulse: 102. Head: Negative. Eyes: No change is noted since the patient's last examination. Neck: The neck is encased in a soft collar. There is a well-healed laminectomy incision over the posterior part of the neck. Heart: No abnormalities. Lungs: Clear. Abdomen: The bladder is palpable four fingerbreadths above the symphysis pubis. No other organs are palpable. Extremities and neurological: Elbow flexion on the right is good plus, on the left is good. Wrist flexion/extension is present through a limited range. Active motion is noted in the fingers of the right hand. Left hand, some active motion is seen in the thumb and index finger. There are multiple contractures noted secondary to the rheumatoid arthritis in the wrist and fingers. Lower extremities: There are well healed surgical incisions over both hips. Sever equines deformity is noted, particularly noticeable on the left. The right lower extremity is stronger than the left. Hip strength is poor to poor plus, knees trace poor. Ankles: The right ankle shows fair dorsiflexion and plantar flexion. The left ankle shows fair minus plantar flexion, zero dorsiflexion.

LABORATORY: Admission urinalysis showed numerous red cells and 2+ occult blood with sterile culture X2. CBC, differential, creatinine and BUN were normal. Fasting blood sugar was 51.

X-RAY: Chest x-ray showed unchanged cardiomegaly, flattening of the diaphragm with hyperlucent lungs, fibrosis, suggestive of chronic obstructive pulmonary disease, and an old healed fracture deformity of the right humeral neck. Cervical spine x-rays showed fusion of C2, 3, 4, and C7, T-1 with upper wire posterior stabilization and pantopaque droplets. Later flexion/extension views were done which showed no instability. There were rheumatoid arthritic changes with erosion of C-1. KUB showed no calculi. Cystogram showed small bladder with trabeculation.

ELECTROCARDIOGRAM: EKG showed incomplete right bundle branch block.

HOSPITAL COURSE: In Physical Therapy patient needed assistance with the parts of his power driven wheelchair or manual wheelchair in preparation for transfer. He was able to push a manual wheelchair for short distance. He learned to do a sliding board transfer with non-contact guarding and occasional minimal assistance. Mat mobility required maximum assistance. He had several times with moderate to maximum assistance, and minimal assistance to maintain with his crutches. There were the stable limitations in passive range of motion of all four extremities. Trunk strength was fair, shoulders fair to fair plus, elbows fair plus good minus, wrist good. Hip was poor plus, fair minus, knees fair minus to fair plus, which was an improvement on the right, ankles fair minus and some increased spasticity was seen.

Occupational therapy found minimal improvements in the hand strength overall –but he did improve in dexterity and manipulation. He became involved in the Yard School of Art and had some equipment at home to pursue this for vocational purposes.

Activities of Daily Living found the patient also could propel the wheelchair manually for a short distance. He needed moderate assistance in use of the side rails to roll in bed, maximum assistance to sit in the soft bed, but had functional short sitting balance. Grooming was independent, except for combing hair, but he did have a combing aid at home. He needed moderate assistance to dress the upper body very slowly, and maximum assistance for the lower body. He was provided previously a shower bench, stair glide, ramping and ADL equipment. New parts for his manual wheelchair were requested and delivered. The bathroom is to be used at home with help from the family.

Social Service did interview the wife, who was in for a session of ADL, and also the daughter. The wife continued to refuse to be involved in meetings with the physician or other team members.

Psychology found him to be passive dependent with poor self-esteem, but he was starting to take some initiative in changing his long-standing rigid behavioral habits in the face of his disability.

Medically there were no complications of stay. He was weaned off the collar. Initially there was poor voiding of the bladder but this improved, documented by residual urine determination. Patient refused IVP and cystogram studies.

DISCHARGE DIAGNOSES:

1. Juvenile rheumatoid arthritis.
2. Quadriplegia secondary to cervical spine arthritis.
3. Status post cervical laminectomy.
4. Remote bilateral total hip replacements.
5. Old history of pancreatitis.
6. Mature cataract left eye.

DISCHARGE MEDICATIONS:

1. Colace 100mg t.i.d.
2. Dulcolax suppository T1W
3. Ascriptin 10gr b.i.d.
4. Prednisone 15mg o.d.

DISCHARGE RECOMMENDATIONS:

1. Home health aid
2. Home Physical Therapy
3. To be seen by Dr. _____ in six weeks.

CONDITION ON DISCHARGE: Improved.

INCOMPLETE MEDICAL RECORDS

TO: Residents

FROM: Diana D. Cardenas, M.D., M.H.A.
Chair
Department of Rehabilitation Medicine
Jackson Memorial Hospital
Miller School of Medicine University of Miami

Andrew L Sherman, M.D.
Residency Program Director
Department of Rehabilitation Medicine
Jackson Memorial Hospital
Miller School of Medicine University of Miami

RE: Medical Records

Incomplete medical records are a serious accreditation deficiency that has important financial ramifications. Medical record completion by house staff as well as attendings is required before billing can be submitted. Charts are not to be compiled. Patients' charts are to be reviewed on a weekly basis.

Severe action will be taken for any resident whose medical records charts are incomplete. Please remember that keeping good medical notes is just as important as seeing the patient.

Thank you for your cooperation.

JOURNALS AND PERIODICALS FOR USE AT JOURNAL CLUB

(Available through our Central Library)

CARDIOVASCULAR

Circulation
Stroke

GENERAL MEDICINE

Journal of the American Medical Association
Lancet
Mayo Clinic Proceeding
New England Journal of Medicine
New York State Journal of Medicine
British Medical Journal

NEUROLOGY

Annals of Neurology
Archives of Neurology
Journal of Neurology, Neurosurgery and Psychiatry
Journal of Neurosurgery
Muscle and Nerve
Neurology Clinics
Neurology
Paraplegia
Surgical Neurology
Yearbook of Neurology and Neurosurgery

NURSING

Rehabilitation Nursing
Rehabilitation Psychology

ORTHOPEDECS

Acta Orthopaedic Scandinavica
Clinical Orthopedics and Related Research
Hand Clinics of North America
Journal of Bone and Joint Surgery (American Volume)
Journal of Bone and Joint Surgery (British Volume)
Journal of Hand Surgery –American
Journal of Hand Surgery – British
Orthopedic Clinics of North America
Spine

PEDIATRICS

Pediatric Clinics of North America
Clinical Pediatrics

PSYCHIATRY, PSYCHOLOGY, MENTAL HEALTH

Child's Nervous System
Journal of Neurology, Neurosurgery and Psychiatry
Rehabilitation Psychology

REHABILITATION

American Journal of Occupational Therapy
American Journal of Physical Medicine
Archives of Physical Medicine and Rehabilitation
Clinics in Sports Medicine
Journal of Burn Care and Rehabilitation
Journal of Head Trauma Rehabilitation
Journal of Speech and Hearing Disorders
Paraplegia
Physical Medicine and Rehabilitation Clinics of North America
Physical Therapy
Rehabilitation Literature
Rehabilitation Nursing
Rehabilitation Psychology
Scandinavia Journal of Rehabilitation Medicine
State-of-the-Art Reviews in Physical Medicine and Rehabilitation

RHEUMATOLOGY

American Journal of Rheumatology
Arthritis and Rheumatism
British Journal of Rheumatology

SURGERY

Journal of hand Surgery (American)
Journal of hand Surgery (British)

UROLOGY

Urological Clinics of North America

DEPARTAMENTAL TELEPHONE NUMBERS

	NAME	PHONE	PAGER
CHAIRPERSON	Diana D. Cardenas, M.D., M.H.A	305-585-1327	305-659-5882
FACULTY ATTENDINGS	Kresimir Banovac, M.D.	305-585-1322	305-678-7981
	Fernando Branco, M.D.	305-585-1323	305-659-2266
	David Kushner, M.D.		305-874-8135
	Zoraya Parrilla, M.D.	305-585-1325	305-659-6863
	Jose Andres Restrepo, M.D.	305-585-1413	305-659-1745
	Andrew Sherman, M.D.	305-243-9814	305-287-8701

VOLUNTARY ATTENDINGS_____

	Ronald Tolchin D.O.	305-346-3075	
	David Lipkin, M.D.	305-604-3261	
	Kester Nedd, D.O.	305-585-1258	
	Salome Perez, Ph.D.	305-324-4455 ext 3717	
	Tie Qian, M.D.	305-324-4455 ext 4793	
	Bruce Rubin, M.D.	305-585-1263	
	Miguel Tabaro, M.D.	305-324-4455 ext4453	
	Jose Toledo, M.D.	305-604-3261	
	Kenneth Ward, M.D.	305-324-4455 ext 6258	
	Katherine Westie, Ph.D.	305-585-5308	

RESIDENTS: 305-585-2255 pager number

PGY 2		
	Enzo Abad, D.O.	2413
	Adam Berliner, D.O.	2420
	Michael Sigler, M.D.	1403
	Allan Vrable, D.O.	1443

PGY 3		
	Lucinda Arenas, M.D.	
	Suzanne Duncan, M.D.	
	Sergio Lenchig, M.D.	
	Luiz Massa, M.D.	

Fellows:

	Uday Bhatt, M.D.
	Gregory Samson, M.D.

EMERGENCY NUMBERS

FIRE & ALL EMERGENCIES _____ 305-585-6123

EMERGENCY, SECURITY _____ 305-585-6111

DEPARTMENT ADMINISTRATION

ADMINISTRATOR _____ Nadine Knight _____ 305-585-1329

SECRETARY _____ Greeyt Hernandez _____ 305-585-1320

EDUCATION COORDINATOR _____ Coretha Davis _____ 305-585-1431

REHABILITATION MEDICINE THERAPY DEPARTMENTS

A.D.L.

Occupational Therapy

Outpatient	5-7224
Hand	5-7224
Neuro	5-8362
Spine	5-6985

Physical Therapy

Outpatient	5-6842
Spine	5-5382
Neuro	3-1923

Speech 3-1260

Pediatric Unit 5-6040

JMH NURSING STATIONS

Rehab 2 Annex 5-5495

Neuro Rehab 3-1257

Pedi Rehab 5-6040

Rehab Outpatient Clinic 5-6262

LIST OF PROCEDURES TO BE OBSERVED WHILE IN PM&R RESIDENCY

REHABILITATION PROCEDURES

- ✓ Modified Barium Swallow
- ✓ Placement of Passy- Muier Valve
- ✓ Audiogram
- ✓ Visit to Gait Analysis Lab
- ✓ Visit to Vocational Rehab
- ✓ Pressure garment use
- ✓ Acupuncture
- ✓ Modalities: heat, ice, TENS, US, E-stim
- ✓ Splint Fabrication
- ✓ Hubbard Tank
- ✓ Whirlpool
- ✓ Crutch walking
- ✓ Bladder Sono
- ✓ Cystometrics

ORTHOPEDIC PROCEDURES

- ✓ Carpal Tunnel Release
- ✓ Total Knee arthroplasty
- ✓ Total Hip arthroplasty
- ✓ ORIF fractures
- ✓ Shoulder Arthroplasty
- ✓ Arthroscopy
- ✓ Rotator Cuff Repair
- ✓ Scoliosis Surgery
- ✓ BKA/AKA

NEUROSURGERY PROCEDURES

- ✓ Muscle/Nerve biopsy
- ✓ Laminectomy/Discectomy
- ✓ Brachial Plexus Surgery
- ✓ Intraop. SSEP
- ✓ Kyphoplasty

CARDIAC PROCEDURES

- ✓ Stress test

EMG

- ✓ SSEP
- ✓ Facial EMG

PEDIATRIC SURGERY

- ✓ Baclofen Pump Placement
- ✓ Botox Injection
- ✓ Tendon Release/Transfer Surgery

PAIN MANAGEMENT

- ✓ Discogram
- ✓ IDET
- ✓ Radio Frequency Facet
- ✓ Lumbar Epidural Steroid Injection
- ✓ Cervical ESI
- ✓ Spinal Cord Stimulator Placement

Residents' Library List

- American Journal of Physical Medicine & Rehabilitation (Starting Volume 84 No. 7 July 2005)
- Atlas of Amputations and Limb Deficiencies
Surgical, Prosthetic, and Rehabilitation Principles.....Douglas G. Smith, M.D.
John W. Michael, Med, CPO & John H. Bowker, M.D.
- Electrodiagnosis and Clinical Neurophysiology:
A High Intensity Review (DVD Set).....Wesley M. & Suzanne S.
Dixon Education & Training Center
- Essentials of Musculoskeletal Care (with CD-ROM).....Walter B. Greene, M.D.
- Essentials of Musculoskeletal Imaging (with CD-ROM).....Thomas R. Johnson, M.D.
Lynne S. Steinbach, M.D.
- Executive Skills for Medical Faculty.....Neal Whitman,
Elaine Weiss & F. Marian Bishop
- Hollinshead's Functional Anatomy of the Limbs and Back, 8th Ed.....David B. Jenkins
- Independent Medical Evaluations (2 Copies)Thomas G. Grace, M.D.
- International Standards for Neurological
Classification of Spinal Cord Injury (19 copies).....ASIA Reprinted 2002
- Orthopaedic knowledge Update – Sports Medicine3.....James G. Garrick, M.D.
- Physical Examination of the Knee (DVD Video).....J. Scott Delaney, M.D.
John Antoniou, MD, PhD
- Physical Examination of the Shoulder (DVD Video).....John Antoniou, MD, PhD
J. Scott Delaney, M.D.
- Physical Medicine and Rehabilitation Board Review.....Sara J. Cuccurullo, M.D.
- Preceptors as Teachers: A Guide to Clinical Teaching.....Neal Whitman, Ed.D &
Thomas L. Schwenk, M.D.
- Residents as Teachers:
A Guide to Educational Practice –Second Edition (2 Copies).....Thomas L. Schwenk, M.D.
Neal Whitman, Ed.D.
- State of the Art Reviews: Spinal Rehabilitation.....Mark Allen Young, M.E
Robert A. Lavin, M.D.
- The Clinical Measurement of Joint Motion.....Walter B. Greene, M.D.
James Heckman, M.D.
- The Choice is Yours -Medical Professionalism:
Using Film to Promote Self-Reflection (with DVD).....Ruth Yorkin Drazen