

# ACGME Program Requirements for Graduate Medical Education in Spinal Cord Injury Medicine

*Common Program Requirements are in BOLD*

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## Introduction

### Int.A. Definition

- Int.A.1. Spinal Cord Injury Medicine (SCIM) addresses the prevention, diagnosis, treatment and management of traumatic spinal cord injury (SCI) and nontraumatic myelopathies, including the prevention, diagnosis and treatment of related medical, physical, psychosocial and vocational disabilities and complications during the lifetime of the patient.
- Int.A.2. The management of persons with spinal cord dysfunction (SCD) requires a team and interspecialty approach with contributions from several medical and surgical specialties, as well as other health care professionals. The SCIM specialist should serve as the team leader after the patient is medically and surgically stabilized. When the spinal dysfunction is due to an active process or a chronic degenerative disorder, the management of the patient's primary disease is the responsibility of a physician in the appropriate discipline.
- Int.A.3. An approved subspecialty program must be designed to provide an educational experience to ensure that its graduates possess the advanced knowledge and competencies necessary to practice this subspecialty.

### Int.B. Duration and Scope of Education

- Int.B.1. The duration of SCIM education is 12 months, beginning after satisfactory completion of an ACGME-approved residency program in a specialty relevant to spinal cord injury medicine, such as anesthesiology, emergency medicine, family medicine, internal medicine, neurological surgery, neurology, orthopaedic surgery, pediatrics, physical medicine and rehabilitation, plastic surgery, surgery, or urology.
- Int.B.2. The program must provide for individuals to acquire, within the interdisciplinary spinal cord injury team, knowledge of emergency care and knowledge and skills in the following areas:
- Int.B.2.a) post-initial care
  - Int.B.2.b) initial and ongoing medical rehabilitation
  - Int.B.2.c) discharge planning
  - Int.B.2.d) lifelong care
  - Int.B.2.e) scholarly activity in support of these skills

Int.B.3. Any program that extends education beyond the 12-month minimum requirement must present a clear educational rationale consonant with the program requirements and objectives for fellowship education. The program director must obtain approval of the Review Committee prior to implementation and at each subsequent review of the program. Prior to entry in the program, each fellow must be notified in writing of the required length of the program.

## **I. Institutions**

### **I.A. Sponsoring Institution**

**One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.**

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

- I.A.1. The institution sponsoring the SCIM program must be (or be affiliated with) a center for care of persons with spinal cord dysfunction. Affiliation with an accredited medical school is desirable. The institution should be accredited by the Joint Commission on Accreditation of Health Care Organizations-Rehabilitation Section (JCAHO-Rehab) or the Commission on Accreditation of Rehabilitation Facilities (CARF).
- I.A.2. Accreditation of a subspecialty program in SCIM will be granted only when the program is administratively attached to an ACGME-accredited residency program in a relevant specialty.
- I.A.3. There must be close cooperation between the core residency program and the fellowship program. The lines of responsibility between residents and fellows must be clearly delineated.
- I.A.4. The sponsoring institution should exercise the necessary administrative management of the program.
- I.A.5. There should be an institutional policy, reviewed at the time of regular institutional or internal review, governing the educational resources committed to the SCIM program assuring cooperation of all involved disciplines.
- I.A.6. The institution must provide for financial resources including, but not limited to, salaries, fringe benefits and opportunities for continuing medical education for fellows.

## **I.B. Participating Sites**

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

**The PLA should:**

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

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

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

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

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

**I.B.3. It is highly desirable for participating sites to be in the same geographic location, and be conveniently and safely accessible to fellows.**

**I.B.4. Participating sites providing more than three months of education must be approved by the Review Committee.**

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

## **II. Program Personnel and Resources**

### **II.A. Program Director**

**II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**

**II.A.2. Qualifications of the program director must include:**

**II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review**

**Committee;**

- II.A.2.b) current certification in the specialty by the American Board of Physical Medicine and Rehabilitation in Spinal Cord Injury Medicine, or specialty qualifications that are acceptable to the Review Committee; and,**
- II.A.2.c) current medical licensure and appropriate medical staff appointment.**
- II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:**
  - II.A.3.a) prepare and submit all information required and requested by the ACGME;**
  - II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
  - II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
    - II.A.3.c).(1) all applications for ACGME accreditation of new programs;**
    - II.A.3.c).(2) changes in fellow complement;**
    - II.A.3.c).(3) major changes in program structure or length of training;**
    - II.A.3.c).(4) progress reports requested by the Review Committee;**
    - II.A.3.c).(5) responses to all proposed adverse actions;**
    - II.A.3.c).(6) requests for increases or any change to fellow duty hours;**
    - II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;**
    - II.A.3.c).(8) requests for appeal of an adverse action;**
    - II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.**
  - II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**

- II.A.3.d).(1) **program citations, and/or**
- II.A.3.d).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.3.e) ensure adequate data collection and analysis for all program evaluation and total quality management. The program director should gather, analyze and maintain data regarding fellow and faculty performance.
- II.A.3.f) have sufficient time to provide continuous leadership;
- II.A.3.g) actively participate in research and scholarly activities in SCIM;
- II.A.3.h) select fellows for appointment to and assignment in the program in accordance with institutional and departmental policies and procedures;
- II.A.3.i) select and supervise the teaching staff and other program personnel at each participating site. The program director should assign faculty and perform annual evaluations of their performance;
- II.A.3.j) supervise fellows through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff. Fellows must be provided with prompt, reliable systems for communication and interaction with supervisory physicians;
- II.A.3.k) regularly evaluate fellows' knowledge, skills, and competence, including the development of professional attitudes consistent with being a physician;
- II.A.3.l) along with the teaching staff:
  - II.A.3.l).(1) At least semi-annually evaluate the knowledge, skills, competence and professional growth of the fellow, using appropriate criteria and procedures.
  - II.A.3.l).(2) Communicate each evaluation to the fellow in a timely manner.
  - II.A.3.l).(3) Advance fellows to positions of higher responsibility based solely on evidence of their satisfactory progressive scholarship and professional growth.
  - II.A.3.l).(4) Maintain a permanent record of evaluation for each fellow and have it accessible to the fellow and other authorized personnel.

- II.A.3.m) monitor fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to fellows. Situations which consistently produce undesirable stress on fellows must be evaluated and modified.
- II.A.3.n) gather and analyze initial, discharge, and follow-up data regarding the functional outcomes of persons served;
- II.A.3.o) along with the teaching staff, prepare and comply with written educational goals for the program;
- II.A.3.p) ensure that required conferences include case oriented multidisciplinary conferences, journal club, and quality management seminars relevant to clinical care on the spinal cord program;
- II.A.3.q) ensure that conferences are of sufficient quality and frequency to provide in-depth coverage of the major topics in spinal cord injury medicine over one year;
- II.A.3.r) document staff and fellow conference attendance;
- II.A.3.s) ensure that educational activities are supervised directly by faculty members.

## **II.B. Faculty**

- II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.**
- II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.**
- II.B.3. The physician faculty must have current certification in the specialty by the American Board of Physical Medicine and Rehabilitation in Spinal Cord Injury Medicine, or possess qualifications acceptable to the Review Committee.**
- II.B.3.a) The physician faculty must demonstrate sound clinical and teaching abilities in the field of SCIM, a commitment to their own continuing medical education, and participation in scholarly activities.
- II.B.4. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**

## **II.C. Other Program Personnel**

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

- II.C.1. In addition to the program director, there must be at least one other faculty member with expertise in SCIM who is dedicated to the program.
- II.C.2. The teaching staff should periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of fellows.
- II.C.3. Specialists in anesthesiology, emergency medicine, internal medicine (including the relevant subspecialties), neurology, neurosurgery, orthopedic surgery, pediatrics, physical medicine and rehabilitation, plastic surgery, psychiatry, radiology, surgery, and urology should take an active role in the didactic curriculum, providing instruction in the areas of their practices relevant to spinal cord dysfunction.

## **II.D. Resources**

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

- II.D.1. Institutional Facilities
  - SCIM education should include experience in both inpatient and outpatient facilities. The sponsoring institution and participating sites must operate or have access to a service delivery system dedicated to the care of persons with spinal cord dysfunction. Necessary resources include:
  - II.D.1.a) an emergency department that treats patients with spinal cord injury
  - II.D.1.b) an accredited acute care hospital
  - II.D.1.c) a dedicated inpatient rehabilitation unit
  - II.D.1.d) a designated outpatient clinic for persons with spinal cord dysfunction
  - II.D.1.e) availability of home care and independent living programs

II.D.2. Specific Facilities and Resources

II.D.2.a) The sponsoring institution must have available the equipment, diagnostic imaging devices, electrodiagnostic devices, laboratory services, a urodynamic laboratory, and clinical facilities necessary to provide appropriate care to persons with spinal cord dysfunction.

II.D.2.b) The sponsoring institutions must have available specialty consultant services in anesthesiology, emergency medicine, family medicine, internal medicine (including the relevant subspecialties), neurological surgery, neurology, orthopedic surgery, pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, psychiatry, radiology, surgery, and urology. Other health care professionals are essential to the care of persons with spinal cord dysfunction.

II.D.3. Patient Population

The patient population must be of sufficient size and diversity of age so as to provide the fellow with the opportunity to care for an adequate number of persons with new spinal cord dysfunction, to care for persons re-admitted to the hospital with intercurrent illness, and to care for appropriate numbers of outpatients. There should be a minimum census of eight patients per fellow.

II.D.4. Other Learners

Rotation to the SCIM program by fellows from other specialties, fellows, or medical students is desirable.

**II.E. Medical Information Access**

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

**III. Fellow Appointments**

**III.A. Eligibility Criteria**

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

III.A.1. The program must establish written policies and procedures regarding selection and appointment of fellows. The fellow complement should be appropriate to the available clinical and educational resources, including faculty. It is highly desirable to have at least one fellow in the program at all times.

### **III.B. Number of Fellows**

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

- III.B.1. The program shall have and implement written policies and procedures, based on the educational resources available, for determining the number of fellow positions.

### **IV. Educational Program**

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

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

**IV.A.2. ACGME Competencies**

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

**IV.A.2.a) Patient Care**

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

IV.A.2.a).(1) must have a sufficient variety, depth and volume of clinical experiences. The educational program should take into consideration the fellow's documented past educational and patient care experiences. The program must provide for the fellow to spend a significant amount of time responsible for the direct care of hospitalized and non-hospitalized patients. Fellows must devote at least 1/3 of their clinical experience to the care of hospitalized patients and at least 1/3 to non-hospitalized patients;

IV.A.2.a).(2) must learn the techniques of appropriate spinal immobilization in order to protect patients from additional neurological damage;

IV.A.2.a).(3) must be able to perform a comprehensive neurologic assessment and determine the appropriate injury level of the patient;

- IV.A.2.a).(4) must assist in the management of the abnormalities and complications in other body systems resulting from spinal cord injury, especially the following: pulmonary, genitourinary, endocrine, metabolic, vascular, cardiac, gastrointestinal, musculoskeletal and integumentary;
- IV.A.2.a).(5) must be able to evaluate the stability of the spine and know the various options for treatment of fractures/ dislocations at all vertebral levels;
- IV.A.2.a).(6) must be able to address special needs and problems of children and adolescents with spinal cord injury in areas such as behavior, bladder and bowel and skin care, growth and development, immunizations, mobility, nutrition, pediatrics, self-care, recreation and schooling. Fellows must also be able to understand the special needs of parents and others in relating to and assisting young patients with these problems;
- IV.A.2.a).(7) must coordinate the transition from post-initial care to rehabilitation and assume primary management responsibility;
- IV.A.2.a).(8) must establish short and long term rehabilitation goals and coordinate the implementation of the rehabilitation program to meet such goals;
- IV.A.2.a).(9) must monitor the evolution of neural dysfunction in order to recognize conditions that may require additional evaluation, consultation, or modification of treatment;
- IV.A.2.a).(10) must participate, after post-initial care and in conjunction with the interspecialty spinal cord injury team, in the management of spinal cord injury following either operative or nonoperative stabilization, including activity restrictions and appropriate orthotic support;
- IV.A.2.a).(11) must recognize, diagnose and coordinate treatment for respiratory complications such as tracheostomies, airway obstruction, atelectasis, pneumonia, tracheal stenosis, mechanical methods of respiration including both fixed and portable equipment. The fellow should be able to manage patients with high quadriplegia; and, with respirator-dependent patients, in weaning them from the respirator, and evaluating indications and contraindications of phrenic nerve pacing, motorized wheelchairs, portable respirators, environmental control systems, home modifications, etc;
- IV.A.2.a).(12) must recognize, diagnose and treat orthostatic hypotension and other cardiovascular abnormalities during initial mobilization of the patient;

- IV.A.2.a).(13) must evaluate and manage skin problems utilizing various techniques of prevention such as the proper use of specialized beds, other surfaces, cushions, wheelchairs, etc., to manage pressure ulcers effectively; and, in consultation with surgical colleagues, determine the indications for various surgical procedures including resection of bone and the development of flaps and other techniques for soft tissue coverage. The fellow should also develop an understanding of the pre- and post-operative management of these patients;
- IV.A.2.a).(14) must, with appropriate consultation, identify the risk of infection and coordinate treatment and infection control including the judicious use of antimicrobials;
- IV.A.2.a).(15) must coordinate and implement management of the neurogenic bowel;
- IV.A.2.a).(16) must diagnose and treat, with appropriate consultation, complications such as deep vein thrombosis, pulmonary embolus, autonomic hyperreflexia, substance abuse, pain, spasticity, depression, and the sequelae of associated illnesses and pre-existing diseases;
- IV.A.2.a).(17) must recognize pharmacologic alterations associated with spinal cord injury, including changes in pharmacokinetics, pharmacodynamics, drug interactions, over-medication, and compliance;
- IV.A.2.a).(18) must diagnose and manage the psychological dysfunction associated with spinal cord injury;
- IV.A.2.a).(19) must perform a functional assessment based on neurological, musculoskeletal and cardiopulmonary examinations and psychosocial and prevocational evaluations;
- IV.A.2.a).(20) must determine functional goals for self-care, mobility, vocational and avocational activities based on the level and completeness of the lesion;
- IV.A.2.a).(21) must, when appropriate, prescribe motor retraining and conditioning activities, orthoses, and the adaptive equipment needed to meet the rehabilitation goals;
- IV.A.2.a).(22) must identify the indications for and the use of clinical neurophysiologic testing to assess the extent of neurapraxia, denervation, reinnervation, phrenic nerve function, and spinal cord function;

- IV.A.2.a).(23) must identify the indications and use of functional electrical stimulation (FES) as applied to the management of spinal cord impairment;
- IV.A.2.a).(24) must, within the interdisciplinary and interspecialty spinal cord injury teams, learn the concepts of muscle and tendon transfers, and of other operative procedures that enhance extremity function, and manage the post-operative retraining, when indicated;
- IV.A.2.a).(25) must determine when the rehabilitation goals have been achieved, finalize the discharge plan, and arrange for the appropriate level of care to match the patient's needs;
- IV.A.2.a).(26) must recognize, diagnose and treat intercurrent disease in conjunction with the proper consultants. There should be special emphasis on the prevention and management of these diseases in patients at various levels of spinal cord injury;
- IV.A.2.a).(27) must diagnose and coordinate the treatment of the complications associated with chronic spinal cord injury including pressure sores, spasticity, pain, urinary calculi, urinary tract infection, fractures, post-traumatic syringomyelia, and progressive respiratory decline;
- IV.A.2.a).(28) must set up a program of regular follow-up, evaluation and preventive health care to keep the person at his/her maximum health and rehabilitation status, and coordinate this care with the patient's personal community physician;
- IV.A.2.a).(29) must have the opportunity to follow individual patients longitudinally as well as the ability to encounter a wide variety of patient problems;
- IV.A.2.a).(30) should have clinical experiences that allow for progressive responsibility with lesser degrees of supervision as the fellow advances and demonstrates additional competencies. The program should be flexible but sufficiently structured to allow for such graded responsibility;
- IV.A.2.a).(31) must be given the opportunity to become proficient in:
- IV.A.2.a).(31).(a) coordination in the post-initial care setting of the impact and timing of treatment of each organ system's dysfunction so that an optimum treatment effect can be obtained;
- IV.A.2.a).(31).(b) planning the most efficient and effective treatment approaches to assist the patient in acquiring the

- skills and knowledge required for optimal function;
- IV.A.2.a).(31).(c) promotion of patient education about all aspects of SCD in order to promote patient independence and patient recognition of illness.
- IV.A.2.a).(32) must be able to implement as a trained SCIM specialist, over the course of the individual patient's lifetime, a health maintenance and disease prevention program with early recognition and effective treatment of complications related to SCD, and must promote awareness of the impact of aging on SCD.

**IV.A.2.b) Medical Knowledge**

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

- IV.A.2.b).(1) should have a didactic curriculum taught by faculty and a self-directed learning program to address the theoretical and clinical principles which form the fundamentals for care of patients with spinal cord dysfunction. Pathophysiology, discussion and knowledge of clinical manifestations and management principles about the care of such patients should constitute the major topics for study;
- IV.A.2.b).(2) must have opportunities to develop a unique set of attitudes, knowledge and psychomotor skills because SCD affects multiple organ systems of the body, and its treatment involves many specialty areas of expertise. The fellow must be given the opportunity to gain knowledge of:
- IV.A.2.b).(2).(a) the impact of SCD on the various organ systems,
- IV.A.2.b).(2).(b) the natural history, pharmacologic management and evolution of organ system functioning after SCD and the interaction among the various organ systems,
- IV.A.2.b).(2).(c) the impact of aging and longstanding injury on organ system decline,
- IV.A.2.b).(2).(d) the prevention and treatment of secondary complications of SCD,
- IV.A.2.b).(2).(e) the maximal functions possible based on the characteristics and level of SCD and how to achieve them.

- IV.A.2.b).(3) must learn the organization and interdisciplinary practices of the Emergency Medical Services system relating to the prehospital and initial Emergency Department care of the spinal cord injured as well as concomitant and associated injuries. This must not interfere with the independent decision making of the attending physician during the initial care;
- IV.A.2.b).(4) must learn the supportive role of SCIM to neurological surgery, orthopedic surgery, emergency medicine, and other appropriate physicians in initial care sites, including intensive and critical care units;
- IV.A.2.b).(5) must learn the relationship between the extent and level of spinal cord injury on the ultimate residual functional capacity and be able to inform and counsel the patient, the family, and other health specialists on a timely basis about the impact of the disability;
- IV.A.2.b).(6) must learn the management of the neurogenic bladder and sexual dysfunction and that the role of the urologist is pivotal in the diagnosis and management of bladder dysfunction, urinary tract infection, urinary calculi, sexual dysfunction, obstructive uropathy with or without stones, infertility and problems of ejaculation; and that such specialists should be utilized early in the care of these patients;
- IV.A.2.b).(7) must learn the kinesiology of upper extremity function and the use of muscle substitution patterns in retraining; the value, indications and contraindications of tendon and muscle transfers and other operative procedures that would enhance function;
- IV.A.2.b).(8) must learn the needs for personal care attendants, architectural modifications, and community follow-up care;
- IV.A.2.b).(9) must learn the prevention and management of complications associated with longstanding disability, the effects of aging with a disability and the provision of long-term follow-up services.

#### **IV.A.2.c)**

#### **Practice-based Learning and Improvement**

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

#### **IV.A.2.c).(1)**

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

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

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

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

IV.A.2.d).(1) Fellows are expected to:

IV.A.2.d).(1).(a) teach local medical communities and the general public about prevention of spinal cord injury;

IV.A.2.d).(1).(b) teach prehospital personnel and other health care providers how to stabilize patients with spinal cord injury and institute a rational protocol for their prehospital care;

IV.A.2.d).(1).(c) teach other hospital personnel and health care providers, patients, and patient support systems about the rehabilitation needs and long-term care of patients with spinal cord injury;

IV.A.2.d).(1).(d) teach medical students, fellows and other health professionals;

IV.A.2.d).(1).(e) understand and utilize learning theory, including assessment of learning needs, development of objectives and curriculum plans, effective use of audiovisual and other teaching materials and evaluation of teaching outcomes;

IV.A.2.d).(1).(f) provide instruction to patients and families;

IV.A.2.d).(1).(g) participate in educational activities within the interspecialty and interdisciplinary SCIM care team.

IV.A.2.d).(2) Fellows must have opportunity to meet and share experiences with residents in the core program and in other specialties. It is desirable for the fellow to interact with peers in primary care and relevant subspecialties. Fellows should have the opportunity to teach other fellows, medical students, and other health care professionals.

IV.A.2.d).(3) Fellows must have an opportunity to develop a management style compatible with the interdisciplinary team process.

- IV.A.2.d).(4) Fellows must collaborate with other integral members of the SCI care team.
- IV.A.2.d).(5) Fellows must understand group process and team dynamics; coordinate the activities of the interdisciplinary team through daily rounds, staff conferences, and patient and family educational and training sessions in order to maximize the goals established by the patient and team;
- IV.A.2.d).(6) Fellows must understand the training and capabilities of rehabilitation nurses, social workers, psychologists, physical therapists, occupational therapists, prosthetists, orthotists, speech/language pathologists and recreational and vocational counselors; recognize the professional role and contributions of the various allied health professions individually and collectively; encourage their full participation in patient care management while maintaining medical responsibility; and appreciate that a team effort, with as much continuity as practical, will produce a more satisfying outcome and experience for the patient, family and team members;
- IV.A.2.d).(7) Fellows must conduct a problem-oriented conference and set goals with the participation of the allied health staff;
- IV.A.2.d).(8) Fellows must organize and conduct programs of patient and family education;
- IV.A.2.d).(9) Fellows must, in concert with appropriate disciplines and other team members, manage the psychological effects of the impairment in order to prevent their interference with the reintegration and re-entry to the community;
- IV.A.2.d).(10) Fellows must participate in family meetings/discharge planning conferences, with focus upon community integration and adjustment to disability;
- IV.A.2.d).(11) Fellows must develop and maintain as needed a professional relationship with primary care physicians and be available to assist with or provide primary care for needed follow-up examination and for complex issues of SCI care.

#### **IV.A.2.e)**

#### **Professionalism**

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

- IV.A.2.e).(1) Fellows must appreciate that the ultimate goal is to return and help maintain the person with spinal cord injury as a

satisfied, and productive member of society.

**IV.A.2.f) Systems-based Practice**

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

- IV.A.2.f).(1) Within the interspecialty and interdisciplinary SCIM care team, the fellow should be taught, understand, and apply principles of organizational and group behavior, leadership and management styles, evaluation and modification of performance, labor-management issues, cost accounting and containment, and quality assurance techniques. The fellow should gain an understanding and some proficiency in the areas of budget planning and presentation, preparation of management briefings, information systems, and external reviews such as the Joint Commission for the Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities (CARF).
- IV.A.2.f).(2) Fellows must learn the optimal coordination of services of the various physicians and other health professionals in the prevention and treatment of complications in each organ system;
- IV.A.2.f).(3) Fellows must develop the skills to initiate and direct appropriate rehabilitation programming in the early hospital phase of treatment;
- IV.A.2.f).(4) Fellows must anticipate the approximate length of stay, cost of hospitalization, equipment needs, etc., with the involvement of the patient, the patient's support persons and appropriate agencies;
- IV.A.2.f).(5) Fellows must prescribe appropriate motor vehicle modifications to promote independence in mobility and transportation.
- IV.A.2.f).(6) Fellows must use the full range of community resources to facilitate the transition to the community;
- IV.A.2.f).(7) Fellows must coordinate and manage a SCI home care program;
- IV.A.2.f).(8) Fellows must direct to or establish the patient in a program of vocational rehabilitation, if appropriate.

IV.A.2.f).(9) In all phases of care, the fellow must understand and define the ethical and legal issues especially pertinent to spinal cord injury including diminished competence and the right to refuse treatment.

#### **IV.B. Fellows' Scholarly Activities**

IV.B.1. Scholarship is the in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice. The fellow should have assigned time to conduct research or other scholarly activities. The goal for the fellow should be at least one scientific presentation, abstract, or publication.

IV.B.2. Graduate medical education must take place in an environment of inquiry and scholarship in which fellows participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility.

#### **V. Evaluation**

##### **V.A. Fellow Evaluation**

##### **V.A.1. Formative Evaluation**

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

V.A.1.a).(1) Evaluation should be based on the program objectives and on the objectives of the fellow's individualized program.

V.A.1.a).(2) Evaluation must be carried out semi-annually and should be followed by extensive feedback to the fellow. Remedial objectives may be established.

V.A.1.a).(3) The following areas should be evaluated:

V.A.1.a).(3).(a) acquisition of described competencies,

V.A.1.a).(3).(b) problem-solving skills,

V.A.1.a).(3).(c) interpersonal relationship skills,

V.A.1.a).(3).(d) ability to access, retrieve, and critically evaluate the literature,

V.A.1.a).(3).(e) information management,

V.A.1.a).(3).(f) quality and cost-effectiveness measures of patient care,

V.A.1.a).(3).(g) research and other scholarly accomplishments.

- V.A.1.b) The program must:**
- V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
  - V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,**
  - V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.**
- V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.**
- V.A.2. Summative Evaluation**
- The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow’s permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:**
- V.A.2.a) document the fellow’s performance during their education, and**
  - V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.**
- V.B. Faculty Evaluation**
- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.**
  - V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**
  - V.B.3. Faculty evaluation by fellows should be on a semi-annual basis.**
  - V.B.4. Areas to be evaluated are:**
    - V.B.4.a) clinical skills and competencies,**
    - V.B.4.b) teaching skills,**
    - V.B.4.c) scholarly activity,**

- V.B.4.d) leadership skills, and
- V.B.4.e) interpersonal skills.
- V.B.5. The faculty should participate in teaching, research, and scholarly activity in the field of SCIM.
- V.B.6. While not all members of a teaching staff must be investigators, the staff as a whole must demonstrate broad involvement in scholarly activity.

## **V.C. Program Evaluation and Improvement**

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

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

**V.C.1.b) faculty development**

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

V.C.3. In particular, the quality of the curriculum and the extent to which the educational goals have been met by the fellows must be assessed. Written, confidential evaluations by fellows should be utilized in this process. Fellow satisfaction at the completion of the program should also be assessed.

V.C.4. One measure of the quality of a program is the performance of its fellows on the examinations of the American Board of Physical Medicine and Rehabilitation for special qualifications in SCIM.

V.C.5. The teaching staff must be organized and have regular documented meetings in order to review program goals and objectives as well as program effectiveness in achieving them. At least one fellow representative should participate in these reviews.

## **VI. Fellow Duty Hours in the Learning and Working Environment**

### **VI.A. Principles**

**VI.A.1. The program must be committed to and be responsible for promoting patient safety and fellow well-being and to providing a supportive educational environment.**

**VI.A.2. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients.**

**VI.B. Supervision of Fellows**

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

**VI.C. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)**

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

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

**VI.C.2. Fellows must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**

**VI.C.3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

**VI.D. On-call Activities**

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

**VI.D.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Fellows may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**

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

**VI.D.3.a) A new patient is defined as any patient for whom the fellow has not previously provided care.**

**VI.D.4. At-home call (or pager call)**

**VI.D.4.a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each fellow.**

**VI.D.4.b) Fellows taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**

**VI.D.4.c) When fellows are called into the hospital from home, the hours fellows spend in-house are counted toward the 80-hour limit.**

**VI.E. Moonlighting**

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

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