# TABLE OF CONTENTS

TABLE OF CONTENTS .............................................................................................................. 1
FOREWORD .......................................................................................................................... 3
INTRODUCTION TO SPINAL CORD INJURY MEDICINE ........................................... 4
PROGRAM DESCRIPTION ............................................................................................. 4
EDUCATIONAL OBJECTIVES .......................................................................................... 7
  OVERALL PROGRAM OBJECTIVES ............................................................................... 7
    Global Learning Objectives of the SCIM Residency Program ....................................... 7
  ROTATION OBJECTIVES & AFFILIATIONS .............................................................. 14
    JMH ROTATION .......................................................................................................... 14
    VAHS INPATIENT ....................................................................................................... 18
    VAHS OUTPATIENT ................................................................................................... 22
    VAHS RESEARCH - INTEGRATED ROTATION ......................................................... 26
GENERAL GUIDELINES .................................................................................................... 28
  RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS ......................... 28
  PROFESSIONAL BEHAVIOR AND DEMEANOR ....................................................... 29
  WORK HOURS AND PUNCTUALITY .......................................................................... 30
  CONFIDENTIALITY OF INFORMATION ...................................................................... 29
  TELEPHONE ADVICE .................................................................................................. 29
  PRESCRIPTION RENEWAL ......................................................................................... 30
  BEEPER ......................................................................................................................... 30
  EMERGENCIES ON IN-PATIENT REHAB ................................................................ 30
PATIENT CARE .................................................................................................................... 31
  ON CALL RESPONSIBILITIES .................................................................................... 33
  MORNING REPORT ........................................................................................................ 33
  CLINICS .......................................................................................................................... 33
  CLINIC ATTENDINGS .................................................................................................... 33
DEPARTMENTAL CONFERENCES ...................................................................................... 33
  TEAM EVALUATION CONFERENCE ......................................................................... 33
  FAMILY MEETINGS ....................................................................................................... 34
  PROGRAM DIRECTOR ROUNDS .............................................................................. 34
  GRAND ROUNDS .......................................................................................................... 36
  JOURNAL CLUB .............................................................................................................. 35
DIDACTIC LECTURE SERIES ............................................................................................ 35
INTERDEPARTMENTAL CONFERENCES ......................................................................... 35
  OTHER LEARNING RESOURCES ............................................................................. 36
    DEPARTMENTAL LIBRARY ......................................................................................... 36
    HOSPITAL LIBRARY .................................................................................................... 36
RESEARCH .......................................................................................................................... 37
RESIDENT SCHEDULING .................................................................................................... 38
  HOSPITAL HOLIDAYS ................................................................................................... 38
  SICK DAYS .................................................................................................................... 38
  VACATION ....................................................................................................................... 41
  TRAVEL POLICY ............................................................................................................ 41
  HURRICANE POLICY .................................................................................................... 43
  SCHEDULE CHANGES .................................................................................................. 43
  ABSENTEEISM .............................................................................................................. 43
MISCELLANEOUS ............................................................................................................... 42
FOREWORD

Welcome.

The entire Department of Rehabilitation 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 Spinal Cord Injury Medicine Residency Training Program in the Department of Rehabilitation. We ask that you read this carefully and familiarize yourself with its content. This 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 year. For the next year, 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 you also assume part of the responsibility in implementing those 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. Cardenas 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.

Diana D. Cardenas, M.D., M.H.A
Professor and Chair
Department of Rehabilitation Medicine
Fellowship Program Director
Jackson Memorial Hospital
Miller School of Medicine University of Miami

Andrew L Sherman, M.D., M.S.
Associate Professor and Vice Chair
Department of Rehabilitation Medicine
Residency Program Director
Jackson Memorial Hospital
Miller School of Medicine University of Miami
INTRODUCTION TO SPINAL CORD INJURY MEDICINE

The specialty of Spinal Cord Injury Medicine is concerned with diagnosis, evaluation, and treatment of patients with limited function as a consequence of injuries or disease that has injured the Spinal Cord. Emphasis is placed on maximal restoration of the physical, psychological, social, and vocational functions of the whole person, on the maintenance of health and the prevention of secondary complications of disability, and on alleviation of pain. 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; and rehabilitation management. All of these learned skills will be utilized in your one year of training in this sub specialized field of Physical Medicine and Rehabilitation.

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 SCIM residency training program is designed to provide the framework for you to implement the philosophy of the practice of Rehabilitation Medicine and apply them to the highly complex medical patient population that is Spinal Cord Injury. By completing this Fellowship, you will be exposed to a large enough patient population that has the full array of spinal cord injuries and diseases that you will encounter throughout your career. It is hoped that your management of these patients, along with their complications and broad array of behavioral and social issues will allow you to graduate this program a confident, compassionate, and highly competent physician in the sub specialty of SCI medicine. If we achieve these goals together, then we believe that you will be able to go on to have a successful career in any setting, academic or private, providing this compassionate and competent care to better the lives of persons with catastrophic devastating physical and emotional injuries while furthering the field itself through research or education.

PROGRAM DESCRIPTION

The residency program in Spinal Cord Injury Medicine (SCIM) sponsored by Jackson Memorial Hospital is a one year program of postgraduate training that leads to eligibility for sub specialty certification by the American Board of Physical Medicine and Rehabilitation. In 2009, our program was granted approval, as a fully functioning program, by the Rehabilitation Residency Committee (RRC) under the Accreditation Council for Graduate Medical Education (ACGME). In 2008 the program was reviewed, as a fully functional program, with all PM&R PGY levels filled. The RRC granted the program a 5 year accreditation, the most time granted to a program. This program trains graduates of those programs in PM&R but also will accept graduates of programs in Neurology (Also PGY 2-4), and in some rare cases, Internal Medicine or Neurosurgery.
The objectives of the program are to provide a post-doctoral specialty training in SCIM and to enable the trainee, upon completion, to provide state-of-the-art clinical care (in an academic or private setting), perform research, and/or pursue an academic or private practice career that includes SCIM care. Therefore, the program is structured to expose the trainee to all areas essential to the attainment of competency and expertise in the profession.

At Jackson Memorial Medical Center we have inpatient units that consist of 25 beds. These beds are shared by the Spinal Cord Injury and Comprehensive Rehabilitation services. At any time there is a minimum of 8 spinal cord injured patients on this unit but the actual numbers vary. All patients are acute in their injury and all levels of SCI from C2 complete to cauda equina syndrome (S4-5) can be encountered. Expect to be exposed to all levels of injury at some point during your residency. Additionally, there is a pediatric rehabilitation service with 14 beds and as a SCIM resident you will be exposed to any SCI patients on this unit. The patients are admitted to the rehabilitation service by Jackson Memorial Hospital physicians only.

At JMH, the core residents rotate through these services every 8 weeks. The core resident will be entrusted with the primary care responsibility of managing the moment to moment problems these patients encounter. The mix of patients is heterogeneous, proportionately reflecting all levels of SCI. Each SCIM resident will rotate through the JMH service for a total of 6 months.

While during the rotation the core resident will be responsible for the comprehensive primary medical and rehabilitative care of their patients, the SCIM resident will be responsible for everything the core resident does with these patients. The SCIM resident will also be responsible for teaching the core resident in the areas of professionalism, interpersonal skills and multidisciplinary care, systems based practice, and practice based learning.

The Rehabilitation Medicine Consultation Service at JMH receives over 2500 annual consultations for patients on other services. The SCIM resident will assist the consult resident by performing a number of consultations on SCI patients on the acute inpatient service and evaluating their suitability for admission to the acute rehabilitation service while minimizing their medical complications and facilitating timely rehabilitation.

Finally, ample clinic exposure will be granted to the SCIM resident. This will allow for continuity of care with patient follow up for problems related to “growing old” with SCI or chronic SCI.

At the VAHS, the SCIM resident will have 6 months (two 3 month sessions) of intensive exposure serving as the primary care provider for their SCI inpatients and outpatients with core residents on the service every month. The six months(two 3 month sessions) at the VAHS will emphasize on both the inpatient and outpatient services and management of SCI patients.

The Neuro-urology and urodynamics exposure will occur at both sites. At the VAHS under the supervision of Angelo Gousse, MD., a specialist in this area. Additionally the SCI resident will serve as a consultant to the ER physicians and all patients with SCI who are admitted to the entire hospital will be admitted to the SCI service under the care of multiple specialists one of whom will be the SCIM resident. In this manner the SCIM resident will gain exposure to all of the potential problems that patients with chronic SCI do experience. Finally, there is a wound care service at the VAHS that will provide in depth teaching in this important area of decubitis assessment and treatment.
All residents will participate in research. The specifics of how this will occur and be integrated into the general program and the requirements of each resident are outlined later in this manual.

Didactic course series include lectures in topics related to SCI medicine. This course series includes but is not limited to: medical complications, acute management, neurogenic bladder and bowel, pain, autonomic dysreflexia, respiratory management, chronic SCI, and decubitus and skin care. Journal clubs and case conferences are set up to mirror the didactic topics. These occur on Fridays.

The department supports the philosophy of adult learning. A major goal of 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.

Residency evaluations occur every three months with electronic evaluations of the resident by the supervising attending physicians. Ten times per rotation, it is expected that the resident will have a supervised history and physical exam and be evaluated on their performance by their supervising attending physician and have these scored as a “Mini CEX” exam. At the halfway point of each rotation, residents will be evaluated by all members of the team via a 360 degree evaluation. Twice per year, the resident will have in-depth individual meetings with the Program Director. The resident also will receive a written evaluation upon completion of each six month rotation. Conversely, residents evaluate the program and the attending physicians annually, in addition to monthly rotation evaluations. The Chairperson/Program Director uses this evaluation process to optimize the resident's learning experience.

SCIM resident assessment is based on ACGME guidelines for residency programs (see Appendix).
EDUCATIONAL OBJECTIVES

OVERALL PROGRAM OBJECTIVES

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

GLOBAL LEARNING OBJECTIVES OF THE SCIM RESIDENCY PROGRAM

The SCIM fellowship 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.

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

Patient care:
Fellows 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. 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 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 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:

1.1 Perform an expanded physiatric history in a manner that conveys compassion, caring, and respect for the patient.
1.2 Perform basic neurological, musculoskeletal, and medical physical exam on SCI patients that includes all aspects of the physiatric exam in a manner that conveys compassion, caring, and respect for the patient.

1.3 Perform the expanded functional exam on SCI patients unique to the physiatric assessment in a manner that conveys compassion, caring, and respect for the patient.

1.4 Perform the ASIA SCI examination.

1.5 Counsel patients appropriately on their injury in a manner that conveys compassion, caring, and respect for the patient.

1.6 Learn basic procedural skills including peripheral joint injection, foley catheter placement, refill Baclofen pumps.

1.7 Competently perform EMG/NCV studies and Botox injections.

1.8 Learn how to document properly in the care of the patients with competent progress notes, discharge summaries, and team evaluation summaries.

1.9 Identify normal and common abnormalities on:
   i. Brain CT, MRI
   ii. Spine X-ray, CT, MRI, Myelogram
   iii. Bone Scan
   iv. KUB X-ray, Chest X-ray, Skeletal X-rays

1.10 On patients needing inpatient rehabilitation, choose appropriate treatment modalities and set goals for treatment.

1.11 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 and are reviewed with the resident by both his attending and program director(s).

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 junior residents and attending staff are held at JMH and with attending staff at the VA four or five days weekly.
2. The SCIM curriculum lecture series provides comprehensive didactics throughout the academic year.
3. Journal Club is held at least once per month.
4. Monthly M & M, Journal club or Performance-Improvement conferences are held and required for all residents.
5. Monthly PMR grand rounds are given.

Areas of Competence (Objectives) that must be achieved:
2.1 Learn the basic pathophysiology, evaluation, treatment, and inpatient rehabilitation management of the core problems of SCI, spinal stenosis, multiple sclerosis and spinal radiculopathies including considerations relating to age, gender, race, ethnicity, genetics, and sociocultural factors due to:
   a. Trauma
   b. Vascular injury
   c. Fall/Central cord
   d. Herniated disc
   e. Spinal tumor
   f. MS
   g. Neuropathies
   h. Transverse myelitis
   i. Gunshot Wound
   j. Posterior Cord Syndrome/B12 deficiency

2.2 Learn to prevent and then identify common and uncommon medical complications that occur in patients with SCI disabling injuries in the inpatient rehabilitation setting including but not limited to
   k. Decubiti
   l. MI
   m. Respiratory insufficiency
   n. Pneumonias
   o. Autonomic dysreflexia
   p. DVT/PE
   q. Heterotopic Ossification
   r. Pain
   s. Spasticity
   t. UTI

2.3 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
   u. Shoulder disorders
   v. Decubiti
   w. Neuropathic pain
   x. Musculoskeletal pain
   y. Cardiovascular disease and lipid abnormalities
   z. Neurogenic bladder management
   aa. Neurogenic bowel management

2.4 Apply learned anatomy of the musculoskeletal, spine, and neurological system
2.5 Learn physical examination maneuvers that test the anatomy when pathology is present.
2.6 Learn how to apply accurate motor and sensory levels to a patient with SCI based upon the ASIA exam.
2.7 Learn the expected functional outcome of patients based on level of injury and the resources they will need to survive.
2.8 Demonstrate comprehensive knowledge in psychiatric disorders and how they impact SCI patients with chronic disease, pain, and disability.
2.9 Demonstrate knowledge of healthcare delivery systems.
2.10 Demonstrate the knowledge of peripheral joint injection and Botox.
2.11 Demonstrate the knowledge of how to properly diagnose and treat Spasticity.
2.12 Demonstrate the knowledge of how to properly classify, diagnose, and treat neurogenic bowel and bladder.

Assessment:
1. Residents are required to take the standardized in-training examination annually. Results are reviewed in detail at the time of the semi-annual reviews.
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.

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:

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 information from scientific and practice literature and other sources 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.

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 Ability to counsel patients regarding the long term impact of SCI

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.

5.1 Demonstrate responsible behavior in the care of patients.
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.
5.4 Demonstrate respect for patients, caregivers, and professional colleagues.
5.5 Demonstrate dependability by arriving to work in a timely manner and performing all assigned work.

Assessment:
1. Rotation 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.

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. Residents will interact with insurance medical directors to obtain increased inpatient rehabilitation days.
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 Be able to accurately predict length of stay in the rehabilitation hospital and work with the medical director of the insurance companies to justify the inpatient stay.

Assessment:
1. Rotation 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 Rotation**

**Patient Care:**
Each resident will be under the supervision of Miami VAHS or Department of Rehabilitation Medicine faculty members specialized in spinal cord medicine throughout this clinical rotation. Residents have rotated through the Miami VAHS as primary SCI physician and have been expected to gain proficiency in the care of SCI at a junior attending physician level. Assuming they have achieved competency on these rotations, the resident will serve in a supervisory role on this service. Alternatively, if they have not, they will carry a service of 5 SCI inpatients as primary care providers until such time it is felt they are competent enough to lead the core resident run team. The attending physician members will supervise both the SCIM and the core PMR 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 that the resident obtains patient care competency as expected for a new practitioner at the level of a new academic attending level. Additionally, the SCIM and core PMR residents will undergo evaluation by a 360 degree type review of all members of the multidisciplinary rehabilitation team.

Specifically the resident will be expected to:
- Perform and supervise the PMR resident performing effective SCI rehabilitation admissions, daily examinations on inpatients on the rehabilitation unit, and discharge summaries.
- Perform and supervise the PMR resident performing all administrative function associated with inpatients care such as but not limited to:
  - Daily progress notes, discharge summaries within 24 hours of discharge when possible, team conference notes, family conference notes, medication prescriptions, and therapy prescriptions.
- Perform and supervise the PMR resident performing effective SCI rehabilitation consultations on inpatients in the acute care hospital. Co-ordinate disposition of these patients with the primary team, the rehabilitation admitting office, and the attending supervising PMR physician.
- Perform and supervise the PMR resident performing competent outpatient history and physical examinations in the outpatient clinic setting.
- Perform and supervise the PMR resident performing yearly evaluations on SCI patients with appropriate preventative medicine diagnostics and follow up.
- Follow SCI inpatients they may admit from the clinic or home care agency that have chronic SCI but acute medical complications such as pneumonia, heart attack, stroke, or decubiti in outpatient clinics.
- 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 in the clinic setting, VAHS ER, or acute hospital.
- Perform comprehensive physiatric examinations on selected patients.
- Create a differential diagnosis appropriate to the physical findings.
- Recommend appropriate rehabilitation plans for inpatient and outpatient SCI patients based upon the level of spinal cord injury, co-morbid conditions or suspected diagnosis.
- Learn to order appropriate diagnostics and interpret the findings of the ordered tests.
- Create an organized, coherent, and comprehensive consultative report 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 and supervise the PMR resident leading a multidisciplinary team in the care of SCI patients.
- Show leadership and supervise the PMR resident performing such leadership in weekly team meetings.
- Show leadership and become proficient at counseling patients and family members regarding their condition.
- Perform and supervise the PMR resident performing appropriate comprehensive examinations on SCI outpatients or acute inpatients on other services.
- Understand when to recommend inpatient vs outpatient placement for care of SCI patients in the hospital.
- Score satisfactory (Over 4/9) on the last three/six Mini-CEX examinations.

Medical Knowledge:
Residents will be expected to gradually increase their knowledge in SCI medicine. Specifically, this rotation will address mainly issues surrounding patients undergoing inpatient rehabilitation soon after their acute injuries. Thus medical complications of SCI are frequent and must be identified and treated appropriately. Residents will receive opportunities to learn from their attendings 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. 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, 10 ‘mini CEX’ exams, and a 360 degree evaluation by the multidisciplinary team.
Specifically the residents will be expected to:

- Learn the physiology behind SCI — all types and all levels.
- Learn what level of spinal cord injury causes which motor, sensory, and functional deficits are associated with specific levels of SCI.
- Prevent immediate causes of secondary co-morbidity in patients with spinal cord injuries.
- Apply learned anatomy and physiology as appropriate.
- Be able to identify and treat specific disorders that are commonly seen in the SCI population who are inpatients on acute services including but not limited to:
  - Autonomic dysreflexia, DVT and prophylaxis, Decubiti, Stress ulcers, Pneumonia, UTI, Ileus, Heterotopic ossification, spasticity, depression
- Be able to identify and treat common outpatient problems in SCI patients such as joint pain, shoulder pain, entrapment neuropathies, renal stones, UTI, contractures, spasticity, depression, neuropathic pain, respiratory illness, cholesterol issues, metabolic issues
- Learn the physiology and basic science of spinal cord injury.
- Be able to determine appropriate goals for patients with specific levels and degrees of SCI in the outpatient setting or consult setting.
- Learn the complications of a patient aging with SCI as it applies to inpatient admission and severe illness and outpatient care.
- Learn physiology of respiratory disorders associated with SCI.
- Address pain in SCI — diagnostic, therapeutic, and experimental.
- Apply assistive technology to the patient in the appropriate manner for level of SCI.
- Know how to create a wheelchair prescription and why.
- Understand the use of and prescribe appropriately the therapies necessary for the SCI patients.
- Score over the 25% percentile nationally in any national standardized examination.

Practice-Based Learning and Improvement:

The resident will be evaluated throughout the rotation by the supervising attending physicians to assure the resident obtains exposure to practice-based learning as expected for a new practitioner. In addition, residents will receive training in practice-based learning through didactic lectures including a separate journal club. Finally, residents will be expected to provide evidence based teaching to the core PMR residents under their supervision on their SCI rotation.

Specifically, residents will:

- Evaluate their own exam skills and knowledge and incorporate feedback from others.
- Evaluate the exam skills of the core resident and provide appropriate feedback.
- Investigate and apply evidence from scientific studies to enhance patient care and teaching throughout the rotation.
- Use information technology (computers, journals, etc.) to access and manage patient information and support treatment decisions.
- Contribute study findings to discussions on the care of the patient with other health care professionals.
- Attend and participate in conferences and rounds in order to facilitate discussions of patient care and disposition.
- Provide in-service talks to allied health personnel.
- Save their reports from early in the rotation and compare them to those done later in the rotation.
- Perform six Mini-CEX exams to gain feedback on their examination proficiency.
- Investigate the outcomes of their treatment decisions.
- Be able to critically appraise studies that affect patient management.

Interpersonal and Communication Skills:
Each resident will be under the supervision of physiatry faculty members throughout their clinical rotation. They will apply appropriate interpersonal skills as they examine and recommend treatments to their patients. Finally, residents will be expected to provide evidence based teaching to the core PMR residents under their supervision on their SCI rotation.

In the rotation setting, the resident will be expected to:
- Establish trust and maintain rapport with patients and family.
- Complete all chart notes and dictations in a timely manner.
- Present material clearly and accurately to patients and family.
- Effectively communicate verbally and in writing patient needs to all multidisciplinary staff and other physicians involved with the patient.
- Utilize effective listening skills.
- Participate in all relevant rounds and discussions.
- Communicate treatment recommendations effectively with the entire multidisciplinary team that cares for the SCI outpatient including PT, OT, speech, Voc rehab, home nursing, caregivers and psychologists.
- Communicate treatment plans effectively to SCI outpatients and family members.
- Present their findings clearly and concisely to supervising faculty so management can be discussed.
- Teach core PMR residents daily on rounds.
- Teach core PMR residents via journal club and didactic lectures.

Professionalism:
Each resident will be working under the supervision of faculty members throughout their clinical rotation who is approved to work within the scope the University of Miami School of Medicine. As such we believe they will offer a good example to residents on professional behavior. The resident will be evaluated in a one-on-one basis and at the end of the rotations by the supervising physicians to assure that resident shows the appropriate professionalism expected for a new practitioner. In addition, residents receive training in professionalism through pairing the resident with attending physicians felt to exhibit the highest levels of professionalism.

Residents will be required to:
- Exemplify respect and compassion towards patients.
- Show reliability, punctuality, integrity, and honesty.
- Accept responsibility for own actions and decisions.
- Apply sound ethical principles in practice, including patient confidentiality, informed consent, provision and withholding of care, and interactions with insurance or disability agencies.
- Consider the effects of personal, social, or cultural factors in the disease process and patient management.
- Demonstrate sensitivity to the patients who have different ages, social status, races, and genders.
- Serve as a role model for core PMR residents who rotate under their service and supervision.
System-Based Practice:
Each resident will be under the supervision of a faculty member throughout their clinical rotation. The resident will be evaluated on each rotation by the supervising physicians and this information will be communicated to the program director to assure the resident understands how to apply the system-based practice principles at a level expected for a new practitioner. In addition, residents will receive training in system-based practice through didactic lectures. Finally, SCIM residents will need to effectively teach the principles that they learn below to core PMR residents rotating on their service.

Specifically, the resident will be expected to:
- Collaborate and work effectively with other health professionals and maintain appropriate behaviors.
- Assess how their decisions affect others—patients, family, other health care professionals.
- Integrate care of patients across hospital and community settings.
- Understand the constraints and difficulties of living with SCI at home.
- Learn how to co-ordinate home care with home health agencies.
- Learn when tests are appropriate or may be under- or over-utilized.
- Understand the cost of the treatments and diagnostic tests that are ordered.
- Understand what physicians are involved in the treatment of patients with disabilities and what their role is.
- Learn when a multi-disciplinary approach to pain management might be the only appropriate course of treatment, the costs and settings of such treatment, and what the outcomes might be.
- Advocate for patients who need tests and treatments that might be inappropriately denied.
- Speak with medical directors by phone to gain rehabilitation length of stay increases.
- Recognize requirements for documentation.
- Learn medicare and medicaid requirements as it relates to documentation, elements of the exam, and billing procedures and codes.
- Realize the limitations on the ability of patients to pay for their medications.

VAHS INPATIENT

Patient Care:
Each resident will be under the supervision of Miami VAHS or 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.

Medical Knowledge:

Residents will be expected to gradually increase their knowledge in SCI medicine. Specifically, this rotation will address mainly issues surrounding patients undergoing inpatient rehabilitation soon after their acute injuries. Thus medical complications of SCI are frequent and must be identified and treated appropriately. Residents will receive opportunities to learn from their attendings 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. 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, 10 ‘mini CEX’ exams, and a 360 degree evaluation by the multidisciplinary team.

Specifically the residents will be expected to:

- Learn the physiology of SCI – all types and all levels.
- Learn what level of spinal cord injury causes which motor, sensory, and functional deficits are associated with specific levels of SCI.
- Apply learned anatomy and physiology as appropriate.
- Be able to identify and treat specific disorders that are commonly seen in the SCI population setting including but not limited to:
  - Autonomic dysreflexia, DVT and prophylaxis, Decubiti, Stress ulcers, Pneumonia, UTI, Ileus, Heterotopic ossification, spasticity, depression

In more depth:
The resident should learn to recognize, diagnose and coordinate treatment for respiratory complications including tracheotomies, airway obstruction, atelectasis, pneumonia, and tracheal stenosis. The resident should be able to manage patients with high tetraplegia and ventilator dependency. They should become knowledgeable in weaning patients from the ventilator and in mechanical methods of management of ventilatory support. They should learn indications and
contraindications of phrenic nerve pacing, motorized wheelchairs, portable respirators, environmental control units and home modifications in the care of high tetraplegic and other SCI patients.

The resident should learn to manage the cardiopulmonary consequences of SCI including orthostatic hypotension and other acute cardiac abnormalities which occur and to diagnose and treat deep vein thrombosis, pulmonary embolus, and autonomic dysreflexia. They must also learn to manage the risk of infection and to coordinate treatment and infection control, including the judicious use of antimicrobial agents. They should also learn to recognize the pharmacology alterations associated with SCI including changes in pharmacokinetics, pharmacodynamics, drug interactions, overmedications and compliance.

The resident should learn to treat skin problems using preventative techniques such as beds, cushions and wheelchairs. The resident should also learn to manage decubiti and in consultation with surgery determine the indications for various procedures including resection of bone and the development of flaps and other techniques for soft tissue coverage. The resident should also develop an understanding of the preoperative and postoperative management of these patients.

The resident should learn to coordinate and implement management of the neurogenic bowel. They should also learn to understand management of the neurogenic bladder and the role of the urologist in its management. They should learn management of bladder dysfunction, urinary tract infection and calculi, sexual dysfunction in males and females, obstructive uropathy with or without stones, infertility and ejaculatory dysfunction.

The resident should learn to diagnose and manage the psychologic dysfunction associated with SCI. They will also learn to diagnose issues of substance abuse, pain and depression associated with SCI. They will also learn to address preexisting and concomitant medical issues and how they relate to SCI.

The resident should learn to understand the kinesiology of upper extremity function and the use of muscle substitution patterns in retraining, the indications and contraindications of muscle and tendon transfers and other operative procedures to enhance function. They should also learn the management of these procedures and postoperative retraining as appropriate and to identify the indications and usage of FES in SCI.

- In the outpatient setting—joint pain, shoulder pain, entrapment neuropathies, Renal stones, UTI, contractures, spasticity, depression, neuropathic pain, respiratory illness, cholesterol issues, metabolic issues
- Learn the physiology and basic science behind these disorders.
- Be able to determine appropriate goals for patients with specific levels and degrees of SCI.
- Learn the complications of a patient aging with SCI as it applies to inpatient admission and severe illness and outpatient care.
- Learn physiology of respiratory disorders associated with SCI
- Learn to diagnose and competently treat pain in SCI. Understand the pathophysiology of neuropathic pain.
- Apply assistive technology to the patient in the appropriate manner for level of SCI
- Know how to create a wheelchair prescription and why.
- Understand the use of and prescribe appropriately the therapies necessary for the SCI patients.
Practice-Based Learning and Improvement:
The resident will be evaluated throughout the rotation by the supervising physicians to assure the resident obtains exposure to practice-based learning as expected for a new practitioner. In addition, residents will receive training in practice-based learning through didactic lectures including a separate journal club.

Specifically, residents will:
- Evaluate their own exam skills and knowledge and incorporate feedback from others
- Investigate and apply evidence from scientific studies to enhance patient care throughout the rotation.
- Use information technology (computers, journals, etc.) to access and manage patient information and support their own education and treatment decisions.
- Contribute their findings to discussions on the care of the patient with other health care professionals.
- Attend and participate in conferences and rounds in order to facilitate such discussions.
- Provide inservice talks to allied health personnel and to the community.
- Save their reports from early in the rotation and compare them to those done later in the rotation.
- Investigate the outcomes of their treatment decisions.
- Be able to critically appraise studies that affect patient management.

Interpersonal and Communication Skills:
Each resident will be under the supervision of physiatry faculty members throughout their clinical rotation. They will learn appropriate interpersonal skills as they examine and recommend treatments to their patients.

In the rotation setting, the resident will be expected to:
- Establish trust and maintain rapport with patients and family.
- Complete all chart notes and dictations in a timely manner.
- Perform discharge summaries within 24 hours of discharge barring illness or vacation to communicate the rehabilitation treatment with other physicians and health care providers.
- Present material clearly and accurately to patients and family.
- Effectively communicate verbally and in writing patient needs to all multidisciplinary staff and other physicians involved with the patient.
- Utilize effective listening skills.
- Participate in all relevant rounds and discussions.
- Participate and eventually lead multidisciplinary rounds
- Participate and eventually lead family conferences
- Present their findings clearly and concisely to supervising faculty so management can be discussed.

Professionalism:
Each resident will be working under the supervision of faculty members throughout their clinical rotation who is approved to work within the scope the University of Miami School of Medicine. As such we believe they will offer a good example to residents on professional behavior. The resident
will be evaluated in a one-on-one basis and at the end of the rotations by the supervising physicians to assure that resident shows the appropriate professionalism expected for a new practitioner. In addition, residents receive training in professionalism through pairing the resident with attending physicians felt to exhibit the highest levels of professionalism.

Residents will be required to:
- Exemplify respect and compassion towards patients.
- Show reliability, punctuality, integrity, and honesty.
- Attend all scheduled lectures on time unless patient emergency does not allow this to happen.
- Accept responsibility for own actions and decisions.
- Apply sound ethical principles in practice, including patient confidentiality, informed consent, provision and withholding of care, and interactions with insurance or disability agencies.
- Consider the effects of personal, social, or cultural factors in the disease process and patient management. Demonstrate sensitivity to the patients who have different ages, social status, races, and genders.

System-Based Practice:
Each resident will be under the supervision of a faculty member throughout their clinical rotation. The resident will be evaluated twice each rotation by the supervising physicians and this information will be communicated to the program director to assure the resident understands how to apply the system-based practice principles at a level expected for a new practitioner. In addition, residents will receive training in system-based practice through didactic lectures.

Specifically, the resident will be expected to:
- Collaborate and work effectively with other health professionals and maintain appropriate behaviors.
- Assess how their decisions affect others—patients, family, other health care professionals.
- Integrate care of patients across hospital and community settings.
- Learn when tests are appropriate or may be under- or over-utilized.
- Understand the cost of the treatments and diagnostic tests that are ordered.
- Understand what physicians are involved in the treatment of patients with disabilities and what their role is.
- Learn when a multi-disciplinary approach to pain management might be the only appropriate course of treatment, the costs and settings of such treatment, and what the outcomes might be.
- Advocate for patients who need tests and treatments that might be inappropriately denied.
- Recognize requirements for documentation.
- Learn medicare and medicaid requirements as it relates to documentation, elements of the exam, and billing procedures and codes.
- Realize the limitations on the ability of patients to pay for their medications.

**VAHS OUTPATIENT AREA (as PART of the VAHS ROTATION)**

Patient Care:
Each resident will be under the supervision of Miami VAHS or 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:

- Perform effective SCI rehabilitation consultations on inpatients in the acute care hospital.
- Perform competent outpatient history and physical examinations in the outpatient clinic setting.
- Perform yearly evaluations on SCI patients with appropriate preventative medicine diagnostics and follow up.
- Follow SCI inpatients they may admit from the clinic or home care agency that have chronic SCI but acute medical complications such as pneumonia, heart attack, stroke, or decubiti.
- 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 in the clinic setting, VAHS ER, or acute hospital.
- Perform comprehensive physiatric examinations on selected patients
- Create a differential diagnosis appropriate to the physical findings.
- Recommend appropriate rehabilitation plans for inpatient and outpatient SCI patients based upon the level of spinal cord injury, co-morbid conditions or suspected diagnosis.
- Learn to order appropriate diagnostics and interpret the findings of the ordered tests.
- Create an organized, coherent, and comprehensive consultative report 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 counseling patients and family members regarding their condition.
- Perform appropriate comprehensive examinations on SCI outpatients or acute inpatients on other services.
- In the capacity of continuing with some inpatient responsibility, mainly for patients with medical problems admitted to the unit who have chronic SCI, perform exams daily and on rounds with attending physicians.
- Understand when to recommend inpatient vs outpatient placement for care of SCI patients in the hospital.
- Score satisfactory (Over 4/9) on the last three/six Mini-CEX examinations.

Medical Knowledge:
Residents will be expected to gradually increase their knowledge in SCI medicine. Specifically, this rotation will address mainly issues surrounding patients undergoing inpatient rehabilitation soon after their acute injuries. Thus medical complications of SCI are frequent and must be identified and treated appropriately. Residents will receive opportunities to learn from their attending physician 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. 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, 10 ‘mini CEX’ exams, and a 360 degree evaluation by the multidisciplinary team.

Specifically the residents will be expected to:

- Learn the physiology behind SCI – all types and all levels.
- Learn what level of spinal cord injury causes which motor, sensory, and functional deficits are associated with specific levels of SCI.
- Prevent immediate causes of secondary co-morbidity in patients with spinal cord injuries.
- Apply learned anatomy and physiology as appropriate.
- Be able to identify and treat specific disorders that are commonly seen in the SCI population who are inpatients on acute services including but not limited to:
  - Autonomic dysreflexia, DVT and prophylaxis, Decubiti, Stress ulcers, Pneumonia, UTI, Ileus, Heterotopic ossification, spasticity, depression
- Be able to identify and treat common outpatient problems in SCI patients such as: joint pain, shoulder pain, entrapment neuropathies, renal stones, UTI, contractures, spasticity, depression, neuropathic pain, respiratory illness, cholesterol issues, metabolic issues
- Learn the physiology and basic science of spinal cord injury.
- Be able to determine appropriate goals for patients with specific levels and degrees of SCI in the outpatient setting or consult setting.
- Learn the complications of a patient aging with SCI as it applies to inpatient admission and severe illness and outpatient care.
- Learn physiology of respiratory disorders associated with SCI.
- Address pain in SCI – diagnostic, therapeutic, and experimental.
- Apply assistive technology to the patient in the appropriate manner for level of SCI.
- Know how to create a wheelchair prescription and why.
- Understand the use of and prescribe appropriately the therapies necessary for the SCI patients.
- Score over the 25% percentile nationally in any national standardized examination.

Practice-Based Learning and Improvement:
The resident will be evaluated throughout the rotation by the supervising physicians to assure the resident obtains exposure to practice-based learning as expected for a new practitioner. In addition, residents will receive training in practice-based learning through didactic lectures including a separate journal club.

Specifically, residents will:

- Evaluate their own exam skills and knowledge and incorporate feedback from others.
- Investigate and apply evidence from scientific studies to enhance patient care throughout the rotation.
- Use information technology (computers, journals, etc.) to access and manage patient information and support treatment decisions.
- Contribute study findings to discussions on the care of the patient with other health care professionals.
- Attend and participate in conferences and rounds in order to facilitate discussions of patient care and disposition.
- Provide in-service talks to allied health personnel.
- Save their reports from early in the rotation and compare them to those done later in the rotation.
- Perform six Mini-CEX exams to gain feedback on their examination proficiency.
- Investigate the outcomes of their treatment decisions.
- Be able to critically appraise studies that affect patient management.

Interpersonal and Communication Skills:
Each resident will be under the supervision of physiatry faculty members throughout their clinical rotation. They will learn appropriate interpersonal skills as they examine and recommend treatments to their patients.

In the rotation setting, the resident will be expected to:
- Establish trust and maintain rapport with patients and family.
- Complete all chart notes and dictations in a timely manner.
- Present material clearly and accurately to patients and family.
- Effectively communicate verbally and in writing patient needs to all multidisciplinary staff and other physicians involved with the patient.
- Utilize effective listening skills.
- Participate in all relevant rounds and discussions.
- Communicate treatment recommendations effectively with the entire multidisciplinary team that cares for the SCI outpatient including PT, OT, speech, Voc rehab, home nursing, caregivers and psychologists.
- Communicate treatment plans effectively to SCI outpatients and family members.
- Present their findings clearly and concisely to supervising faculty so management can be discussed.

Professionalism:
Each resident will be working under the supervision of faculty members throughout their clinical rotation who is approved to work within the scope the University of Miami School of Medicine. As such we believe they will offer a good example to residents on professional behavior. The resident will be evaluated in a one-on-one basis and at the end of the rotations by the supervising physicians to assure that resident shows the appropriate professionalism expected for a new practitioner. In addition, residents receive training in professionalism through pairing the resident with attending physicians felt to exhibit the highest levels of professionalism.

Residents will be required to:
- Exemplify respect and compassion towards patients.
- Show reliability, punctuality, integrity, and honesty.
- Accept responsibility for own actions and decisions.
- Apply sound ethical principles in practice, including patient confidentiality, informed consent, provision and withholding of care, and interactions with insurance or disability agencies.
- Consider the effects of personal, social, or cultural factors in the disease process and patient management.
- Demonstrate sensitivity to the patients who have different ages, social status, races, and genders.

System-Based Practice:
Each resident will be under the supervision of a faculty member throughout their clinical rotation. The resident will be evaluated twice each rotation by the supervising physicians and this information will be communicated to the program director to assure the resident understands how to apply the
system-based practice principles at a level expected for a new practitioner. In addition, residents will receive training in system-based practice through didactic lectures.

Specifically, the resident will be expected to:

- Collaborate and work effectively with other health professionals and maintain appropriate behaviors.
- Assess how their decisions affect others—patients, family, other health care professionals.
- Integrate care of patients across hospital and community settings.
- Understand the constraints and difficulties of living with SCI at home.
- Learn how to co-ordinate home care with home health agencies.
- Learn when tests are appropriate or may be under- or over-utilized.
- Understand the cost of the treatments and diagnostic tests that are ordered.
- Understand what physicians are involved in the treatment of patients with disabilities and what their role is.
- Learn when a multi-disciplinary approach to pain management might be the only appropriate course of treatment, the costs and settings of such treatment, and what the outcomes might be.
- Advocate for patients who need tests and treatments that might be inappropriately denied.
- Recognize requirements for documentation.
- Learn medicare and medicaid requirements as it relates to documentation, elements of the exam, and billing procedures and codes.
- Realize the limitations on the ability of patients to pay for their medications.

**RESEARCH – INTEGRATED ROTATION**

**Patient Care:**
Each resident will be under the supervision of a supervisor who is a physician or chosen research mentor throughout this research rotation. The resident should identify early in the year a mentor who will work with the resident during this rotation to help them progress through the research project(s) they have chosen to do. Some residents will choose clinical based research and thus will be involved in direct patient care during this time. The requirement is that the resident must present their findings, either preliminary or final, in a lecture format during the department’s “research day” during the last month of the year. Additionally, the resident must either submit one abstract to a national conference for platform or poster presentation or a manuscript to a peer-reviewed journal in PMR or SCI during their year.

Specifically, the resident will be expected to:

- Demonstrate caring and respectful behaviors (verbal and non-verbal) with patients, parents, and families.
- Elicit information using effective questioning and listening skills.
- Perform a full comprehensive neuromuscular examination on patients as needed.
- Learn to interpret the findings of tests that may be used to screen patients.
- Create an organized, coherent, and comprehensive report that can be easily interpreted by referring physicians.
- Demonstrate caring with the research subjects who are going through chronic illness and disability.
- Present patients with the risks and benefits of the research they will participate in.
- Learn to create an informed consent letter.
- Obtain informed consent ethically and correctly.
- Deal with any complications that might arise promptly.
Medical Knowledge:
The resident will be expected to gradually increase their knowledge in the medical field for the research they are performing. This will include clinical knowledge and basic science knowledge.

Specifically the residents will be expected to:
- Lean the physiology behind the medical problems in that they may be researching.
- Learn the anatomy and physiology of SCI both acute and chronic.
- Understand the barriers to neurologic recovery and neuroplasticity that inhibit recovery in SCI.
- Learn some of the latest research approaches being employed at the Miami Project to Cure Paralysis.
- Apply learned anatomy and physiology as appropriate.
- Learn what similar research has been done in the area of their study and how the outcomes apply to their project.
- If a pharmacologic agent(s) is being studied, learn the physiology of such agents(s).
- Learn to organize their findings into a coherent report. This includes oral presentations, poster presentations, and or a journal article presentation.
- Learn the procedure of medical writing.
- Learn the components of good clinical practice.
- Attend a full one week course that teaches the basics of higher level academic research.

Practice-Based Learning and Improvement:
Specifically, residents will:
- Evaluate their own research skills and knowledge and incorporate feedback from others.
- Investigate and apply evidence from scientific studies to enhance their research project throughout the rotation.
- Perform a full literature review on the project(s) they are working on.
- Use information technology (computers, journals, etc.) to access and manage data.
- Contribute their findings to discussions on the care of the patient with other health care professionals.
- Attend and participate in conferences and rounds in order to facilitate such discussions.
- Save their reports from early in the rotation and compare them to those done later in the rotation.
- Investigate the outcomes of their treatment decisions.
- Satisfactorily understand the process of human subject protection and how the IRB process works.

Interpersonal and Communication Skills:
Each resident will be under the supervision of a research director throughout their rotation. They will learn appropriate interpersonal skills as they interact with other researchers, physicians, and research subjects.

In the rotation setting, the resident will be expected to:
- Establish trust and maintain rapport with research subjects and family.
- Present material clearly and accurately to patients and family.
- Effectively communicate their findings in the form of oral presentation, poster, or written article presentation.
- Participate in all relevant rounds and discussions.
- Present their findings clearly and concisely to mentor faculty.
- Learn how to write a research proposal.
- Learn how to write an IRB proposal.
- Learn how to write an informed consent.
- Create an abstract that must be submitted to a national conference in PMR or spinal cord injury as poster or platform presentation.

Professionalism:
Each resident will be working under the supervision of the research director throughout this rotation who is approved to work within the scope the University of Miami School of Medicine and Jackson Medical Center. As such we believe they will offer a positive example to residents on professional behavior. The resident will be evaluated in a one-on one basis and at the end of the rotations by the supervising research director to assure that resident shows the appropriate professionalism expected for a new practitioner. In addition, residents receive training in professionalism through paring the resident with research mentors felt to exhibit the highest levels of professionalism.

Residents will be required to:
- Exemplify respect and compassion toward patients.
- Show reliability, punctuality, integrity, and honesty.
- Accept responsibility for own actions and decisions.
- Apply sound ethical principles in practice, including patient confidentiality, informed consent, and provision and withholding of care, and interactions with insurance or disability agencies.
- Consider the effects of personal, social, or cultural factors in the disease process and patient management.
- Demonstrate sensitivity to the patients who have different ages, social status, races and genders.
- Obtain informed consent ethically and correctly.

System-Based Practice:
Residents will be under the supervision of a research director throughout this rotation. The resident will be evaluated twice each rotation by the supervising physicians and communicated to the program director to assure the resident understands how to apply the system-based practice principles at a level expected for a new practitioner. In addition, residents will receive training in system-based practice through didactic lectures including journal club and ethics.

Specifically, the resident will be expected to:
- Collaborate and work effectively with other health professionals and maintain appropriate behaviors.
- Assess how their decisions affect others—patients, family, and other health care professionals.
- Understand the cost of the treatments and diagnostic tests that are ordered as part of any clinical research project.
- Recognize requirements for documentation.
- Understand how research projects gain funding and why.
- Learn the role of NIH and other pertinent federal funding agencies in the achievement of research.
- Learn how research findings are utilized in clinical practice.
GENERAL GUIDELINES

RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS

GENERAL GUIDELINES

RESPONSIBILITY, CLINICAL SUPERVISION, AND INSTRUCTIONS

The amount of responsibility a SCIM fellow 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 fellow on the inpatient unit will be supervised 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 fellow. The fellow is 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. Fellows 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.

It is expected however, that the SCIM resident will have a level of competence equal to that of a fully trained PMR physician as they have been documented by their previous program directors to have met the minimum level of competence to practice PMR medicine independently.

PROFESSIONAL BEHAVIOR AND DEMEANOR

Rehabilitation patients are disabled, physically ill, often in pain, and sometimes mentally depressed. SCIM fellows are taught by the attending physician that these patients are placing their trust in them. Fellows are made to understand that by accepting the career in medicine they are accepting the serious responsibility of acting on 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 fellows will achieve competence in all of the six competency areas outlined by the ACGME.

WORK HOURS AND PUNCTUALITY

All SCIM 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 patients 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.

SCIM residents are not allowed to work more than 80 hours per week. 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. Residents will have 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 7:00 a.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 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 resident and leave the hospital vicinity without permission from the supervising attending physician.

Weekend days are free from clinical duties when not on call at JMH. While at the VAHS residents may be asked to work a half day every third Saturday with no clinical duties on Sunday. Residents will have then still an 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 whom 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. They 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 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 attending physicians, 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 transfers and admissions are cleared by the attending physicians regarding suitability. If the resident has any question, they should contact the attending physician.

At JMH the assigned resident is responsible for completion of the history and physical examination form and initial rehabilitation orders on any admission until 5:30 p.m. The resident-on-call is responsible for 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.

At the VAHS, the history and physical examination form available in the nurses station is to 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.

At both JMH and VAHS, the supervising resident, SCIM resident, will ensure that the CORE resident completes all of this work before they leave for home. Alternatively, if there are multiple
admissions and discharges, the SCI resident will assist the CORE resident with the work that is necessary to allow the CORE resident to function properly in a learning environment.

All rehabilitation orders on inpatients must be updated and reviewed every two weeks by the resident. Opioid pain medication orders must be renewed every 3 days. The resident is responsible for writing a meaningful, complete, rehabilitation-oriented progress note each day on every patient under his/her care. 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 (or the day before) 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

1. 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 except the resident rotating at Mount Sinai Medical Center (he/she will participate in call at that location). The individual dates may vary but on average, an individual resident will be on at home call, if you live more than 10 miles away from the hospital, otherwise, you will have in-house call at Jackson Memorial Hospital one night every two weeks. Residents doing at home call will be able to leave by 8:00 pm on weeknights only if all patients are clearly stabilized. On weekends you will stay in house until 5 PM on Saturday and 5 PM on Sunday and may leave if all patients are stabilized. Residents on in-house 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 physiatric 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**

2. Residents in PM&R are allowed to do at-house call, if you live within 10 miles of the hospital.
3. The residents carry a central on-call beeper to minimize any confusion with communication.
4. 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.
5. **AT HOME CALL:** On weeknights, the resident on call will stay at JMH until 8:00 PM or until all patients are clearly stabilized. They will stay in house until 5 PM on Saturday and 5 PM on Sunday and may leave if all patients are stabilized. 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.
6. **IN-HOUSE CALL:** 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. On weekends, the resident on call will arrive at 7 AM after which the previous resident will give report and then leave the hospital.
7. 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.
8. 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.
9. 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.
10. 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 judgement. Nevertheless, the nursing staff has the responsibility of contacting the on-call attending in cases where that judgment is within question.
10. death or cardiac arrest

**MORNING REPORT FOR RESIDENTS ON CALL**

In order to maintain complete continuity and an unbroken line of communication, a morning review of patients who were cared for during the night by the on call resident must be reported to the resident taking care of that patient by 7 AM that morning. Since there are multiple residents to contact, it is expected that the entire process of notification may take until 7:30 AM. Each resident must have an accessible list of the other CORE residents in the program.

**CLINICS**

SCIM residents must report to the clinics on time. They may not leave the clinic area without informing the attending physician. If the SCIM resident is unable to come to the clinic on time for any reason, the program director must be informed immediately so that other provisions can be made.

**CLINIC ATTENDINGS**

1. Spinal Cord Injury
   - Kresimir Banovac, M.D.
   - Diana Cardenas, M.D.
   - Alberto Martinez-Anizala, M.D.
   - Gregory Samson, M.D.
   - Kevin Dalal, M.D.

2. Multiple Sclerosis
   - Seema Khurana, D.O.

**DEPARTMENTAL CONFERENCES**

**TEAM EVALUATION CONFERENCE**

Team evaluation conferences discuss patients on the inpatient rehabilitation service. At JMH they are held every Monday with Dr. Banovac and Dr. Dalal at 11a.m. SCIM residents are expected to
know their patient’s comprehensive medical rehabilitation status. Team conference discussions are recorded by the SCIM resident on the team evaluation sheet in the patient’s chart. This is a JCAHO and Florida State requirement. Rehabilitation therapy orders are to be updated every 2 weeks on all patients, based on the goals established in the team meeting.

Team meetings at the VAHS are also held once per week on the CARF inpatients with Dr. Samson every Tuesday at 11am. Walking interdisciplinary team rounds including all attending and staff are held on all inpatients every Wednesday at 8 am.

Formal bedside rounds with private attending physicians will occur regularly. At the VAHS and JMH, SCIM resident will be supervising the CORE SCI resident under the supervision of Dr. Banovac and Dr. Dalal at JMH and attending physicians including Dr. Martinez-Anizala and Dr. Samson at VAHS. The SCIM resident will consult with each attending to determine the time rounds will be made. At both JMH and VAHS SCIM residents are required to hold teaching rounds and seminars with the CORE SCI resident.

The SCIM residents will also hold teaching rounds following rounds with the attending. During this time the SCIM resident will advise and instruct the CORE SCI residents on the care of the patients.

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.

PROGRAM DIRECTOR ROUNDS

Integrated into the program will be case conferences on topics that were discussed in didactics the week before. The resident will find a relevant case to present to the assigned attending physician in conference. An evidence based discussion on diagnosis and management will be expected from residents and attending physicians. An evaluation sheet will be filled out by the attending and resident to ensure the quality of the program.

GRAND ROUNDS

The departmental grand rounds are held once per month, on the fourth Monday from 4 pm – 5 pm at Lois Pope LIFE Center 7th floor, Apex Center. 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**

Associated with the lecture topic presented the week prior, journal club offers the resident the ability to follow up didactic material with evidence based management of the problem (Practice Based Learning). At 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 – power point format preferred (20 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.

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
- Archive of Neurology
- American Journal of Neurology
- JAMA
- NEJM
- SPINE
- Spinal Cord

Others can be added if necessary

The attending assigned will be given a copy of the article prior to the Journal Club to prepare. At times there will be an evening Journal Club. Fellows will participate with the core residents.

**DIDACTIC LECTURE SERIES** (See schedule)

Each Friday morning from 8:10 a.m. to 10:00 a.m. has been set aside for the didactic teaching program. The lecture cycle will occur over the course of the 12 months. Some weeks will consist of didactics only and other weeks will consist of journal club, clinical case conference associated
with the topic presented the week before. Most lectures will be delivered by staff attendings and research staff. Residents will be expected to present cases and journal articles frequently and present two didactic lectures per year.

In addition to the PM&R core didactic program, all PM&R 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 PM&R residents are encouraged to attend to gain research experience.

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

INTERDEPARTMENTAL CONFERENCES

1. MIAMI PROJECT LECTURE SERIES
2. COMBINED NEUROSUGERY ORTHOPEDICS/PMR NEURORADIOLOGY SPINE CLINICAL CASE CONFERENCE
3. NEUROLOGY GRAND ROUNDS
4. ORTHOPEDIC GRAND ROUNDS
5. NEUROSURGERY GRAND ROUNDS
6. MIAMI PROJECT GRAND ROUNDS AND VISITING LECTURER SERIES

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. 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 residency coordinator.

HOSPITAL LIBRARY

The Medical Library at Jackson Memorial Medical Center-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 University of Miami –Miller School of Medicine, where medical search and database facilities are available to the resident, as well as connection to selected Internet sites.

**RESEARCH**

Research will be a key component of the SCIM fellowship. Your ability to show ability to not only perform research, but to understand how research gets completed, how funds are acquired, and to actually write and publish a poster and paper is critical to become a complete SCI physician. The way the research will accomplished is as follows:

1. One half day per week will be time protected for research. At the VAHS and JMH this will be on Monday afternoons. You will first however, come in the morning to round on your patients and complete all paperwork associated with the patient care. Additionally, lectures at the Miami Project will also be attended. However, you will not be expected to cover for patient emergencies other than basic calls for questions regarding orders on your patients. It is critical that the patients are well cared for in the morning rounds to avoid excessive calls in the afternoon that will interfere with your research time.

2. You will be exposed to lectures throughout the year that will teach you to understand research methodology, create an informed consent, navigate through the IRB process, and obtain grant funding.

3. You are required to complete two tasks. The first is to complete one form of the following activities:
   
   a. Submit an abstract to a national SCI meeting (ASIA) for poster or platform presentation. That poster will also be displayed at the “PM&R Research Day”
   
   b. Write a case report for the AAPMR website that is accepted for publication.
   
   c. Write a book chapter that is accepted for publication.
   
   d. Submit a completed manuscript to a peer reviewed journal. This manuscript must be converted to a poster for the departmental “PMR research day”

   The second task is to complete or participate significantly in an original research project. The findings of the research will be presented at the end of year department “PMR research day”; this may be an ongoing project that you join for the year or a new project. Most new projects will consist of data processing of already collected data. This is acceptable but you must demonstrate that you have an in depth knowledge of where the data came from, how it was collected and why it was collected. This knowledge will be exhibited in the presentation you give during research day.

4. You will choose a mentor who will monitor your progress. Importantly, they will view your end of year presentation to give feedback that it meets the requirements to show
knowledge acquired, present data and results, and to form conclusions related to the results.

5. Failure to meet the research requirement will result in you not being granted full credit for the year and graduating the program. If the presentation does not meet basic minimum standards, the research requirement can still be met by submitting a completed manuscript to the Archives of PMR or the Journal of Spinal Cord Injury or the American Journal of Physical Medicine and Rehabilitation and receiving a written review that shows a sincere effort has been put forth.

6. If the research component is not completed but the clinical component is completed satisfactorily, the completion certificate will be held until the research component is fulfilled.

RESIDENT SCHEDULING

Coretha Davis, Residency Coordinator, will monitor the call schedule and resident duty hours. New Innovations, an online electronic residency management system is used to monitor duty hours. Into this system, residents will input their work hours and days off to make certain the SCIM 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 VAHS 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 per year. 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-months of
residency training 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 overused, that resident may be asked to make up the on-call days. The resident must call the program director/residency coordinator AND the supervising attending of that rotation by 8am 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 20 paid vacation days. The residents’ 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. Requests for more than one week vacation must be granted by the supervising attending physician – then from the fellowship program director. If a signed document from the supervising attending physician is obtained then the vacation may be granted. Due to critical manpower needs, vacation time must still be approved in advance by the program director. Vacation requests for the entire year are to be submitted to the fellowship program coordinator by July 30th. Changes in vacation are strongly discouraged and must be approved, in writing, by the supervising attending of the rotation and then the program director, subject to the needs of the residency program. Failure to abide by this policy may result in forfeiture of unused vacation time.

**TRAVEL POLICY**

The Department of Rehabilitation Medicine will pay for a resident to attend the AAPM&R meeting during the PGY4 year if his/her paper/poster is accepted for presentation. The department will reimburse allowable travel expense with receipts for up to $960.00 and any costs in excess of the travel allowance will be the personal responsibility of the resident. If the paper/poster was not accepted due to content and was submitted in good faith the department will reimburse the allowable travel expense for up to $560.00 and any costs in excess of the travel allowance will be the personal responsibility of the resident. There will be no travel allowance if the abstract is rejected due to improper submission format or missed deadline. No reimbursement is allowed for spouse or family member as per University of Miami policy.

The resident/fellow is not allowed to split his/her travel allowance between two conferences. Resident/Fellow should submit the appropriate forms (scientific/educational leave request and a copy of conference brochure) at least six to eight weeks prior to the trip for approval by their rotation attending, residency coordinator and department administrator before making any travel arrangements for educational purposes. The department will not be responsible for business expenses that have not been approved by the rotation attending and department administration.
Travel request for educational leave not paid by the department also require six to eight weeks approval by rotation attending and submitted to residency coordinator. This process will assist in accessing clinical coverage during resident absence.

**Pre-conference course:** The traveler is responsible for all costs associated with a pre-conference course which includes airfare, registration fee, lodging, meals and incidental expenses. The department will only cover the airfare if the pre-course is associated with the approved meeting and proof of attendance to the pre-course is required.

**Electronic Ticket/Ticketless Airline Travel:** air travel that is reserved with an airline for which no paper ticket is issued. The reservation and seat assignment is secured within the airline's computer reservation system only. The traveler must request a receipt from the airline of the booking or check-in at the airport. Only coach airfare is allowable.

**Domestic travel:** federal regulations define domestic travel as within the United States, its possessions and territories. US possessions and territories include Guam, American Samoa, Puerto Rico, and the Virgin Islands.

**Documentation Requirements**
Under the IRS Accountable Plan Rules expenses are required to meet these conditions:

- There must be a legitimate business purpose—explanation of the business conducted
- Expenses must be substantiated: original receipt with date, place and amount of the expense
- Receipt must indicate payment; proof of payment must be apparent (cancelled check).
- A conference brochure must be provided for conference/seminar attendance.
- Airfare receipt/itinerary and boarding passes are required for airfare reimbursement.

**Reimbursable Travel Expenses:**

- Commercial transportation expense, including airline, bus and rail.
- Meals — per diem meal allowance. Domestic travel per diem of $50 a day ($25 for departure after 3pm and $25 for returns before 3pm).
- Lodging — actual cost only and a zero balance receipt is required.
- Incidental expenses — include tolls, parking and taxi. Receipts are required

**Non-reimbursable Travel Expenses:**

- Conference & convention meals, if already included in registration fees.
- Personal entertainment such as hotel room movies, theater tickets, newspaper, magazines, prescriptions, over the counter drugs, health club facilities, barber/beautician services, etc.
- Personal care items.
- Clothing and clothing rental.
- Hotel “no show” charges, airline, hotel cancellation fees.
- Credit card delinquency assessments due to the action of the traveler.
- Life or travel accident insurance premiums.
- Parking tickets and traffic violations.
- Personal portion of airfare, and hotel.
- Late fee registration charge.
- First class or business class airfare upgrade vouchers.
• Airline tickets obtained using frequent flyer miles or travel vouchers.
• Expenses submitted more than 12 months after expenses were incurred.
• Other expenses not directly related to the travel assignment.

An original receipt is lost: for an incidentally lost receipt, the traveler should write statement to this effect. Submit this along with any additional support such as a fax copy (hotel bill), or credit card statement.

Upon return, the traveler must submit all original receipts including airfare receipt/itinerary, zero balance receipt for lodging, etc. to the departmental secretary for reimbursement within 10 days.

**Professional Reimbursement Allowance**

Jackson Memorial Hospital provides each housestaff officer $1,250 per residency academic year an allowance to be used as reimbursement for professional/educational expenses. The allowance should be used for professional/educational expenses including but not limited to educational courses, conferences, workshops, books, tapes, supplies, study-guides, board review courses, licensure expenses, palm pilots and out of country travel and expenses related to such aforementioned activities. Attendance at outside conferences must be approved in advance by the program director.

**HURRICANE COVERAGE**

Unfortunately, the one downside to summer/fall in Miami is the hurricane season (not the football team). Our department has tried to allocate coverage in a fair manner. If you are on call, then you must be in the hospital as the hurricane arrives and plan to stay as long as roads are not passable. The on-call resident will similarly remain in-house during the storm. You must make arrangements for your family during this time or ask a co-worker for assistance if family is an issue. You will stay in the residents lounge or can sleep in Dr. Sherman’s office if necessary. As soon as roads are passable, even if the university is closed, we expect everyone who is available to come in and help out. If the damage is extensive, we can set up a rotation system so each faculty member can also take care of things at home.

**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.

**ABSENTEEISM**

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

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.

SEXUAL HARASSMENT

It is the policy of The Rehabilitation Department at the Miller School of Medicine at the University of Miami and the PMR residency at Jackson Memorial hospital that no male or female member of the University and Hospital community - students, faculty, administrators, or staff - may sexually harass any other member of the community. Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute harassment when:

- submission to such conduct is made or threatened to be made, either explicitly or implicitly, a term or condition of an individual’s employment or education, or
- submission to or rejection of such conduct is used or threatened to be used as the basis for academic or employment decisions affecting that individual, or
- such conduct has the purpose or effect of substantially interfering with an individual’s academic or professional performance or creating what a reasonable person would sense as an intimidating, hostile, or offensive employment, educational, or living environment.
Examples of sexual harassment include...

- Pressure for a dating, romantic, or intimate relationship
- Unwelcome touching, patting, or hugging
- Pressure for or forced sexual activity
- Unnecessary and unwelcome references to various parts of the body
- Belittling remarks about a person's gender or sexual orientation
- Inappropriate sexual innuendoes or humor
- Obscene gestures
- Offensive sexual graffiti, pictures, or posters
- E-mail and Internet use that violates this policy

GUIDANCE ON DISCRIMINATION AND HARASSMENT ISSUES

Investigation and Confidentiality
All reports describing conduct that is inconsistent with these policies will be promptly and thoroughly investigated. Complaints about violations of these policies will be handled confidentially, with facts made available only to those who need to know in order to investigate and resolve the matter.

Retaliation
The Department of Rehabilitation prohibits retaliation against anyone for registering a complaint pursuant to these policies, assisting another in making a complaint, or participating in an investigation under the policies. Anyone experiencing any conduct that he or she believes to be retaliatory should immediately report it to one of the individuals listed under “Where to Get Advice and Help.”

Resolution
If a complaint of discrimination, harassment or sexual harassment is found to be substantiated, appropriate corrective action will follow, up to and including separation of the offending party from the Department, consistent with Department procedure.

Academic Freedom
The Department of Rehabilitation is committed to the principles of free inquiry and free expression -- to providing an environment that encourages the exploration and exchange of ideas. The University’s discrimination and harassment policies are not intended to stifle this freedom, nor will they be permitted to do so. Prohibited discrimination and harassment, however, are neither legally protected expression nor the proper exercise of academic freedom, and such conduct is incompatible with the values of Department.

You Have Responsibilities Under This Policy

All members of the Department and Hospital community are responsible for creating a working, learning and living environment that is free of discrimination and harassment, including sexual harassment. It is important to contact one of the individuals listed under “Where to Get Advice and Help,” if any of the following occurs:
• You believe you have been subjected to conduct or comments that may violate this policy
• You believe you have been retaliated against in violation of this policy
• You hold a supervisory, management or teaching position, and have been told about or witnessed conduct that you think may violate this policy.

Vendors, Contractors and Third Parties

The Department's policies on discrimination and harassment, including sexual harassment, apply to the conduct of vendors, contractors and third parties. If a member of the University or Hospital community believes that he or she has been subjected to conduct that violates this policy by a vendor, contractor or third party, he or she should contact one of the individuals listed under “Where to Get Advice and Help.” The Department will respond as appropriate, given the nature of its relationship to the vendor, contractor or third party.

If you are discriminated against or harassed . . .

• Don’t blame yourself.
• Say no.
• Remember that harassment and discrimination, including sexual harassment, are against University policy and may be against the law.
• Know your rights under policy of the Jackson Memorial Hospital and University of Miami.
• Keep a written, dated record of events.
• Tell someone.
• Get help.
• Don’t delay.

If the incident is of sufficient magnitude then please report the incident to the program director, or the chairman of the department, the head of the residency GME committee, the DIO, or to the confidential resident psychology or physician hotline.

Are you the harasser?
Accused harassers are often surprised to learn how others view their behavior.

• Review your attitudes and actions toward others. Do you base your behavior on stereotypes? Is your behavior bias free?
• Consider the impact you have on others’ attitudes toward their work, education, and self-esteem.
• Examine how others respond to what you say and do.
• Do not assume that colleagues, peers, employees or students enjoy racial or ethic jokes, sexually oriented comments, remarks about their appearance or religion, or being touched or stared at.
• Do not assume that others will tell you they are offended – or harassed – by what you say and do.

If you think you may have offended or harassed someone . . .

• Apologize as soon as possible.
• Change your behavior.
• Read the policies on discrimination, harassment and sexual harassment
• Get advice from the confidential Resident behavioral medicine department.

**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. All residents should become members of the American Paraplegia Society. This typically includes a paid for trip to the national meeting in September. 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 Hospital-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.
4) Mini CEX

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

1- Diana D. Cardenas, MD, MHA Program Director
2- Andrew Sherman, MD Residency Program Director
3- Andres Restrepo, MD Associate Residency Program Director
The disciplinary committee will meet only if called upon by one of three issues:

1. Resident non-performance
3. Resident promotion

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 (If approved by the hospital).

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.

Residents may be placed on probation with a majority vote of the promotions committee above. Probation will be removed when the resident demonstrates they have remediated the issues that led to probation. Residents placed on probation for a third time in the residency may be subject to termination. Repeated actions that demonstrate the inability to remediate the cited problems would typically be grounds for termination.
Residents can also be placed upon probation for non-compliance with any of the professional rules stated above. Ultimately it is expected that the level of punishment will fit the severity of the infraction with minor infractions given appropriate verbal warnings and major infractions acted upon with probation and/or termination. At times, a resident may be given the option to discuss the cited infractions with the promotions committee before punishment is voted upon to state any objection or explanation of the cited infractions.

Residents may appeal any action as is their right as listed in the collective bargaining agreement. All rules are listed separately in that CIR document and will be respected fully by this department.

**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:

The 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 house staff 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 Act.

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 approval from the Graduate Medical Education Office. 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 Graduate Medical Education Office. Such approval will not be unreasonably denied.

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

MIAMI VA HEALTHCARE SYSTEM

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, quadripareisis 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.

ELECTROCARDIAGRAM: 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. Quadriplegic secondary to cervical spine arthritis.
4. Remote bilateral total hip replacements.
5. Old history of pancreatitis.

**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 Cardenas MD, MHA
Program Director

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

ORTHOPEDICS
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
Journal of Spinal Cord Injury Rehabilitation
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
**DEPARTMENTAL TELEPHONE NUMBERS**

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE</th>
<th>PAGER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHAIRPERSON</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diana D. Cardenas, M.D., M.H.A</td>
<td>305-243-9516</td>
<td>305-276-5882</td>
</tr>
<tr>
<td><strong>FACULTY ATTENDINGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kresimir Banovac, M.D.</td>
<td>305-585-1322</td>
<td>305-276-7981</td>
</tr>
<tr>
<td>Elizabeth Felix, Ph.D.</td>
<td>305-243-4497</td>
<td></td>
</tr>
<tr>
<td>Robert Irwin, M.D.</td>
<td>305-585-1323</td>
<td>305-291-0883</td>
</tr>
<tr>
<td>Seema Khurana, D.O.</td>
<td>305-243-4518</td>
<td>305-750-1982</td>
</tr>
<tr>
<td>David Kushner, M.D.</td>
<td>305-259-6418</td>
<td>305-874-8135</td>
</tr>
<tr>
<td>Alberto Martinez-Arizala, M.D.</td>
<td>305-575-3174</td>
<td></td>
</tr>
<tr>
<td>Jasmine Martinez-Barrizonte, D.O.</td>
<td>305-585-1335</td>
<td></td>
</tr>
<tr>
<td>Jose Andres Restrepo, M.D.</td>
<td>305-585-1413</td>
<td>305-750-1745</td>
</tr>
<tr>
<td>Andrew Sherman, M.D.</td>
<td>305-243-3289</td>
<td>305-287-8701</td>
</tr>
<tr>
<td>Lucinda Adriana Arenas, M.D.</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td><strong>VOLUNTARY ATTENDINGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ronald Tolchin, D.O.</td>
<td>305-575-3217</td>
<td>305-212-4402</td>
</tr>
<tr>
<td>David Lipkin, M.D.</td>
<td>305-604-3261</td>
<td></td>
</tr>
<tr>
<td>Kester Nedd, D.O.</td>
<td>305-585-1258</td>
<td></td>
</tr>
<tr>
<td>Salome Perez, Ph.D.</td>
<td>305-324-4455 ext 3717</td>
<td></td>
</tr>
<tr>
<td>Bruce Rubin, M.D.</td>
<td>305-585-1263</td>
<td></td>
</tr>
<tr>
<td>Miguel Tabaro, M.D.</td>
<td>305-324-4455 ext 4453</td>
<td></td>
</tr>
<tr>
<td>Jose Toledo, M.D.</td>
<td>305-604-3261</td>
<td></td>
</tr>
<tr>
<td>Kenneth Ward, M.D.</td>
<td>305-324-4455 ext 6258</td>
<td></td>
</tr>
<tr>
<td>Katherine Westie, Ph.D.</td>
<td>305-585-5308</td>
<td></td>
</tr>
<tr>
<td><strong>RESIDENTS</strong></td>
<td>305-585-2255</td>
<td></td>
</tr>
<tr>
<td><strong>PGY 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lauren Abratt, D.O.</td>
<td>1648</td>
<td></td>
</tr>
<tr>
<td>Shaun Corbett, M.D.</td>
<td>1937</td>
<td></td>
</tr>
<tr>
<td>David DeChellis, D.O.</td>
<td>0356</td>
<td></td>
</tr>
<tr>
<td>Joseph Hadi, M.D.</td>
<td>2310</td>
<td></td>
</tr>
<tr>
<td>Jose Santos, M.D.</td>
<td>0957</td>
<td></td>
</tr>
<tr>
<td>Sebastian Tobon, M.D.</td>
<td>0703</td>
<td></td>
</tr>
<tr>
<td><strong>PGY 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Allen, D.O.</td>
<td>2858</td>
<td></td>
</tr>
<tr>
<td>Junney Baeza-Dager, M.D.</td>
<td>2420</td>
<td></td>
</tr>
<tr>
<td>Poonam Manasa, M.D.</td>
<td>1443</td>
<td></td>
</tr>
<tr>
<td>Hector Miranda, M.D.</td>
<td>2045</td>
<td></td>
</tr>
<tr>
<td>German Ojeda, M.D.</td>
<td>2424</td>
<td></td>
</tr>
<tr>
<td>Michelle Weiner</td>
<td>2544</td>
<td></td>
</tr>
<tr>
<td><strong>PGY 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandee Bristow, M.D.</td>
<td>2585</td>
<td></td>
</tr>
<tr>
<td>Halland Chen, M.D.</td>
<td>2221</td>
<td></td>
</tr>
<tr>
<td>Anne Douglas, D.O.</td>
<td>9312</td>
<td></td>
</tr>
<tr>
<td>Gabriel Marrero, M.D.</td>
<td>2644</td>
<td></td>
</tr>
<tr>
<td>James Salerno, M.D.</td>
<td>0278</td>
<td></td>
</tr>
<tr>
<td>Ajmal Sultan, M.D.</td>
<td>2579</td>
<td></td>
</tr>
</tbody>
</table>
Fellows:

Samantha Mendelson, D.O.  0592
Sergio Lenchig, M.D.    1984

**EMERGENCY NUMBERS**

FIRE & ALL EMERGENCIES ________________________________ 305-585-6123
EMERGENCY, SECURITY _________________________________ 305-585-6111

**DEPARTMENT ADMINISTRATION**

EDUCATION COORDINATOR  Coretha Davis   305-585-1431
ADMINISTRATOR__________ Nadine Knight ____________ 305-243-4593
ADMINISTRATIVE ASST. __________ Jesus Sanchez-Reyes ____________ 305-243-9516
SECRETARY ______________ Greeyt Hernandez ____________ 305-585-1327

**REHABILITATION MEDICINE THERAPY DEPARTMENTS**

**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, Ultrasound, E-stim
✓ Splint Fabrication – upper and lower limb orthosis
✓ Hubbard Tank
✓ Whirlpool
✓ Crutch walking
✓ Bladder Sono
✓ Cystometrics

NEUROSURGERY PROCEDURES

✓ Laminectomy/Discectomy
✓ Brachial Plexus Surgery
✓ Intraop. SSEP
✓ Kyphoplasty

EMG

✓ SSEP
✓ Botox injections
✓ Baclofen pump renewal

PEDIATRIC SURGERY

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

PAIN MANAGEMENT

✓ Discogram
✓ Lumbar Epidural Steroid Injection
✓ Cervical ESI
✓ Spinal Cord Stimulator Placement

✓

RESIDENT BASIC READING LIST

Spinal Cord Injury
Stephen Kirshbloom, MD

Spine
Frank Eismont Ed.

Physical Medicine and Rehabilitation
Braddom ed.

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

International Standards for Neurological Classification of Spinal Cord Injury
ASIA Reprinted 2002

Orthopaedic knowledge Update – Sports Medicine
James G. Garrick, M.D.

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 Choice is Yours -Medical Professionalism:
Using Film to Promote Self-Reflection (with DVD)
Ruth Yorkin Drazen

MRI of the Brain, Head and Neck, and Spine

Musculoskeletal MRI