

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

One-year Common Program Requirements are in BOLD

Effective: July 1, 2011

Introduction

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

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

Int.B. Spinal cord injury medicine addresses the prevention, diagnosis, treatment and management of traumatic spinal cord injury 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.C. The management of persons with spinal cord dysfunction requires a team and interspecialty approach with contributions from several medical and surgical specialties, as well as other health care professionals. 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.D. Fellows acquire, within the interdisciplinary spinal cord injury team, knowledge of emergency care, and knowledge and skills in the following areas: acute care; initial and ongoing medical rehabilitation; discharge planning; lifelong care; scholarly activity in support of these skills.

Int.E. The educational program in spinal cord injury medicine must be 12 months in length.

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 sponsoring institution must be a care center for persons with spinal cord dysfunction, or be affiliated with such a center. Affiliation with an accredited medical school is suggested.

I.A.2. The sponsoring institution must sponsor an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in physical medicine and rehabilitation.

I.A.3. The sponsoring institution must provide for financial resources, including salaries, fringe benefits and opportunities for fellows' continuing medical education.

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. All participating sites providing clinical experiences should be in the same geographic location as the primary clinical site, limited to a travel time of no more than one hour for rotations requiring daily attendance, unless appropriate overnight accommodations are provided by the program or institution.

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 subspecialty by the American Board of Physical Medicine and Rehabilitation, or subspecialty 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) in cooperation with the program director of the core residency program, develop and implement a written supervision policy that specifies lines of responsibility for faculty and fellows, as well as for residents in the core program;

- II.A.3.f) ensure close cooperation between the core residency program and the fellowship program; and,

- II.A.3.g) monitor fellow stress, including mental or emotional conditions inhibiting performance or learning, and drug or alcohol-related dysfunction.
 - II.A.3.g).(1) Program directors and faculty members should be sensitive to the need for timely provision of confidential counseling and psychological support services to fellows.
 - II.A.3.g).(2) Educational experiences in clinical situations which consistently produce undesirable stress on fellows must be evaluated and modified.

- II.A.4. The program director must demonstrate active participation in research or scholarly activities in spinal cord injury medicine by one or more of the following:
 - II.A.4.a) peer-reviewed funding;
 - II.A.4.b) publication of original research or review articles in peer-reviewed journals or chapters in textbooks;
 - II.A.4.c) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
 - II.A.4.d) participation in national committees or educational organizations.

II.B. Faculty

II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

- II.B.1.a) In addition to the program director there must be at least one other FTE faculty member with expertise in spinal cord injury medicine.

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

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

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

- II.B.5. The faculty should participate in scholarly activity in the field of spinal cord injury medicine. The faculty must demonstrate active participation in scholarly activities by one or more of the following:

- II.B.5.a) peer-reviewed funding;
- II.B.5.b) publication of original research or review articles in peer-reviewed journals or chapters in textbooks;
- II.B.5.c) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
- II.B.5.d) participation in national committees or educational organizations.

II.B.6. Faculty members in anesthesiology, emergency medicine, internal

medicine (including the relevant subspecialties), neurological surgery, neurology, orthopaedic surgery, pediatrics, physical medicine and rehabilitation, plastic surgery, psychiatry, diagnostic radiology, general and/or trauma surgery, and urology should take an active role in the curriculum, providing instruction in the areas of their practices relevant to spinal cord dysfunction.

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. Appropriately-qualified professional staff must be available in the disciplines of occupational therapy, orthotics and prosthetics, physical therapy, psychology, rehabilitation nursing, respiratory therapy, social service, speech-language pathology, therapeutic recreation, and vocational counseling.

II.D. Resources

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

- II.D.1. The program must have access to a service delivery system dedicated to the care of persons with spinal cord dysfunction. Resources must 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 other community reintegration resources;
 - II.D.1.f) 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; and,
 - II.D.1.g) specialty and subspecialty consultant services in anesthesiology, emergency medicine, internal medicine, neurological surgery, neurology, orthopaedic surgery, pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, psychiatry, diagnostic radiology, general and/or trauma surgery, and urology.

II.D.2. The patient population must be of sufficient size and diversity of age, and include persons with new and continuing spinal cord care dysfunction, persons re-admitted to the hospital, and outpatients.

II.D.3. Fellows must be provided with prompt, reliable systems for communication and interactions with supervisory physician faculty members.

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. Prior to appointment in the program, fellows must have successfully completed an ACGME-accredited program in one of the following: anesthesiology; emergency medicine; family medicine; internal medicine; neurological surgery; neurology; orthopaedic surgery; pediatrics; physical medicine and rehabilitation; plastic surgery; surgery; or urology.

III.A.2. Prior to appointment in the program, each fellow must be notified in writing of the required length of the program.

III.B. Number of Fellows

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

IV. Educational Program

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

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

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

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

- IV.A.2.a).(1) must demonstrate proficiency in:
- IV.A.2.a).(1).(a) performing a comprehensive neurologic assessment and determining the injury level of the patient;
 - IV.A.2.a).(1).(b) performing a functional assessment based on neurological, musculoskeletal and cardiopulmonary examinations and psychosocial and prevocational evaluations;
 - IV.A.2.a).(1).(c) evaluating the stability of the spine;
 - IV.A.2.a).(1).(d) coordinating and managing the transition from acute care to rehabilitation;
 - IV.A.2.a).(1).(e) referring and collaborating with programs of vocational rehabilitation in order to determine the functional goals for self-care, mobility, vocational and avocational activities based on the level and completeness of the lesion;
 - IV.A.2.a).(1).(f) establishing short- and long-term rehabilitation goals and coordinating the implementation of the rehabilitation program to meet such goals;
 - IV.A.2.a).(1).(g) prescribing appropriate vehicle modifications and motor retraining and conditioning activities in order to promote independence in mobility and transportation, orthoses, and the adaptive equipment needed to meet the rehabilitation goals;
 - IV.A.2.a).(1).(h) management and evaluation of assistive equipment, including motorized wheelchairs, environmental control systems, and home modifications; and,
 - IV.A.2.a).(1).(i) determining when the rehabilitation goals have been achieved, finalizing the discharge plan, and arranging for the appropriate level of care to match the patient's needs.

- IV.A.2.a).(2) must, with appropriate consultation, demonstrate proficiency in:
- IV.A.2.a).(2).(a) coordinating treatment and infection control, including the judicious use of antimicrobials;
- IV.A.2.a).(2).(b) evaluating and managing complications, including 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).(2).(c) evaluating and managing intercurrent disease, with special emphasis on the prevention and management of these diseases in patients at various levels of spinal cord injury; and,
- IV.A.2.a).(2).(d) evaluating and managing the use of appropriate surgical procedures for skin problems, including resection of bone, the development of flaps, for soft tissue coverage, and the pre- and post-operative management of these patients.
- IV.A.2.a).(3) must demonstrate proficiency in evaluating and managing:
- IV.A.2.a).(3).(a) orthostatic hypotension and other cardiovascular abnormalities during initial mobilization of the patient;
- IV.A.2.a).(3).(b) abnormalities and complications in other body systems resulting from spinal cord injury, including: pulmonary, genitourinary, endocrine, metabolic, vascular, cardiac, gastrointestinal, and integumentary;
- IV.A.2.a).(3).(c) respiratory complications, including: airway obstruction, atelectasis, pneumonia, and tracheal stenosis; and complications associated with -ventilator -dependent patients with spinal cord injury;
- IV.A.2.a).(3).(d) care of patients with neurogenic bowel and bladder dysfunction;
- IV.A.2.a).(3).(e) pain disorders associated with spinal cord disease/injury;
- IV.A.2.a).(3).(f) musculoskeletal disorders associated with spinal cord disease/dysfunction, including shoulder pain, overuse syndromes, neck pain, shoulder

- subluxation, and heterotopic ossification;
- IV.A.2.a).(3).(g) skin problems utilizing specialized beds, cushions, wheelchairs, and pressure mapping;
- IV.A.2.a).(3).(h) 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).(3).(i) post-acute medical care of patients with medical spinal cord disease/dysfunction, including multiple sclerosis, motor neuron disease, transverse myelitis, and disorders affecting the spinal cord, including: infectious disorders, neoplastic disease, vascular disorders, toxic/metabolic disorders and congenital/developmental disorders;
- IV.A.2.a).(3).(j) the special needs and problems of children and adolescents with spinal cord injury, including behavior, bladder, bowel, skin care, growth and development, immunizations, mobility, nutrition, pediatrics, self-care, recreation and schooling; and,
- IV.A.2.a).(3).(k) medications of patients with spinal cord injury, including changes in pharmacokinetics, pharmacodynamics, drug interactions, over-medication, and compliance.
- IV.A.2.a).(4) must demonstrate proficiency in providing regular follow-up, evaluation and preventive health care to keep the patient at his/her maximum health and rehabilitation status, and coordinating this care with the patient's personal community physician;
- IV.A.2.a).(5) must demonstrate proficiency in implementing, 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 spinal cord dysfunction; and
- IV.A.2.a).(6) must demonstrate proficiency in monitoring the evolution of neural dysfunction in order to recognize conditions that may require additional evaluation, consultation, or modification of treatment.

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) must demonstrate proficiency in their knowledge of:
- IV.A.2.b).(1).(a) the organization and interdisciplinary practices of the Emergency Medical Services system relating to the prehospital and initial Emergency Department care of persons with spinal cord injury and associated injuries;
- IV.A.2.b).(1).(b) the supportive role of spinal cord injury medicine to emergency medicine, neurological surgery, orthopaedic surgery, and other appropriate physicians in initial acute care sites, including intensive and critical care units;
- IV.A.2.b).(1).(c) the relationship between the extent and level of spinal cord injury on the ultimate residual functional capacity;
- IV.A.2.b).(1).(d) the management of the neurogenic bladder and sexual dysfunction and the role of the urologist in assisting with 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;
- IV.A.2.b).(1).(e) the kinesiology of upper extremity function and the use of muscle substitution patterns in retraining;
- IV.A.2.b).(1).(f) the value, indications, and contraindications of tendon and muscle transfers and other operative procedures that would enhance function;
- IV.A.2.b).(1).(g) indications and contraindications of phrenic nerve pacing and diaphragm, as well as invasive (i.e., tracheostomy) and non-invasive (i.e., oral/nasal interfaces) ventilator approaches;
- IV.A.2.b).(1).(h) indications for personal care attendants, types of architectural modifications to accommodate patient needs, and community resources for follow-up care;
- IV.A.2.b).(1).(i) 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.b).(1).(j) the techniques of appropriate spinal immobilization required to protect patients from additional neurological damage;
- IV.A.2.b).(1).(k) the various options for treatment of fractures and dislocations at all vertebral levels;
- IV.A.2.b).(1).(l) the indications for and use of clinical neurophysiologic testing to assess the extent of neurapraxia, denervation, reinnervation, phrenic nerve function, and spinal cord function;
- IV.A.2.b).(1).(m) the indications and use of functional electrical stimulation (FES) as applied to the management of spinal cord impairment;
- IV.A.2.b).(1).(n) the professional role and contributions of the various allied health professions individually and collectively; and,
- IV.A.2.b).(1).(o) interdisciplinary and interspecialty spinal cord injury teams, demonstrate the knowledge regarding the management of the pre- and post-operative care of patients undergoing operative procedures that enhance extremity function, including muscle and tendon transfers.

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.c).(3) inform and counsel patients, their families, and other health specialists on a timely basis about the impact of a patient's disability;
- IV.A.2.c).(4) participate in patient education about all aspects of spinal cord dysfunction in order to promote patient independence and patient recognition of illness; and,
- IV.A.2.c).(5) teach hospital personnel, including medical students, residents, and fellows, as well as other health care providers, patients, local medical communities, and the

general public, about relevant topics in spinal cord injury medicine. Demonstrated teaching skills must include:

- IV.A.2.c).(5).(a) assessing learning needs;
- IV.A.2.c).(5).(b) developing objectives and curriculum plans;
- IV.A.2.c).(5).(c) effectively using audiovisual and other teaching materials; and,
- IV.A.2.c).(5).(d) evaluating teaching outcomes.

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 must demonstrate competence in counseling patients and families in family meetings/discharge planning conferences, with a focus on community integration and adjustment to disability.

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 develop and maintain a professional relationship with primary care physicians, and assist with or provide primary care for needed follow-up examination and complex issues of spinal cord injury care.
- IV.A.2.e).(2) In all phases of care, fellows must apply legal principles especially pertinent to spinal cord injury, including diminished competence and the right to refuse treatment.

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) Fellows must demonstrate a management style compatible with an interdisciplinary team process.

IV.A.3. Curriculum Organization and Fellow Experiences

- IV.A.3.a) Fellows must devote at least three months of their clinical experience to the care of hospitalized rehabilitation patients and at least three months to non-hospitalized patients.
- IV.A.3.a).(1) Each fellow must provide care (directly or in a direct supervisory role) for a case load of at least eight hospitalized patients when on an inpatient rotation.
- IV.A.3.a).(2) Fellows must, in concert with appropriate disciplines and other team members, manage the psychological effects of patients' impairments in order to prevent the interference of these with the reintegration and re-entry to the community.
- IV.A.3.b) Fellows must participate in prescribing a home care plan for their spinal cord injury patients, as appropriate.
- IV.A.3.c) Fellows must coordinate participation of occupational therapists, orthotists, physical therapists, prosthetists, psychologists, recreational and vocational counselors, rehabilitation nurses, social workers, speech/language pathologists, and in-patient care management through daily rounds, patient care conferences, and patient and family educational sessions.
- IV.A.3.d) Fellows must have the opportunity to meet and share experiences with residents in the core program and in other specialties.
- IV.A.3.e) Didactic Curriculum
- IV.A.3.e).(1) The program must have conferences that include case-oriented multidisciplinary conferences, journal club, and quality improvement seminars relevant to clinical care within the spinal cord injury medicine program.
- IV.A.3.e).(1).(a) At a minimum, each fellow must have documented attendance at conferences that provide in-depth coverage of the major topics required for competence in spinal cord injury medicine over the duration of the 12-month program.
- IV.A.3.e).(1).(b) Quality improvement seminars must include discussion of initial, discharge, and follow-up data that have been analyzed regarding the functional outcomes of persons served, as well as other practice improvement activities that will help engage fellows in maintenance of certification.

IV.B. Fellows' Scholarly Activities

- IV.B.1. Fellows should have assigned time to conduct research or other scholarly activities.

IV.B.2. Each fellow should demonstrate scholarship through at least one scientific presentation, abstract, or publication.

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.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 confidential and conducted semi-annually.

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. At least 50% of a program's graduates from the preceding five years who are taking the American Board of Physical Medicine and Rehabilitation's certifying examination for spinal cord injury medicine for the first time must pass.

V.C.4. At least 50% of those who completed their education in the preceding five years should have taken the certifying examination.

VI. Fellow Duty Hours in the Learning and Working Environment

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

VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.

VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.

VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b) provision of patient- and family-centered care;

VI.A.5.c) assurance of their fitness for duty;

VI.A.5.d) management of their time before, during, and after clinical assignments;

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

VI.A.5.f) attention to lifelong learning;

VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,

VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

- VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;**
- VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,**
- VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.

VI.D. Supervision of Fellows

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

VI.D.1.a) This information should be available to fellows, faculty members, and patients.

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) **Indirect Supervision:**
 - VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
 - VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**
 - VI.D.4.a) **The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
 - VI.D.4.c) **Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**
- VI.D.5. **Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
 - VI.D.5.a) **Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**

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

VI.E. Clinical Responsibilities

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

VI.F. Teamwork

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

VI.G. Fellow Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

The Review Committee for Physical Medicine and Rehabilitation will not consider requests for exceptions to the 80-hour limit to the fellows' work week.

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

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

VI.G.2. Moonlighting

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

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting

(as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.3. Mandatory Time Free of Duty

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

VI.G.4. Maximum Duty Period Length

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

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

VI.G.4.b) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

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

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

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

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

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

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

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

Fellows in the subspecialties of physical medicine and rehabilitation are considered to be in the final years of education.

VI.G.5.a).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

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

VI.G.5.a).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

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

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

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

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

VI.G.8. At-Home Call

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

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

VI.G.8.b)

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

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