# Neurology Residency Program at the University of Florida

## INFORMATION FOR RESIDENTS

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Objectives</td>
<td>3</td>
</tr>
<tr>
<td>The ACGME &amp; Residency Requirements</td>
<td>3</td>
</tr>
<tr>
<td>Specific Objectives for Each Residency Year</td>
<td>4</td>
</tr>
<tr>
<td>Evaluation</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Competency Committee</td>
<td>8</td>
</tr>
<tr>
<td>Resident Supervision</td>
<td>8</td>
</tr>
<tr>
<td>Teaching by Residents</td>
<td>9</td>
</tr>
<tr>
<td>Documentation of Experience</td>
<td>9</td>
</tr>
<tr>
<td>Economic, Ethical and Legal Issues</td>
<td>10</td>
</tr>
<tr>
<td>On Call Schedule (Duty Hours)</td>
<td>12</td>
</tr>
<tr>
<td>Vacation</td>
<td>14</td>
</tr>
<tr>
<td>Outside Employment</td>
<td>15</td>
</tr>
<tr>
<td>Overview of the Residency</td>
<td>15</td>
</tr>
<tr>
<td>Core rotations</td>
<td>15</td>
</tr>
<tr>
<td>Selective rotations</td>
<td>16</td>
</tr>
<tr>
<td>Elective rotations</td>
<td>16</td>
</tr>
<tr>
<td>Housestaff salary support</td>
<td>16</td>
</tr>
<tr>
<td>Clinic Responsibilities</td>
<td>16</td>
</tr>
<tr>
<td>Conferences</td>
<td>16</td>
</tr>
<tr>
<td>Detailed Description, Goals and Objectives of the Core, Selective and Elective Rotations</td>
<td>18</td>
</tr>
<tr>
<td>Core rotations</td>
<td>18</td>
</tr>
<tr>
<td>Shands General Neurology Junior</td>
<td>18</td>
</tr>
<tr>
<td>Shands General Neurology Senior</td>
<td>20</td>
</tr>
<tr>
<td>Shands Stroke Junior</td>
<td>23</td>
</tr>
<tr>
<td>Shands Stroke Senior</td>
<td>25</td>
</tr>
<tr>
<td>VA In-patient/Consult Junior rotation</td>
<td>27</td>
</tr>
<tr>
<td>VA In-patient/Consult Senior rotation</td>
<td>29</td>
</tr>
<tr>
<td>Night Float Shands rotation</td>
<td>30</td>
</tr>
<tr>
<td>Night Float VA Rotation</td>
<td>33</td>
</tr>
<tr>
<td>Pediatric Neurology rotation</td>
<td>35</td>
</tr>
<tr>
<td>Continuity Clinic longitudinal rotation</td>
<td>36</td>
</tr>
<tr>
<td>VA Neuro I Clinic longitudinal rotation</td>
<td>38</td>
</tr>
<tr>
<td>Selective rotations</td>
<td>39</td>
</tr>
<tr>
<td>General Clinic Block rotation</td>
<td>39</td>
</tr>
<tr>
<td>Epilepsy I</td>
<td>40</td>
</tr>
<tr>
<td>Behavioral Neurology Clinic rotation</td>
<td>42</td>
</tr>
<tr>
<td>Movement Disorders Clinic rotation</td>
<td>43</td>
</tr>
<tr>
<td>Neuromuscular Clinic rotation</td>
<td>44</td>
</tr>
</tbody>
</table>
Neuropsychiatry rotation 45
Basic Science-Neuroscience rotation 46
Basic Science-Neuropathology rotation 47
Epilepsy II 48
Elective rotations 50
Outpatient Clinic block elective 50
Neuroradiology rotation 51
Movement disorders rotation 52
Sleep medicine rotation 53
Behavioral neurology rotation 54
Neuro-oncology 55
Neurosurgery 57
Behavioral Neurology Mini-Fellowship 58
Neuromuscular Mini-Fellowship 60
Research elective 61
Research 62
Faculty 65
Core Neurology Faculty 65
Core Pediatric Neurology Faculty 69
Non-Neurology Faculty at UF Gainesville 70
Neurology Faculty at UF Jacksonville 71
Faculty of Related Departments 71
Hospital, Outpatient & Administration Facilities 76
Library & Computer Facilities 76
Other Computer resources 76
Benefits 77
Awards 82
If there are problems 83
Technical Requirements for Residents 83
Gainesville and Environs 84
ATTACHMENTS:
Attachment 1: Neurology Milestones 85
Attachment 2: Clinical Skills Assessment Rules and Regulations
and sample Evaluation Form 91
Attachment 3: Evaluation Form by faculty at the end of each rotation 93
Attachment 4: Promotion and Graduation Guidelines 99
Attachment 5: Grievance procedures that are approved by the institution 104
Attachment 6: Sample form of the Resident’s Evaluation of faculty members 106
Attachment 7: Sample form of Resident’s Evaluation of each rotation 108
Attachment 8: Summary of documentation required for evaluation
& management (E&M) codes 109
Attachment 9: General issues related to cost-awareness 111
Attachment 10: Impaired physician policy 114
Attachment 11: The Institutional policy regarding sexual harassment 115
Attachment 12: Extra Duty Policy 116
Attachment 14: UF College of Medicine Policy on Industry Conflicts of Interest / Industry Academic Relations 119
Attachment 15: VAMC Primary Care / Neurology Provider Agreement 124

Note: The most current information about all institutional policies and procedures are on the Website (http://housestaff.medinfo.ufl.edu) under Graduate Medical Education Policies
GENERAL OBJECTIVES

The goal of the neurology residency program is to prepare you for the independent practice of clinical neurology. This is achieved by exposure to a wide variety of clinical situations, including in-patients, out-patients, adults and children, first with the close guidance of senior residents and faculty, and then, as you demonstrate increasing competency, with lesser intensity of supervision. You will enhance your knowledge of the basic neurological sciences as they apply to clinical neurology, and you will learn the pathological appearance and pathogenesis of neurological diseases. You will have the opportunity to develop skill in the performance and interpretation of electrodagnostic procedures. You will be assisted in achieving competence not only in medical knowledge and patient care, but also in the ability to learn from your own practice, in communicating effectively with patients and professionals, in developing professional principles and attitudes, and in understanding how your practice relates to the larger context of the health care system. You will be able to develop special interests and abilities by selecting appropriate elective experiences in preparation for a career in clinical practice or academics. We are confident that every resident that we accept into our program will be able, with suitable application, to become a first rate clinical neurologist.

In addition to these universal goals, faculty and graduates of the University of Florida Department of Neurology has a strong tradition of leadership in neurology in all aspects including academia, industry, private practice, and advocacy. During your three years as a neurology resident, you will be taught and mentored in leadership in neurology. We strongly believe that our residents represent the future of neurology and we stand ready to prepare you for a leadership role in your profession.

THE ACGME AND RESIDENCY REQUIREMENTS

The requirements for Neurology Residency Programs are set by the Accreditation Council for Graduate Medical Education (ACGME), and are enforced by periodic reviews of the programs by the ACGME’s Residency Review Committees (RRCs). Current ACGME requirements can be found at the ACGME’s website, www.acgme.org. Our program was fully accredited in 2003 and will be reviewed again in 2008. We have a new ACGME accredited fellowship in Vascular Neurology. We also provide a fellowship in Clinical Neurophysiology, which also was granted full accreditation in 2008. The Department of Pediatrics has approval of a program in Pediatric Neurology. The Department of Neurology also offers a non-ACGME-accredited fellowship programs in Behavioral Neurology (accredited through the UCNS), an NIH T-32 grant fellowship in Rehabilitation Neuroscience, and Movement Disorders.

ACGME STATEMENT OF GOALS & OBJECTIVES FOR NEUROLOGY RESIDENCIES

GENERAL GOALS AND OBJECTIVES

Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident. 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 physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty who give value, context, and meaning to those interactions. As residents 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 the development of the skills, knowledge, and attitudes in the resident required to enter the unsupervised practice of neurology; and establishing a foundation for continued professional growth.

The purpose of neurology training is to prepare the physician for the independent practice of clinical neurology. This training must be based on supervised clinical work with increasing responsibility for outpatients and inpatients. It must have a foundation of organized instruction in the basic neurosciences.

THE COMPETENCIES & MILESTONES

The Neurology Residency will provide educational experiences to ensure that each resident has the knowledge, skills, and attitudes in each of the six areas of competence defined by the ACGME, and will are devising methods to assess the resident’s competence in each of these areas:

1. Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemi-
logical and social-behavioral) sciences and the application of this knowledge to patient care.

3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of the resident’s patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

4. **Interpersonal and Communication Skills** that result in effective information exchange between residents and their patients, their patients’ families, and other health professionals.

5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

6. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide optimal care.

Over 10 years ago the American Council on Graduate Medical Education (ACGME) announced the six core competencies as part of an overhaul of post-graduate training for residents. In 2012 the next step, aptly termed the Next Accreditation System (NAS) went into effect for many disciplines. The competencies were the lofty goals to be achieved through training, the NAS incorporates milestones that must be achieved during the residency program. The milestones, while specialty specific are based on the Dreyfus Model of Skill Acquisition (Dreyfus SA, Dreyfus HI. A Five Stage Model of the Mental Activities involved in Direct Skill Acquisition. UC, Berkeley).

The Novice is taught a set of rules before they acquire experience. This is the medical student and intern. Competent the learner applies the rules to the situation. This is the beginning neurology resident. Proficient this learner can handle more than one situation at a time, and is able to appropriately and independently exclude irrelevant details. This is the advanced resident. Expert learner is able to intuitively grasp the situation and to do the appropriate steps or actions. This is the resident who is about to complete their training. Master in this stage the performer (or physician, or athlete...) no longer has to self monitor their activities and they can transcend their performance at the expert level by using freed resources from self-monitoring into the task at hand. The master seeks out unusual and difficult situations and welcomes surprises. This is the experienced clinician who has developed style. The labels have been changed over time and in the current ACGME learner model, master is level four and expert is level five. The take home messages are that the levels are not equivalent to PGY and that a learner can perform at different levels for different milestones in their training.

The first proposed milestone is: History–Patient Care

Level 1 - Obtains a neurological history
Level 2 - Obtains a complete and relevant neurological history
Level 3 - Obtains a complete, relevant, and organized neurological history
Level 4 - Efficiently obtains a complete, relevant, and organized neurological history
Level 5 - Efficiently obtains a complete, relevant, and organized neurological history incorporating verbal and non-verbal clues.

When you review the milestones you will note that they are divided into the six competencies mentioned above. A complete list of the Milestones can be found in Attachment 1.

**SPECIFIC OBJECTIVES FOR EACH YEAR OF RESIDENCY**

At all levels of training, you are expected to demonstrate: polite, compassionate and professional behavior towards patients, nurses, secretarial staff, and peers.

**PGY-1**

Select residents will use the categorical, 4 year neurology pathway to becoming neurologists in our program. The main goal of the PGY1 resident is to transition from graduating medical student to practicing general physician, and to prepare for neurology training. All residents on this path are expected to complete a minimum of six months on internal medicine rotations, with direct responsibility for patient care, under the supervision of an internal medicine attending. Some of these months will be spent on general medicine inpatient rotations, but others will expose you to subspecialties of internal medicine germane to a future career in neurology. You will also have exposure to medical intensive care during this year. An additional two months is to be spent on further internal medicine training, emergency medicine training, or a combination of the two. You will also be expected to do one month of neurosurgery where you will be exposed to principles of care of neurosurgical patients. The remainder of your year may be spent on additional internal medicine selectives, or non-medicine selectives such as Physical Medicine & Rehabilitation, that are relevant to the profession of neurology.

At the end of the PGY1 year of training, you will have gained competence in the care of patients with a range of common medical illnesses, both in the acute and chronic setting. You will have obtained a satisfactory rating on all 6 ACGME competencies. To insure that you acquire the clinical and basic information outlined above, you are expected in your first to develop a self-study program and to effectively use the resources of the library and internet.
PGY-2

During the PGY2 year of residency, you will have maximal exposure to in-patients, spending several months on the wards (VA Junior; Shands Junior; and Stroke). There are also several half-month blocks of Nightfloat. Furthermore, you will gain experience in epilepsy, both on the Epilepsy Monitoring Unit and in epilepsy clinic as part of the Epilepsy I rotation. You will also spend several months in outpatient neurology clinics as well, gaining exposure to general neurology clinic and then one or more subspecialty clinics. Either during this year or the next you will be expected to participate in the January Neuroscience course as well. PGY2 residents who have a strong and clear interest in a specific clinical or research area may request specific subspecialty clinics or research rotations at the beginning of the year.

You will be paired with a Senior resident when you are in the wards. It is expected during the first year of neurology training you will learn to obtain complete and reliable histories, do a thorough and accurate neurological examination, and learn how to manage common neurological problems, including stroke, seizure disorders, headache, and disorders of similar prevalence. In addition, it is expected that you will learn how to respond to neurological emergencies, such as status epilepticus, acute stroke, respiratory compromise in neuromuscular disorders, acute encephalopathy, meningitis and encephalitis, spinal cord compression, raised intracranial pressure and space-occupying lesions. During the first months of training, you will be given the opportunity to learn how to read electroencephalograms (EEG). You are expected to acquire sufficient knowledge of neuroanatomy and neuroradiology to understand clinical localization and to develop skills in reading CT and MR scans. You should also read about basic neuropathology, neurochemistry, and neuropharmacology.

During your first year of residency you may have the opportunity to teach Neuroscience to first year Medical Students, which provides an ideal time to solidify this knowledge.

At the end of the PGY2 year of training, you will be allowed to proceed to the next level of training provided you have demonstrated progress in your daily care of patients to the satisfaction of the faculty, and you have obtained a satisfactory rating on all 6 ACGME competencies. To insure that you acquire the clinical and basic information outlined above, you are expected in your first and all subsequent years of training to develop a self-study program and to effectively use the resources of the library and internet. You are to document your progress in a portfolio that will include your experiences and achievements, examples of your ability to use library and on-line resources in patient care, progress of research projects, and similar material. You will have the opportunity to review the appropriateness of patient care, by review of untoward results, and by comparison of your care with practice standards suggested by the American Academy of Neurology. You are expected to develop effective communication skills by observing faculty and senior residents, to insure that your patients are appropriately counseled and informed. You will develop an understanding of ethical, socioeconomic, medicolegal and cost-containment issues through supervised experience in patient care, quarterly departmental conferences on these subjects, and resident lecture series including these topics.

Each resident must complete a structured clinical assessment and evaluation in 5 clinical areas (Emergency/Critical Care, Neurodegenerative Disorders, Episodic Disorders, and Neuromuscular). You are required to undergo this formal assessment in 5 clinical areas during your PGY3 year, but required to pass all before your graduate.

Residents who have excelled during the PGY2 year and have a strong and clearly laid out plan for research or a mini-fellowship may request at the end of this year deferment of certain selectives and/or pediatric neurology in order to pursue these interests in the PGY3 year.

PGY-3

During your PGY3 year of residency, you will have increasing responsibility on your months on the neurology wards (Shands General Senior; VA Senior; and Stroke Senior). You will also continue to demonstrate independence during nightfloat. It is also at this time that you will begin to be exposed to clinical pediatric neurology.

The remaining months are spent gaining more exposure to subspecialty clinical experience, complete the neuroscience course in January if you have not done so in PGY2 year, and begin to explore research and electives.

Specific objectives for the PGY3 resident include improving clinical skills so that by the end of the year you are able to expertly to summarize cases, reason soundly from the history and examination to a formulation of a complete differential diagnosis, and develop appropriate plans for diagnosis and management. You should be able to interpret CT and MR scans and EEGs with some confidence. Your attending physicians will expect graduating second year residents to demonstrate this degree of expertise in patient care, and promotion to the final year will be dependent upon the faculty’s judgment that these abilities have been acquired. Residents must demonstrate a satisfactory rating or better on all 6 ACGME competencies.

As a PGY3 resident your ability to practice independent, competent, compassionate neurology will be assessed. If you have not already done so in the PGY2 year, you must develop plans for a research project. You must meet with the faculty research adviser to approve your project during or before your PGY3 year of Neurology residency. During the PGY3 year, you should be developing career plans. If you decide to pursue fellowship training, you should acquire information about available programs and
begin the application process. You should be prepared to discuss these plans with the Residency Director at the December and June semi-annual evaluations.

Residents who had received permission to defer selectives and other requirements during the PGY3 year will be expected to successfully complete either a research or clinical mini-fellowship. For residents who have not done their research or mini-fellowship early by the end of this year would be expected to identify such for the final year if they intend to do so, otherwise they are expected to identify electives that will provide a well-rounded completion of their neurology education.

PGY-4

During your final year of residency, you will complete the majority of your months of ward duties (General Senior, Stroke Senior, VA Senior) and the last of nightfloat. The remaining months are spent on research, selective, and elective rotations. You will also complete your pediatric neurology rotations (3 months total). The elective months allow the resident to acquire essential clinical information, but also allow you to learn what interests you most in Neurology, so that you may make appropriate career plans.

Four to six months of time may be grouped together to create a mini-fellowship in such subspecialties as behavioral neurology, movement disorders, neuromuscular, epilepsy, and vascular. Elective experiences are available in Neuroradiology, Epilepsy, Sleep Medicine, Neuro-ophthalmology, Movement Disorders, EMG/Rehabilitation, Behavioral Neurology, Neurosurgery & Neuro-oncology, and Research Electives. Descriptions and specific objectives for each elective are described later in this document.

As a PGY4 year resident, you are expected to demonstrate leadership abilities, and to mentor junior residents. Beginning PGY4 year residents should have clear career goals, Arrangements for fellowships are generally made in the spring of the PGY3 year of residency and in the summer and early fall of the PGY4 year of residency. Residents will make use of the elective time provided to acquire knowledge and skills that will specifically apply to their future goals, as well as filling in gaps in their clinical training by appropriate selection of elective rotations, and by appropriate study plans.

Residents are required to participate in clinical or laboratory research during a portion of their three years of residency. This can be done in your spare time during other rotations, but some residents will want to reserve one or more months during which to work on specific research projects. If three or more months are required, the resident will have to demonstrate sufficient progress in learning clinical neurology to allow for this expenditure of time in research. In the third year, residents will be required to present a summary of their research to the faculty and co-residents. One graduating resident is awarded for the Best Research Presentation each year (see Awards section later in the document).

Graduation from the program will depend upon the resident having demonstrating consistently competent care in all areas. The graduating 3rd year resident should demonstrate the ability to practice independent, competent, compassionate neurology. Each resident must satisfactorily complete a structured clinical assessment and evaluation in 5 clinical areas (Emergency/Critical Care, Neurodegenerative Disorders, Episodic Disorders, Neuromuscular and Pediatric Neurology).

EVALUATION

EXAMINATIONS

Annual Neurology Resident In-Service Examination (RITE). This examination is prepared by the American Academy of Neurology and the American Neurological Association and is given each spring. It is similar to the written portion (Part I) of the Neurology Board Examination that you will take after you complete your residency. Every resident is required to take the In-Service Examination every year. You may use your scores to judge your progress in Neurology as compared with residents nationally. Residents who score below the 50th percentile will be counseled, and will have close faculty supervision of a study plan.

Clinical Skills Assessment: In accordance with the standards set by the ABPN Neurology Council, the residents of the UF Neurology Residency Training Program who are in their PGY-3 year of training will participate in five encounters. These encounters will be in the areas of 1) Child Neurology, 2) Critical Care, 3) Neuromuscular, 4) Episodic (headache, seizure), and 5) Neurodegenerative/ Movement/ Inflammatory. All PGY-3 residents will need to take the 4 Adult Clinical Skills Evaluations and will need to take the Pediatric Neurology Clinical Skills Evaluation (See ATTACHMENT 2 A and B for the Clinical Skills Assessment rules and sample evaluation form). Residents who do not pass the first time will be allowed to reexamine until such time as they pass all 5 Clinical Skills Evaluations.

1. This exercise is mandatory for all residents who have not yet passed all their Clinical Skills Examinations. It is recommended that PGY2 residents complete two of these by the end of that year, and required that they complete one. In the PGY3 year you are required to complete two, at least of one of which must be your Pediatric Neurology CSE. If you did not complete two in your PGY2, then it is recommended that you complete three in the
PGY3 year. In the PGY4 year you must complete all remaining CSEs. This will take the place of Part II of the Boards. Certification of successful completion is required for each resident to be able to sit for the boards.

2. The resident should consider this as part of his/her Board requirement and is responsible for arranging a mutually convenient day with his/her selected faculty evaluator. The patient to be examined should not be familiar to the resident.

3. The patient assessment should not last longer than 45 minutes.

4. The faculty member is not allowed to interrupt the assessment. The main purpose is to determine whether the resident can practice as an independent neurologist in the area being assessed. He may provide feedback at the end of the assessment.

5. The UF faculty member's grade is the final grade. Faculty are instructed to evaluate the resident's performance compared to the level of a practicing neurologist, not a resident.

Neuroscience examination: Residents who teach the Neuroscience course also help in the creation and administration of the final examination given to the first year medical students. Therefore, Neurology Residents can use the final examination as an assessment of their fund of knowledge in the basic neurosciences.

FACULTY EVALUATION OF RESIDENTS

Rotation evaluations: During each rotation/tour of duty, each attending who supervised the resident is instructed to provide a mid-rotation feedback on the resident's performance. We have incorporated the ACGME Neurology milestones into the end of rotation evaluations that faculty complete on residents whom they have worked with. Faculty members are encouraged to also provide their feedback and evaluation personally to the resident. But all evaluations on line can be accessed by the resident, if the faculty member did not get a chance to do this at the end of the rotation (See ATTACHMENT 3 for the base evaluation form by faculty at the end of each rotation. Individual rotations may also have appropriate milestone boxes added to the bottom of the evaluation.)

Portfolio: The resident is expected to keep a portfolio, which will be reviewed periodically by the Program Director. This portfolio will contain the records of your achievements and milestones. Your portfolio is kept up in New Innovations management suite. Residents may add any scholarly activities to their own portfolio or they may send the information to the program coordinator for her to add after the activity has been completed. Examples of scholarly activity include poster presentations at a national, regional or local level; lectures/presentations given at the national, regional, or local level, awards received, articles published in peer-reviewed publications (must have a pubmed number), & other publications.

6-month evaluations: The semi-annual evaluation is a complete summary of all evaluations for the past 6 months on the resident's performance in the 6 ACGME areas of competency as well as the milestones. This evaluation is written by the Program Director for each resident. A faculty meeting is then convened to discuss each resident's performance, and to critique and make adjustments to the 6 month evaluation if needed.

This evaluation also contains medical student evaluation of the resident's teaching efforts; 360 degree evaluation by department staff members, the residency coordinator, nurses, EEG and EMG technicians, etc; documentation of the resident's attendance in various local, national and international meetings; documentation of the resident's participation in hospital and university committees, especially systems-based practice efforts; accounting of the resident's attendance to Grand Rounds, lecture series, M and M conferences, CPCs, and Journal Club; tracking of the resident's yearly score in the RITE examination; documentation of the resident's adherence to administrative tasks such as timely dictations of charts and discharges; documentation of the resident's scholarly activities such as submission of abstracts, manuscripts and book chapters and presentations during CPCs; and, the overall summary and rating of the resident's performance (probation, warning, satisfactory, very good or exemplary) with suggestions for improvement.

Each resident meets with the Program Director every 6 months to discuss their performance. This meeting takes approximately 1 hour each and the resident's strengths and weaknesses in each ACGME competency and observed milestones for that time period are discussed in detail. An overall summary of the resident's performance, suggestions for improvement, and resident self-assessment and reflection are embedded in this evaluation.

We hope that our evaluations will be helpful in guiding your development as neurologists. Promotion to the next year of training is contingent upon a satisfactory end-of-year evaluation. (Promotion guidelines are outlined in ATTACHMENT 4). Residents who are not satisfied with their evaluations should discuss their concerns with the Program Director. If the issues are not resolved to the satisfaction of the resident, the resident may follow grievance procedures that are approved by the institution and are detailed in ATTACHMENT 5.

RESIDENT EVALUATION OF FACULTY

After each ward or elective rotation, residents will be asked to fill out an on-line questionnaire evaluating the faculty member supervising that rotation. Please complete these questionnaires honestly and completely, and provide comments when possible. Your responses will be entirely
confidential. Your evaluations are required for annual Departmental faculty evaluations (see ATTACHMENT 6 for a sample form of the resident’s evaluation of faculty members)

RESIDENT EVALUATION OF PROGRAM

At the end of each rotation, you will be asked to complete an on-line evaluation of specific rotations (see ATTACHMENT 7 for a sample form of resident’s evaluation of each rotation). Please take this opportunity to suggest how rotations can be improved. These evaluations will be submitted to, and reviewed by, the program director, and recommendations and criticisms will be discussed at the Annual Departmental Faculty Retreat on Education.

Although we require these on-line evaluations, it may also be more helpful for residents to meet with each other to discuss the adequacy of specific rotations, and any other aspects of the residency program that give them concern. Constructive suggestions that arise from these discussions can be brought to the attention of any of the faculty but particularly the Program Director and/or the Associate Program Director.

In addition, residents can voice their concerns and suggestions during: 1) the regular Resident-Program Director Business meetings; 2) the monthly Neurology Residency Oversight Committee (NROC) meetings; 3) Resident’s Retreat; 4) Faculty Retreat on Education. The NROC is a committee comprised of the Department Chair, Residency Program Director, Residency Associate Program Director, Residency Coordinator, select other faculty members, 1 resident representative from each year of training, 1 faculty representative each from the VA and Shands. The group meets monthly to discuss how the training program can be enhanced and to address complaints and concerns from the residents and faculty.

CLINICAL COMPETENCY COMMITTEE

In accordance with ACGME program requirements, we have a Clinical Competency Committee that is made up of several neurology faculty members from different divisions that assists the program director with resident evaluation. The Clinical Competency Committee is responsible for 1. Review of all resident evaluations semi-annually. 2. Preparing and assuring the report of Milestones evaluations of each resident semi-annually to the ACGME and 3. Advising the program director regarding resident progress, including promotion, remediation, and dismissal. In addition the Competency Committee will serve to suggest new teaching & educational initiatives for our program.

Each resident will have an academic advisor that is responsible for overseeing their academic performance. The academic advisor will get a progress report on their residents performance in the beginning of November and again in the beginning of May. The academic advisor will then make a brief summation report on their residents progress and forward this to the competency committee. The competency committee will take these summation reports into consideration during their deliberations.

RESIDENT SUPERVISION

In the clinical learning environment, each patient has an Identified, appropriately-credentialled and privileged attending physician who is ultimately responsible for that patient’s care, and this information should be available to residents, faculty members, and patients. Residents and faculty members are expected to inform patients of their respective roles in each patient’s care. Our program provides an appropriate level of supervision for all residents who care for patients, and is exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Some portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision will include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care (such as discharges from the ED overnight after discussion with the attending).

This program uses the following definitions of supervision.

- Direct Supervision – the supervising physician is physically present with the resident and patient.
- Indirect Supervision 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.
- Indirect Supervision 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.
- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members. The program director evaluates each resident’s abilities based on specific criteria
found throughout our resident manual. Our evaluations are in harmony with national standards-based criteria for residency, such as the core competencies. Faculty members functioning as supervising physicians will delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Senior residents and fellows serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

As part of the maturity process for a physician, each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. In particular, when PGY-1 residents are in our program, they should be supervised either directly or indirectly with direct supervision immediately available.

Our faculty supervision assignments are of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Resident supervision of patient care generally occurs in 2 settings: the in-patient hospital and the out-patient clinics.

In the in-patient setting, 3 separate teams comprised of 1 Junior resident, 1 Senior resident and 1 Attending, are assigned for each facility (Shands General Neurology; Shands Stroke; and the VA General Neurology). During the day, each attending provides in the morning direct supervision, overseeing the Morning Report with the nightfloat resident and teams, then rounds during the morning on patients. Each patient is examined and discussed. After morning rounds during the regular work week, attendings provide indirect supervision with direct supervision immediately available. The residents have their attending's pager and they can be called at any time with any questions. In addition, when one resident is in his/her own continuity clinic, the attending is first line for non-ER consults while the remaining in-patient resident is first line for ER consults and admissions. Then, whenever needed, "wrap-up rounds" are led by the attending at the end of each business day prior to signing out to the short call resident.

At night and after morning rounds on weekends, attendings provide indirect supervision with direct supervision available, and the Shands and VA attendings serve as second-line/back-up for all consults and admissions. Each resident is instructed to call their attending for every new admission and discharge or for any patient related question.

In the out-patient setting, each resident has his/her weekly continuity clinic. The continuity clinic alternates between the VA and Shands to benefit from the unique patient population of each setting. A dedicated attending is assigned to supervise the resident continuity clinics to provide better patient care and greater resident supervision. These attending provide a mixture of direct and indirect supervision with direct supervision immediately available during these clinics. Each resident is told to present every case to his/her assigned clinic attending.

Thus, there is always a designated faculty member responsible for the care of each patient. You should therefore always be able to call on a faculty person for assistance. The responsible faculty physician must always be fully informed about the patients under his or her care. Beginning first year residents should discuss each case with the attending physician at the time of service. After you have gained some experience, you may be able to make disposition on some patients before discussing them with the attending. If you have any doubt, call the attending. Attending availability is of paramount importance. If you have difficulty reaching the responsible attending, you should not hesitate to call upon any of the attending staff for help, at any time of day or night. The Program Director should be informed if you are not able to reach an attending in a timely fashion.

**TEACHING BY RESIDENTS**

Teaching is a wonderful way to learn: in order to teach students, you must first have knowledge that is accurate and usefully organized. Teaching responsibilities are integrated into the residency program.

**Teaching of medical students on the in-patient services.**

An important object of medical education that guides the curriculum in Neurology is to insure that every student has achieved certain minimal clinical competencies by the time of graduation. For example, they must know how to recognize, examine and treat patients with headache, stroke, dementia, dizziness, seizures, back pain, and common neuromuscular disorders. You will have the opportunity to read the excellent basic and clinical science teaching material provided to medical students when you teach the neuroscience course. You should also read and thoroughly understand the reading material provided third year students on their clerkship rotation. Every third year student is assigned to the in-patient services at Shands and the VA for two weeks. These students will round with you (on work-rounds and attending rounds), and will work up most new admissions. The student on call will, if not otherwise occupied, accompany you when you see consults in the hospital or in the ER on your nights on call. Students should present to you on work-rounds, and you should prepare them for their presentation of new patients to the attending. You should do as much teaching as feasible on work-rounds. During the rotation you should see that the student is writing appropriate notes, learns how to write orders, is able to function well on the ward team, and is acquiring a basic knowledge of clinical neurology. If a student is not doing well, it is your responsibility to communicate your concerns to the attending physician by
Developing your instructional and evaluative skills. Program offers workshops and lectures that are helpful in educators program.

Morbidity and Mortality Conference. Monthly Journal clubs, Weekly Board Review Sessions and coordinating the dates) the Resident’s Noon Lecture Series, selecting the topic and finding the reading materials, and finally, turns in preparing the clinical weekly Grand Rounds.

“Survival kits” for junior residents. The neurology residents, and neurology residents in general take every opportunity to help their fellow residents learn. The neurology residents also have the opportunity to teach residents from other services who rotate on the Neurology service. Residents from Anesthesiology, Medicine, Psychiatry, Neurosurgery, and Family Medicine rotate on the Neurology service and interaction with these residents is mutually beneficial. Each rotator has different goals and objectives when they rotate through neurology. It is your responsibility to make sure that their goals are met by the end of their rotation.

Teaching of residents and interns from other departments: Neurology residents also have the opportunity to teach residents from other services who rotate on the Neurology service. Residents from Anesthesiology, Medicine, Psychiatry, Neurosurgery, and Family Medicine rotate on the Neurology service and interaction with these residents is mutually beneficial. Each rotator has different goals and objectives when they rotate through neurology. It is your responsibility to make sure that their goals are met by the end of their rotation.

Teaching of Junior Neurology Residents: Senior neurology residents are expected to act as mentors to incoming neurology residents, and neurology residents in general take every opportunity to help their fellow residents learn. The senior residents help create and update guidelines and “survival kits” for junior residents. The neurology residents also take turns in preparing cases for presentation during weekly Grand Rounds. In Neuropathology, residents take turns in preparing the clinical-pathological conferences: They select cases, write protocols, and prepare a 10-15 minute presentation on the topic(s) that the case illustrates. Finally, the Chief resident or the senior residents divide the responsibility of facilitating (i.e. choosing the speakers, selecting the topic and finding the reading materials, and coordinating the dates) the Resident’s Noon Lecture Series, Monthly Journal clubs, Weekly Board Review Sessions and Morbidity and Mortality Conference.

All residents are required to participate in the Residents As Educators Program sponsored by the institution. This program offers workshops and lectures that are helpful in developing your instructional and evaluative skills.

ECONOMIC, ETHICAL AND LEGAL ISSUES

Medicare Compliance:

House officers are paid in part by funds from Medicare. For many years Medicare also reimbursed attending physicians for their care of the same patients, and it was considered adequate documentation of service if the attending physician merely countersigned the resident’s note. As of July 1, 1996, Medicare required that attending physicians (whom they now call teaching physicians) independently document their involvement with the patient. Medicare will only pay the teaching physicians for the time they spend in direct patient care. They will not pay for the time teaching physicians spend with residents, even if this indirectly benefits the patient, and even though the attending is still legally responsible for the patient. The teaching physician must document that he or she has personally provided the requisite level of service. Medicare will allow the teaching physician to reference the resident’s notes for some aspects of documentation, such as past medical history, review of systems, social history, but the teaching physician must personally document key portions of the history, examination, and decision-making. Rules announced in November of 2002 allow the teaching physician to rely more on the resident’s notes for documentation of the teaching physician’s involvement. Thus, the attending physician may simply provide for each encounter an attestation that they have personally seen and examined the patient, discussed care with the resident, and that the resident’s not accurately documents the assessment and plan. This makes it even more important that resident’s notes are complete and support the level of billing.

Audits of teaching hospitals in the past decade have routinely resulted in large settlements assessed against medical schools, up to $40 million. The settlement agreements have typically included an Institutional Compliance Agreement that details requirements for education of employees (including house officers), internal (or external) audits of compliance, and specification of penalties for non-compliance (such as a $1000/day penalty for each employee who has not received education in the specified time period, and similar penalties for failure to refund charges that were not supported by proper documentation -- for example, a note that did not include all of the specified information). In 2001 the University of Florida negotiated a settlement with the government which involved a payment of around $8,000,000 and entered into an Institutional Compliance Agreement. Under this agreement, residents are required to attend annual educational sessions that review the terms of the agreement and review special requirements for neurologists. The agreement terminated in 2007; however, there is still a requirement for mandatory annual training for all residents and faculty.
You must therefore become aware of Medicare requirements for documentation of billing (which are becoming the standard for all compensation by third parties), since not only must you comply with these regulations while a resident, but you must comply once you go out in practice. For each level of billing Medicare requires that specific information be included in the history, examination, review of records and films, diagnostic considerations, plan and treatment. ATTACHMENT 7 contains a summary of documentation required for evaluation & management (E&M) codes. When dictating about a patient seen in conjunction with an attending, residents letters should contain:

- A statement that you saw the patient in conjunction with Dr. [Attending’s name].
- Make sure your dictation contains documentation of services required for the bill rendered. For billing at the highest level, a detailed history of present illness, a review of systems that contains 10 systems or pertinent positives plus a statement that “all other systems were negative,” and a past medical, family, and social history are required. Your physical examination must contain sufficient detail (a comprehensive examination must include documentation of 3 vital signs, general appearance, examination of either carotid pulses, heart or pulses, ophthalmic examination, and a complete neurological examination, including orientation, memory, attention, language, fund of knowledge, CN 2-12 (you may state CN 2-12 intact, or provide details when there are abnormalities), strength, tone, observation for abnormal movements, sensation, reflexes, coordination, gait and station. In addition, you should specifically note who you spoke with to obtain the history, if you and your attending reviewed records and/or films, and briefly summarize what of importance was derived from these reviews. You should document all requests for records, and all discussions with other physicians about the case (be specific who was involved in these discussions). You should document all diagnoses that apply, as well as diagnoses you have considered as important in the differential.
- To document involvement in the case, the attending can write or dictate a separate note or letter or add an attestation to the resident’s note. The attending may refer to your note for documentation of history and examination findings.

Bills that are submitted for patients seen by both residents and attending physicians must include a GC modifier code. It is helpful if you remember to check this code on the billing sheet for each out-patient you see with an attending.

Laboratory and Radiology Requests: It is necessary that each request for laboratory or radiologic examinations include an appropriate diagnosis, that is, a diagnosis that justifies the test. Thus, if you are requesting a chest x-ray on a patient with Guillain-Barré to rule out pneumonia, you should not put Guillain-Barré as the diagnosis, but rather, fever, cough, or aspiration. In most instances, this is self-evident; however, you must be aware of particular regulations. For example, you may not put down “tube placement” as a diagnosis, even if this is why you are requesting an x-ray. Not only is this required for reimbursement, but clinical pathology and radiology faculty are liable for prosecution for fraud if they bill for a procedure without appropriate documentation.

License requirements:
Residents with temporary licenses will be given a number (UM number) that must be indicated on every pharmaceutical prescription provided by the resident. Residents with permanent State licenses must include their license number on prescriptions.

Prescription requirements:
All prescriptions must be written electronically or on special fraud-proof prescription pads that will be provided to each resident. Please remember to carry your personal prescription pad with you.

Patient Confidentiality (HIPAA):
You must respect the confidential nature medical information. You must have the patient’s permission to speak to anybody else about the patient’s medical condition, even to first degree relatives. If the patient is not present to ask, you must have the patient’s written permission. You must routinely exercise care that your discussions of patient information with colleagues is not overheard by anyone who is not entitled to the information (do not, for example, discuss patients with your colleagues on elevators, even if you don’t refer to the patients by name). Whenever possible, you should make presentations at the bedside rather than in the hallway, after requesting that persons who should not be privy to the information leave the room. An exception can be made of patients who share the room with your patient. You should also make others, such as medical students and secretaries, aware that casual talk about patients’ medical information that may broach confidentiality is not to be tolerated. You may access medical records on any patient for whom you are caring, either as their resident physician, or as a consultant, or covering for another resident. You may also access medical records for valid teaching purposes (for example, presentation to the Neuropathology Conference). You may not access medical records of any other patient, including not only famous patients, but also other faculty, medical students, or even members of your own family. Remember that the electronic medical system tracks every record access, and flags suspicious events. If asked, you will have to be able to justify every record review, and unauthorized access can be a cause for reprimand, probation and eventually dismissal. Following implementation of the Health Insurance Portability and Accountability Act (HIPAA) in April of 2003, breaches of
confidentiality become punishable by fines, and intentional breaches are punishable by fines and imprisonment. You are required to have HIPAA training for Shands and for the VA (training is separate). HIPAA also increases the regulation of protected health information for research. You must obtain IRB (Institutional Review Board) approval before initiating any research that entails review of patient records or other protected health information.

Cost-awareness:
It has become increasingly important that we inform ourselves about the cost of our medical practice. ATTACHMENT 8 addresses general issues related to cost-awareness. Specific policies relating to cost of services will be addressed in the context of individual patient care. Development of algorithms regulating management of specific neurological problems (paths) will impact on our management of patients increasingly in coming years. One aspect of practicing cost-effective medicine is the appropriate ordering of lab tests. Recurring orders for lab tests (i.e., morning CBC and metabolic profile) are to be discouraged unless there is a compelling reason for monitoring. They are usually unnecessary, they are costly and they cause pain and contribute to anemia.

Impaired physician policy:
Faculty, staff, peers, family or other individuals who suspect that a member of the housestaff is suffering from a psychological or substance abuse problem are obligated by law to report such problems. Individuals suspecting such impairment can either report directly to the Physician’s Recovery Network (PRN) or can discuss their concerns with the Program Director, Chairman, or Director of Graduate Medical Education. The specific regulations are in ATTACHMENT 10.

Gender Harassment:
Inappropriate professional behavior in any form is not permissible. The Institutional policy regarding gender harassment is provided in ATTACHMENT 11.

Medical-legal issues:
Residents must be aware of medical-legal issues relating to informed consent, standard of care, competency, restraints, HIV testing, confidentiality, and similar issues, and must know how to document their care so that it complies with medical and legal requirements. Residents are encouraged to attend seminars given at the Health Center each year dealing with medical-legal issues. Attendings will discuss such issues when relevant to the care of individual patients.

Quality Assurance:
Residents participate in quality assurance by filling out quality assurance forms on each patient admitted to the hospital, and by participating in quality assurance reviews. It is essential that forms are completed during the month that any death or complication has occurred. Complications and deaths are discussed at monthly Departmental Meetings. In addition, for the Shands inpatient services we have a monthly Quality Debrief to review potential systems problems that may decrease quality of care for our patients.

ON-CALL SCHEDULE (DUTY HOURS)
We have two nightfloat systems where a single resident is responsible for Shands and another resident is responsible for the VA hospitals from 8 pm to 8 am. Nightfloat is done in half month blocks. Shands Night Float begins on Monday night and runs through Sunday morning. VA Night Float begins on Sunday night and runs through until Saturday morning. In the gap between end of the normal work day at 5 pm until 8 pm, residents will be assigned to short call to cover the Shands and VA services. On the weekends, during the days there will be residents covering Shands and the VA. These residents cover from 8 am until 8 pm. Another resident will be on call overnight from 8 pm to 8 am on Saturdays, and the nightfloat resumes 8 pm Sunday night. There are two Saturdays of the month where a VA resident does a 24 hour call. They will not resume work until 24 hours later. PGY-2 residents do approximately 8 weeks total of nightfloat, PGY-3 residents do approximately 4 weeks total of nightfloat, and PGY-4 residents do approximately 2 weeks total of nightfloat. Shands coverage remains at Shands during their shift, whereas VA short call and weekend call can be covered from home by beeper depending on the workload of the VA neurology service and as long as the resident can arrive in the hospital within 15 minutes of being called. A designated call room is assigned for the on-call neurology house officers for resting. The resident on call is also responsible for answering outside calls from patients and physicians. You will notify the attending neurologist on call at Shands or at the VAMC of any but the most routine occurrence, and even of routine matters if you are a beginning resident. When more than one resident is covering Shands and the VA, they may serve as emergency reserve should one be tied up with another emergency or otherwise unable to respond to an emergent call in an expeditious manner, but it should only be for long enough to allow the regularly responsible resident to take over care. Attendings are responsible for back-up, in case the neurology resident(s) have more than one to two emergent situations to handle at the same time. Ward residents on each side of the street must sign out to the short-call residents each afternoon, the short-call residents must sign out to the nightfloat resident or overnight call resident on Saturdays and flex weeks, and the nightfloat must report to the ward teams each morning during Morning Report. The coverage schedule will be listed on our online system New Innovations , online on our neurology webpage, and in our weekly departmental newsletter. In addition, Shands intranet has an online coverage listing and both Shands and VA operators receive a copy of the coverage schedules.
The resident duty hours as specified above are to be in compliance with ACGME requirements. Residents may not work more than 80 hours a week, averaged over a four-week period during a rotation. Residents must get at least one day (24-hours) off in seven, averaged over a four-week period, during which they are free from all educational, clinical, and administrative responsibilities. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain in house for up to four additional hours to participate in didactic activities, transfer care of patients, and maintain continuity of medical and surgical care; but they may not admit or consult upon new patients during this time. There must be at least an 8-hour and preferably a 10-hour time period provided between all daily duty periods and after in-house call.

PGY-2 residents are considered to be at the intermediate level. PGY-3 and PGY-4 residents are considered to be in the final years of education. Duty hours may be rarely amended in special circumstances such 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. Residents should not have more than two consecutive weeks of night float or half of a calendar month (maximum 16 days).

Resident Duty Hours

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.

Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-hour Maximum Weekly Hour Limit. PGY-1 residents are not permitted to moonlight.

Mandatory Time Free of Duty
Residents 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.

Common Program Requirements

Maximum Duty Period Length
Duty periods of PGY-1 residents must not exceed 16 hours in duration.
Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Residents are encouraged 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 recommended. Residents will not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents, 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. Under those circumstances, the resident must: appropriately hand over the care of all other patients to the team responsible for their continuing care; and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Hand-Offs

It is essential for patient safety and resident education that effective transitions in care occur. Residents are 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.

Minimum Time Off between Scheduled Duty Periods
PGY1 residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods. Intermediate-level residents [PGY2 residents] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. Residents in the final years of education [PGY3, PGY4] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. 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 residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be reported in writing (New Innovations) to the program so as to be monitored by the program director.

Maximum Frequency of In-House Night Float
Residents must not be scheduled for more than six consecutive nights of night float.

Maximum In-House On-Call Frequency
PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

At-Home Call

Time spent in the hospital by residents 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. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Residents 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”.
If a resident recognizes or is observed to show signs of fatigue, or if a resident must go home because they would otherwise exceed the limits of contiguous in-house service, the resident should request relief from the resident designated as a back-up resident, or from the attending physician.

Continuity clinic responsibility will be assumed by the faculty member supervising the VA continuity clinic, and by a resident on elective rotation at Shands. Ward responsibilities will be assumed by the other Neurology resident on the service at Shands, or by the resident designated to be on call that evening, provided this is not a resident on a ward rotation. It is assumed that this will no longer occur except in rare instances.

The 80-hour rule and the 8 (10 preferred)-hour between-shift rule will apply to hours spent in approved outside employment (see next section).

### VACATION

There are institution-wide provisions for annual leave that are stipulated in the section on BENEFITS in this document. Fifteen days of annual leave are allowed each year. Annual leave (vacation) may not be taken in increments of less than five days, except for special permission from the program. All vacations must be approved in advance by the program director. It is preferable for vacations to be scheduled during Elective, Clinic or some Selective rotation blocks. They should be scheduled at the beginning or end of the block when possible, so as to minimize disruption of the elective experience. Except for unusual circumstances, vacations should not be scheduled during ward months (Shands, VA or Pediatrics). All vacations must be approved in advance by the program director or designee.

Vacation leave is generally scheduled in advance prior to the academic year beginning on July 1. We understand that changes and emergencies happen and residents may need to adjust leave time. Any changes to scheduled leave times, as well as leave for illness, family illness, leave to take a required exam (USMLE step, Board Certification exam, etc.) or interviews need to be done by officially requesting leave using the online form on the department website. Leave is not approved until the resident receives an e-mail stating such.

Additional Information on leave:

1. If the resident is assigned to a duty in New Innovations, meaning it is listed in New Innovations, the resident is expected and required to perform that duty. There are **absolutely no exceptions** to this outside of unexpected emergencies.

2. If the resident wants to change their schedule, and an inpatient service is affected by this change (VA, Shands General, Shands Stroke, Night Float), the resident is expected and required to switch with another resident to ensure the service remains covered. It is **solely the resident’s responsibility** to arrange the necessary switches and trades. Both parties must agree to the switch beforehand and it must be documented in an e-mail sent to the Chief Resident, Program Director & Program Coordinator with all participating parties listed as recipients of the e-mail.

3. Once all switches have been agreed upon and properly documented (if the change affects an inpatient service) the resident may request the change by submitting the online leave request found on the departmental website.

4. If there are concerns or problems with the switch, the Chief will attempt to facilitate the request as possible. In this situation, due to the complexities of the yearly schedule, the request may or may not be possible/approved. **Until the change has been officially approved by Department and the change shown in NI, it has not been made.** Regardless of any requests that the resident voices or otherwise states, if the change has not been approved and changed in New Innovations, the resident is expected to work their assigned duty.

5. If the change affects either the resident’s Shands and / or VA continuity clinic or Neuro 1 clinic, the resident is expected re-schedule any patients ahead of time and clearly communicate with the Shands and VA staff about the change.

6. The resident is expected to make schedule change requests a reasonable amount of time ahead of time. There is no set-in-stone rule for this but a minimum of 1 month is typically required in order to facilitate outpatient clinic changes in order to avoid burdening our patients. The resident should strive to make changes requests at least 1 month in advance.

7. Unexpected emergencies are handled on a case-by-case basis. The resident is expected to inform the Chief Resident with the Program Director and Program Coordinator cc’ed and request leave through the online leave request found on the Departmental Website as soon as possible in
these situations and the Chief Resident will arrange the necessary emergency coverage.

8. The resident is ultimately responsible for their own schedule; any changes made to it or pending to be made, and performing and ensuring all the necessary steps in order for the change to become official.

OUTSIDE EMPLOYMENT

The institutional policy regarding Outside Employment (formerly referred to as “moonlighting”) is provided in ATTACHMENT 12. The Department of Neurology’s policy is more restrictive than the institutional policy. We do not permit our neurology residents to engage in non-programmatic outside professional employment except in specific circumstances, which include Compensation and Pension Examinations at the VA and staffing the Emergency Room at the VA. Residents who have completed three years of neurology training (e.g., residents in Clinical Neurophysiology or Behavioral Neurology) are allowed to cover for neurologists at Shands at AGH on week-ends, as per our contractual agreement with this institution.

Residents must understand that outside employment hours apply to the calculation of resident duty hours (see above). Therefore, approval will not be given to outside employment that exceeds these limits. Residents must inform the Program Director of the dates and times of all outside employment, and obtain the Program Director’s approval in advance. The Program Director is responsible for submitting a summary annual report of outside professional employment of housestaff to the GMEC indicating that the Program Director is aware of the activities and approves.

The ACGME expects programs to monitor and approve any outside employment, even if it occurs during annual leave (vacation) time. Vacation is considered time during which the resident may recoup strength and resources so that he or she may return to the residency refreshed. This purpose is defeated by working during that time.

Housestaff who are tempted to consider non-programmatic outside professional employment despite these restrictions should consider: (a) that they are not covered by the College of Medicine’s malpractice insurance for nonprogrammatic outside employment; (b) that they may not represent themselves as agents of the University of Florida; and (c) most importantly, that violation of the Department’s outside employment policy by the resident will lead to disciplinary action, which could include dismissal from the program.

OVERVIEW OF THE RESIDENCY

The Neurology residency program is designed to meet specific goals and objectives, which have been discussed in the first section, and to be in compliance with the Requirements for Residency set forth by the ACGME. In this section we will specify how the major requirements are to be fulfilled during your residency.

CORE ROTATIONS: Neurology residents are required to have at least 18 months during their residency of direct patient care on the adult neurology in-patient or out-patient services, and they must have experience caring for patients in an intensive care setting. They must see neurological consultations, and they must evaluate patients in emergency settings. Residents on the Shands or VA ward/consult services gain this experience. In addition, neurology residents must have three months of pediatric neurology direct patient care.

Therefore, the following are your core rotations throughout the three years of residency:

- Shands General Neurology Junior
- Shands General Neurology Senior
- Shands Stroke Junior
- Shands Stroke Senior
- VA General Neurology Junior
- VA General Neurology Senior
- Pediatric Neurology
- Neuropsychiatry
- Longitudinal Neuro I Clinic
- Longitudinal Continuity Clinics

SELECTIVE ROTATIONS: In addition, our program must have basic science instruction, and they must spend at least two months studying one of the basic clinical sciences, such as neuropathology. They must have experience in the management of patients with psychiatric disease. We fulfill these requirements by the following required selective rotations, distributed over the two years (three years with special permission of the program director) of training:

- Neuroscience
- Neuropathology
- Epilepsy I
- Epilepsy II
- General Neurology Clinic
- Behavioral Neurology Clinic
- Movement Disorders Clinic
- Neuromuscular Clinic

ELECTIVE ROTATIONS: Neurology residents must also become proficient in reading neuroimaging studies, and in understanding the indications for, physiology underlying, and techniques of performing electrodiagnostic studies. In
addition, you must have the opportunity to study in sub-specialty areas of neurology, and in neurosurgery. You must understand the principles of neurological rehabilitation, and you must be involved in planning and supervising the rehabilitation of your patients. The following elective experiences are designed to help achieve these goals. They are more specifically described in later sections.

- Additional Behavioral neurology
- Sleep disorders
- Additional Neuromuscular
- Additional Epilepsy
- Neuropsychology
- Neurorehabilitation
- Neuroradiology
- Neurosurgery/Neuro-oncology
- Neuro-ophthalmology
- Movement disorders
- Research electives

In summary, the block and longitudinal rotations should fulfill the ACGME recommended curriculum for core, selective and elective rotations. The following is the distribution of block and longitudinal rotations throughout the 3 years of Neurology Residency at the University of Florida.

**Block Rotations:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Approximate Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shands General Neurology</td>
<td>4-5 months</td>
</tr>
<tr>
<td>Shands Stroke Service</td>
<td>4-5 months</td>
</tr>
<tr>
<td>VA In-patient/Consult</td>
<td>4-5 months</td>
</tr>
<tr>
<td>Nightfloat</td>
<td>2 1/2-3 months</td>
</tr>
<tr>
<td>Epilepsy I &amp; II</td>
<td>2 months</td>
</tr>
<tr>
<td>General Neurology Clinic</td>
<td>1 month</td>
</tr>
<tr>
<td>Behavioral Neurology Clinic</td>
<td>1 month</td>
</tr>
<tr>
<td>Movement Disorders Clinic</td>
<td>1 month</td>
</tr>
<tr>
<td>Neuromuscular Clinic</td>
<td>1 month</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>1 month</td>
</tr>
<tr>
<td>Pediatric Neurology</td>
<td>3 months</td>
</tr>
<tr>
<td>Neuropsychiatry</td>
<td>1 month</td>
</tr>
<tr>
<td>Neuropathology</td>
<td>1 month</td>
</tr>
<tr>
<td>Electives</td>
<td>6 months</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>36 months</strong></td>
</tr>
</tbody>
</table>

**Longitudinal Rotations:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Approximate Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro I Clinic</td>
<td>1.2 month</td>
</tr>
<tr>
<td>Continuity Clinics</td>
<td>2 months</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>2 months</strong></td>
</tr>
</tbody>
</table>

**HOUSESTAFF SALARY SUPPORT**

Your salary is provided by Shands Hospital and by the Veterans Administration. You must document your service to each institution to justify your salary. The Department takes care of such documentation; however, the VA requires that your time at the VA hospital is logged in. This is the responsibility of the Neurology secretary at the VA. It is important that residents inform this secretary when they are present, particularly when they are on elective rotations that have a VA component. Whenever starting a VA rotation, please check in with the VA Neurology office to make certain you are following proper procedure logging in your VA time.

**CLINIC RESPONSIBILITIES**

**Longitudinal Clinic Rotations:**

**New-patient clinics:** During your VA ward and your selective and elective months you will attend the Thursday morning (Neuro I) clinics at the VA with the following exceptions: you are not expected to attend this clinic when you are on the General Neurology or Stroke rotations at Shands, when you are on Nightfloat, when you are on Pediatric Neurology, when you are on the Epilepsy rotations, and when you are on Neuroscience.

**Continuity clinics:** To provide continuity of care, experience in following the course of neurologic illness, and experience in long-term management, you have your own half-day return patient clinic each week. You alternate between Shands and the VAMC (Neuro II clinic). There is attending supervision available at all clinics. You are expected to provide long-term out-patient care for your patients who require it. In this way you will learn the course of chronic neurological illness, the benefits and risks of treatments, and the value of establishing strong patient-physician professional relationships.

**CONFERENCES**

You must attend each of the following conferences, except when you are on nightfloat, on vacation, or taking an away elective more than an hour’s drive away that may preclude attendance. You must sign the attendance roster for each conference. The Neurology Chief resident or designee is responsible for reporting the roster to the secretary in charge of keeping these records. The attendance roster for Neuropathology neuroradiology is kept by the pathology department.

**Grand Rounds** (Tuesdays from 11:00 am to 1:00 pm, DeWeese Auditorium, McKnight Brain Institute. One case is presented and a faculty member discusses the case and a guest lecturer is featured. Neurology Grand Rounds lectures are accredited for CME.

**M&M conference:** Quarterly conference held on Thursday afternoons. Residents are responsible for reporting complications or poor outcome (death, hospital-acquired infection, or any case in which there is a question of patient safety to the Neurology Chief Resident. The Chief Resident will review the salient features of each of these cases, and there will be discussion by residents and faculty. Periodically, the Chief Resident will organize a review of quality care for common neurologic illness and compare our practice with national benchmarks.
Morning Report: See Shands inpatient service descriptions for details.

Board Review Sessions: From 12:00-1:00 pm at the UF MBI conference room as part of your resident lecture series, board review is held highlighting a “high yield topic” in in-service and/or board examinations. Every resident should attend these sessions.

Clinico-Pathological Conference (A monthly conference held during Grand Rounds, the conference is devoted to radiology and pathology. You should take this opportunity to learn about clinical, radiological and pathological aspects of neurological diseases, and about their treatment. A clinical case protocol is provided to neurology residents in advance of the conference. Residents are expected to be prepared to discuss the case. Following this discussion, other residents are invited to comment. Clinical faculty will comment, and then the pathologist will discuss the pathology. There may be further didactic presentation by the neurology or neurosurgery resident on the neuropathology service. When such residents are on the neuropathology service, they are responsible for organizing this conference.

Vertical Integration Lecture Series: Incorporated as part of the noon lecture series on Mondays, Wednesdays and Fridays from noon to 1 pm in the UF MBI conference room (L3-101). Each year faculty and residents will confer to organize a list of subjects of importance for didactic presentations by faculty or residents. During July and August, lectures cover basic clinical material of importance for incoming residents. At other times, the presentations address basic science areas not covered by other conferences or seminars, such as statistics, epidemiology, and basic genetics. They should also cover other basic and clinical areas of particular interest to residents. All subspecialties are represented including: Stroke, Movement Disorders, Dementia and Neurobehavior, Neuropathology, Neuroradiology, Neurehabilitation, Neuro-ophthalmology, Ethics, and “Life after Residency”. Faculty are assigned lectures, but in addition, each resident is expected to prepare at least one talk each year directed at fellow residents on one or more topics of clinical interest. It is expected that the resident review the current literature and prepare a handout for this presentation.

Journal clubs: This is a regularly recurring meeting quarterly during Neurology Grand Rounds. Discussed article on a particular theme is discussed. Both residents and faculty participate in this activity.

Annual Status Epileptics/EEG Workshop: Held once per year, this interactive session is held from 10:30 am to 1:00 pm in lieu of one Grand Rounds Session in August. Both residents and faculty are given an “in service” in spotting status epilepticus, especially non-convulsive status via EEG, and its proper management.

Resident-Program Director Business Meeting: This is a regularly recurring meeting held at the UF MBI from 12-2 pm for residents to express any problems or concerns regarding the residency curriculum and other similar matters to the residency program director.

Resident Quality Debrief: This is a regularly recurring meeting held at the Shands Resident Workroom on the last Thursday of the rotation from 12:30 – 1:30 pm to review quality of inpatient care and residents are able to identify and formulate remedies for systems improvement in quality of care.

Residents’ Lab Meeting: This is a regularly recurring meeting with the residents to discuss in a group session their research ideas and progress.

Other Conferences:

Behavioral Neurology “CNS” conference (Fridays from 1:30 to 2:30, 3rd floor VA conference room E-336), This is a meeting of the Center for Neuropsychological Studies. The research of Center faculty and fellows or by invited guests is presented. The format varies: case presentations, informal discussions, prepared debates, and formal lectures are all included.

EMG conference (2nd and 4th Mondays, 11:30-12:30, Neurology Small Conference Room). EMG Faculty, CNP residents, and neurology residents on the EMG rotation meet. There is an annual curriculum for CNP residents, with a different topic each week. The other half of the conference is devoted to reviewing interesting cases of the week and discussing questions that residents may have.

Epilepsy Management conference (Tuesdays from 8:30 to 10 AM). You should attend this conference if you are on the EEG rotation, or if your patient is to be discussed.

Movement Disorders Video conference (1st and 3rd Tuesday of the month from 8-9 AM) Held at the UF MBI DeWeese Auditorium. This is a video-based conference of interesting and challenging movement disorders conference with the entire multi-disciplinary team of the Movement Disorders Center.

Pediatric Morning Report (Monday, 7:30-8:30am) When you are on Pediatric neurology, you should attend Pediatric Morning Report. Management of current cases seen will be discussed.
Psychiatry Grand Rounds. (Check with Department of Psychiatry for schedule) **Attendance at Psychiatry grand rounds will be strongly recommended when the topic or speaker is appropriate.**

Psychiatry resident teaching conferences. (Times vary) **We will announce those conferences that are of value for neurology residents.**

**Neurosurgery conferences:**

Tumor Conference. (Tuesday at 4pm) **Held at the Neurosurgery Conference Room. This is an interdisciplinary Conference participated by Neurosurgery, Neuroradiology, Neurooncology and Neuropathology.**

Chief Conference (Wednesday at 7am). **Mandatory during Pathology Rotation. Lectures by neurosurgery residents with attending participation. Joint orthopedics / neurosurgery conference first Wednesday of each month.**

Neurosurgical case conference (Monday, Tuesday, Thursday 7am) **Review of surgical cases.**

Medicine Grand Rounds (Thursdays, 11am - noon, Communicore building). **We will announce those conferences that are of value for neurology residents.**

---

**DETAILED DESCRIPTION, GOALS & OBJECTIVES OF CORE, SELECTIVE AND ELECTIVE ROTATIONS**

**A) Core Block Rotations:**

**1. Shands General Neurology Junior**

**Description:**

You will be expected to gain experience caring for patients on the neurology general service, including consultations from the Emergency Department and Hospital Services, neurology in-patients, and neurology intensive care unit (NICU) service, and you will assist the attending physician and provide leadership in supervising students and rotating residents. You will also evaluate, treat, and make dispositions on patients in the Emergency Room. You are expected to fully evaluate each patient before conferring with the attending physician. Based on your evaluation, you should be able to comment upon localization and differential diagnosis, and you should have a plan for evaluation and treatment. You must confer with the attending prior to making important decisions in the management of cases; but you should not expect that the attending will do your thinking for you. The socio-economic and emotional aspects of patient care are to be addressed, and you will be conferring with the social worker to make appropriate plans for your patients. The rehabilitation of every patient begins with admission, and you will be involved in the planning and execution of rehabilitation efforts in every patient.

Your day starts with Morning Report from 7:45 to 8:45am daily, held at the Shands Neurology Team Room. The overnight resident presents all admissions to the general team. A concise but comprehensive presentation is given to the team on each patient admitted. The case, including differentials, diagnosis and management are discussed within the time allotted. Immediately following Morning Report, the general neurology teaching rounds follow. All resident-assigned new and old patients seen in consultation and admitted to the Neurology service in the regular floors and the NICU are seen and the day’s management are discussed and carried out. The daily teaching rounds should end by 11:30 am (10:30 am on Tuesdays). The rest of your day should be spent admitting new patients and seeing new consultations, discharging old patients, and attending all conferences during the day. You should prepare to sign out to the short-call resident at 5pm every day on the weekdays.

As the Junior resident in this rotation, you may be assigned by your Senior resident to assess patients in the emergency room (ER) as promptly as possible. As a resident educator, you are also responsible for preparing students, rotators (anesthesia, neurosurgery and psychiatry interns, and internal medicine and family medicine rotators) in presenting their cases to the attending physician. At the end of their rotation, each resident must complete their respective evaluation forms and return it to the Neurology Office.

You are responsible for signing out your patients in an efficient but effective manner at the end of your day, 5 pm. You will also take short call several days of the week, in which case you will receive sign out from your colleagues on the Shands service starting at 5 pm, and be responsible for all service patients, whether ward, consult, or ED, until you sign them out to the nightfloat at 8 pm. You will be responsible for seeing new ED and inpatient consults during short call.

During the weekend there will be times when you are called upon to cover the dayshift where you
will be responsible for all neurology patients on the Shands service and in the ED, as well as new ED consults. These shifts are from 8 am to 8 pm, when you will be relieved by the overnight resident or nightfloat. Sign out responsibilities are the same as during short call.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate proficiency in obtaining a complete and accurate neurological history and perform a complete neurological examination.
- You should be able to perform technical skills for neurological procedures such as lumbar puncture, assessment of brain death, operating EEG long term monitoring equipment.
- You should begin to demonstrate knowledge in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the inpatient setting.
- You should effectively carry out the management plans for all your patients in an organized and efficient manner.
- You should be able to adequately carry out the management of neurological emergencies such as acute stroke, status epilepticus, spinal cord compression, brain herniation, respiratory decompensation, etc under the supervision of your Senior resident or attending neurologist.
- You should demonstrate awareness in assessing the rehabilitation potential for each patient, and to make appropriate plans for rehabilitation, both during the hospital stay, and after discharge.

**Medical Knowledge**

- You should demonstrate knowledge about major neurological diseases that require inpatient care, including stroke, seizures, CNS infections, coma, dementia, common movement disorders, myelopathy, neuromuscular disorders, and specific neurological situations that require urgent or emergent responses.
- You should demonstrate ability to localize disease in the nervous system, and formulate a complete differential diagnosis.

**Practice-based Learning**

- You should demonstrate ability to use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning.
- You should demonstrate the ability to extract information and salient features from the history, examination, and caregiver and paramedical personnel interview, and organize them to base your differential diagnosis and management.
- You should demonstrate the ability to use the review of your own practice to guide your own learning objectives.

**Interpersonal and communication skills**

- You should demonstrate the ability to communicate effectively with patients, families in the inpatient setting.
- You should demonstrate the ability to efficiently and effectively present information about your patients to your Senior resident, attending physicians, and other health care professionals.
- You should demonstrate the ability to participate with other members of the health care team (nurses, physical and occupational therapists, speech therapists, social workers and others) to promote the best care for your patients (team-work).

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the management of your patients.
- You should be on time and prepared for Morning Report and daily work rounds.
- Most importantly, you should do all documentation—admission notes and discharges comprehensively and in a timely manner.

**Systems-based practice**

- You should demonstrate consideration the costs of medical care, and learn about resources available to cover these costs.
- You should demonstrate the ability to work with social services to plan for the care of patients after discharge; about resources
available in the patient’s community to promote the patient’s health.

- You should demonstrate the ability to consider and discuss ways to improve the practice of neurology at your institution.

**Suggested Textbooks/Reading Materials:**

- Localization in Neurology 2006 by Paul Brazis and Joseph Masdeu ($143.20)
- Technique of the Neurological Examination 2003 by William DeMyer ($64.76)
- The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Widjicks ($108)
- Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)
- Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)
- Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)

2. **Shands General Neurology Senior**

**Description:**

As the Senior in the general service, you are expected to act as the Junior Attending and you will play a supervisory role in addition to caring for patients on the neurology general, neurology intensive care unit (NICU) service, and the Emergency Room. Your team will usually be comprised of 1 Junior Resident, 1 Neurosurgery and/or Anesthesiology Intern, 2 medical students and other rotators. As the team leader, you are expected to assist the attending physician in supervising students and rotators. You are expected to fully evaluate each patient seen by your team before conferring with the attending physician. You also have the responsibility of distributing patients and workload to your team, making sure that everyone is able to attend lectures, conferences and Grand Rounds, and ensuring that daily Morning Report and teaching rounds start and end on time.

Your day may start before 8am as the Senior resident to familiarize yourself with the events from last night, update the patient census and prepare the team for Morning Report. Daily Morning Report is held from 8:15 to 8:45 at the Neurology Team Room, followed by work rounds with the attending which should last no longer than 3 hours, and preferably 2 hours. It is your responsibility to ensure that Morning Report and work rounds are organized and start and end on time. The rest of your day should be spent personally admitting new patients, discharging old patients, or supervising your team members, and attending all conferences during the day. You should prepare your team to sign out to the night-call resident at 5pm every day on the weekends.

Your team is also responsible for all non-stroke neurology consultations from the Emergency Room (ER). You should confer each case seen in the ER with your attending physician.

As the Senior on service, you will also field requests for admission to the neurology service in conjuncture with the attending, including hospital to hospital transfers. You may not accept patients from emergency departments in other hospitals. Requests to transfer patients from outside emergency rooms must be referred to our Emergency Department.

You are also responsible for helping to select cases to present at Neurology Grand Rounds, and prepare presentations.

As a resident educator, you are also responsible for preparing students, rotators (anesthesia, neurosurgery and psychiatry interns, and internal medicine and family medicine rotators) to present to the attending physician. You are expected to provide third year medical students on their clerkship with daily formative feedback and to reply to the daily summative evaluations sent you via email.

You are responsible for signing out your patients in an efficient but effective manner at the end of your day, 5 pm. You will also take short call once or twice a week, in which case you will receive sign out from your colleagues on the Shands services starting at 5 pm, and be responsible for all Shands neurology patients, whether ward, consult, or ED, until you sign them out to the nightfloat at 8 pm. You will be responsible for seeing new ED and inpatient consults during short call.

During the weekend there will be times when you are called upon to cover the dayshift where you will be responsible for all neurology patients on the Shands ward service and in the ED, as well as new ED consults. These shifts are from 8 am to either 5 pm or 8 pm, depending on whether you are on short call that weekend, when you will be relieved by the overnight resident or nightfloat. Sign out responsibilities are the same as during short call.
Therefore, in summary, as the Senior resident your main administrative responsibilities include:

- supervising the entire team in caring for all inpatients and consults on the general neurology service on the neurology floor, NICU and ER
- distributing patients and workload to your team
- ensuring that everyone is able to attend lectures, conferences and Grand Rounds
- ensuring that daily Morning Report and work rounds start and end on time.
- preparing your team to sign out to the night-call resident at 5pm on the weekends
- help attending field all requests for admission to the neurology service, including hospital to hospital transfers
- selecting cases to present at Grand Rounds, and preparing/supervising presentations
- preparing students, rotators, interns and junior residents in their case presentations to the attending physician.
- completing student evaluations daily, both formative and summative, for each student (student has formative feedback form and summative evaluation is sent daily in your email).

**Goals and Objectives:**

**Patient Care**

- You should consistently demonstrate the abilities achieved in the PGY-2 year to obtain accurate histories, perform accurate neurological examinations, localize lesions, and plan for effective diagnosis, management and rehabilitation.

- You should demonstrate proficiency in the neurological examination, and in the performance of routine neurological procedures such as lumbar punctures, operating EEG long term monitoring equipment, assessing brain death, checking for the integrity of implanted devices such as baclofen pumps, deep brain stimulation and vagal nerve stimulation.

- You should demonstrate proficiency in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the inpatient setting, at the level of a junior attending.

- You should demonstrate proficiency in the care and management of patients with neurological emergencies such as acute strokes (including intravenous TPA administration and other interventional procedures), status epilepticus (including placing a patient on burst suppression), brain herniation, spinal cord compression, neuroleptic malignant syndrome, and respiratory decompensation from myasthenia gravis and Guillain Barre syndrome.

- You should demonstrate proficiency in assessing the rehabilitation potential for each patient, and to make appropriate plans for rehabilitation, both during the hospital stay, and after discharge.

**Medical Knowledge**

- You should demonstrate basic knowledge acquired during the PGY-2 year about major neurological diseases that require inpatient care, and about specific neurological situations that require urgent or emergent responses

- You should demonstrate in-depth understanding of common and uncommon/rare neurological disorders, including basic mechanisms of disease, neuropathology, and current methods of diagnosis and treatment.

**Practice-based Learning**

- You should demonstrate proficiency in utilizing computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.

- You should demonstrate proficiency in reviewing your own practice to guide learning.

- You should demonstrate the proficiency to extract information and salient features from the history, examination, and caregiver and paramedical personnel interview, and organize them to base your differential diagnosis and management.

- You should be able to use the review of your own practice to guide learning.

**Interpersonal and communication skills**

- You should demonstrate effective communication with patients, families in the inpatient setting.

- You should demonstrate effective communication with fellow residents, attending physicians, and other health care professionals; help junior residents to improve their communication skills.
• You should demonstrate team-work: Supervise and teach neurology Junior residents, and residents from other services. You should take a leading role in student teaching; ensure that ward responsibilities are effectively shared among rotating residents.

Professionalism
• You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
• You should demonstrate proficiency in discussing ethical issues of patient care with junior residents and students, and raise these issues on attending rounds. Be prepared to use selected ethical problems encountered on the ward as a focus for discussion in conferences devoted to ethical issues.
• You should make sure that your team is on time and prepared for Morning Report and daily work rounds.
• You should ensure that all your dictations are complete, accurate and on time.

Systems-based practice
• You should now always demonstrate awareness and careful consideration of the costs of the resources needed to care for your patients.
• You should demonstrate the ability to lead your team, work with social services to plan for the care of patients after discharge; You should be very familiar with the resources available in the patient’s community to promote the patient’s health. You should make junior residents aware of these issues and resources.
• You should demonstrate proficiency in utilizing resources in the hospital and in the community to foster the best quality care for all patients, including the poor and the uninsured.
• You should demonstrate the ability to suggest specific ways to improve the practice of neurology at your institution.
• You should demonstrate how to use what you have learned to plan your own practice of neurology after residency.

Suggested Textbooks/Reading Materials:
• The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Widjicks ($108)
• Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)
• Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)
• Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)
• Emergency Neurology: Principles and Practice 2007 by John Wigenstein et al. ($83.60)
• AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

3. Shands Stroke Junior

Description:
You will be expected to gain experience caring for patients on the stroke service, including stroke alerts and stroke consultations from the Emergency Department and Hospital Services, neurology in-patients, and neurology intensive care unit (NICU) service, and you will assist the attending physician and provide leadership in supervising students and rotating residents. You will also evaluate, treat, and make dispositions on patients in the Emergency Room. You are expected to fully evaluate each patient before conferring with the attending physician. Based on your evaluation, you should be able to comment upon localization and differential diagnosis, and you should have a plan for evaluation and treatment. You must confer with the attending prior to making important decisions in the management of cases; but you should not expect that the attending will do your thinking for you. The socio-economic and emotional aspects of patient care are to be addressed, and you will be conferring with the social worker to make appropriate plans for your patients. The rehabilitation of every patient begins with admission, and you will be involved in the planning and execution of rehabilitation efforts in every patient.

Your day starts with Morning Report from 7:45 to 8:15am daily, held in the conference room on 82. The overnight resident presents all admissions to the general team. A concise but comprehensive presentation is given to the team on each patient admitted. The case, including differentials, diagnosis and management are discussed within the time allotted. Immediately following Morning Report, the stroke teaching rounds follow. All resident-assigned new and old patients seen in consultation and admitted to the Stroke service in the regular floors and the NICU are seen and the day’s management are discussed and carried out.
The daily teaching rounds should end by 11:30 am. The rest of your day should be spent admitting new patients and seeing new consultations, discharging old patients, and attending all conferences during the day. You should prepare to sign out to the short-call resident at 5 pm every day on the weekdays.

As the Junior resident in this rotation, you may be assigned by your Senior resident to assess patients in the emergency room (ER) as promptly as possible, especially stroke alerts where time is of the essence.

As a resident educator, you are also responsible for preparing students, rotators (anesthesia, neurosurgery and psychiatry interns, and internal medicine and family medicine rotators) in presenting their cases to the attending physician.

You are responsible for signing out your patients in an efficient but effective manner at the end of your day, 5 pm. You will also take short call several days of the week, in which case you will receive sign out from your colleagues on the Shands service starting at 5 pm, and be responsible for all service patients, whether ward, consult, or ED, until you sign them out to the nightfloat at 8 pm. You will be responsible for seeing new ED and inpatient consults during short call.

During the weekend there will be times when you are called upon to cover the dayshift where you will be responsible for all neurology patients on the Shands service and in the ED, as well as new ED consults. These shifts are from 8 am to either 5 pm or 8 pm, depending whether you are on short call, when you will be relieved by the overnight resident or nightfloat. Sign out responsibilities are the same as during short call.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate proficiency in obtaining a complete and accurate neurological history and perform a complete neurological examination.
- You should be able to perform technical skills for neurological procedures such as lumbar puncture, assessment of brain death, operating EEG long term monitoring equipment.
- You should begin to demonstrate knowledge in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the inpatient setting.
- You should effectively carry out the management plans for all your patients in an organized and efficient manner.
- You should be able to adequately carry out the management of neurological emergencies such as acute stroke, status epilepticus, spinal cord compression, brain herniation, respiratory decompensation, etc. under the supervision of your Senior resident or attending neurologist.
- You should demonstrate awareness in assessing the rehabilitation potential for each patient, and to make appropriate plans for rehabilitation, both during the hospital stay, and after discharge.

**Medical Knowledge**

- You should demonstrate knowledge about major neurological diseases that require inpatient care, including stroke, seizures, CNS infections, coma, dementia, common movement disorders, myelopathy, neuromuscular disorders, and specific neurological situations that require urgent or emergent responses.
- You should demonstrate ability to localize disease in the nervous system, and formulate a complete differential diagnosis.

**Practice-based Learning**

- You should demonstrate ability to use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning.
- You should demonstrate the ability to extract information and salient features from the history, examination, and caregiver and paramedical personnel interview, and organize them to base your differential diagnosis and management.
- You should demonstrate the ability to use the review of your own practice to guide your own learning objectives.

**Interpersonal and communication skills**

- You should demonstrate the ability to communicate effectively with patients, families in the inpatient setting.
- You should demonstrate the ability to efficiently and effectively present information about your patients to your Senior resident, attending physicians, and other health care professionals.
You should demonstrate the ability to participate with other members of the health care team (nurses, physical and occupational therapists, speech therapists, social workers and others) to promote the best care for your patients (team-work).

**Professionalism**
- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the management of your patients.
- You should be on time and prepared for Morning Report and daily work rounds.
- Most importantly, you should do all documentation—admission notes and discharges comprehensively and in a timely manner.

**Systems-based practice**
- You should demonstrate consideration the costs of medical care, and learn about resources available to cover these costs.
- You should demonstrate the ability to work with social services to plan for the care of patients after discharge; about resources available in the patient’s community to promote the patient’s health.
- You should demonstrate the ability to consider and discuss ways to improve the practice of neurology at your institution.

**Suggested Textbooks/Reading Materials:**
- Localization in Neurology 2006 by Paul Brazis and Joseph Masdeu ($143.20)
- Technique of the Neurological Examination 2003 by William DeMyer ($64.76)
- The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Wijdicks ($108)
- Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)
- Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)
- Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)
- AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

4. Shands Stroke Senior

**Description:**
As the Senior in the stroke service, you are expected to act as the Junior Attending and you will play a supervisory role in addition to caring for patients on the neurology stroke service, neurology intensive care unit (NICU) service, and the Emergency Room. You will be assisted in this role by the Stroke fellow when one is rotating on the service. Your team will usually be comprised of 1 Junior Resident, 1 Neurosurgery and/or Anesthesiology Intern, 1-2 medical students and other rotators. As the team leader, you are expected to assist the attending physician in supervising students and rotators. You are expected to fully evaluate each patient seen by your team before conferring with the attending physician. You also have the responsibility of distributing patients and workload to your team, making sure that everyone is able to attend lectures, conferences and Grand Rounds, and ensuring that daily Morning Report and teaching rounds start and end on time.

Your day usually starts before 8am as the Senior resident to familiarize yourself with the events from last night, update the patient census and prepare the team for Morning Report. Daily Morning Report is held from 7:45 to 8:15 held in the conference room on 82, followed by work rounds with the attending which should last no longer than 3 hours, and preferably 2 hours. It is your responsibility to ensure that Morning Report and work rounds are organized and start and end on time. The rest of your day should be spent personally admitting new patients, discharging old patients, or supervising your team members, and attending all conferences during the day. You should prepare your team to sign out to the night-call resident at 5pm every day on the weekends.

Your team is also responsible for all stroke neurology consultations from the Emergency Room (ER). You should confer each case seen in the ER with your attending physician.

As the Senior on service, you will also field requests for admission to the stroke service in conjunction with the attending, including hospital to hospital transfers. You may not accept patients from emergency departments in other hospitals. Requests to transfer patients from outside emergency rooms must be referred to our Emergency Department.
You are also responsible for helping to select cases to present at Neurology Grand Rounds, and prepare presentations.

As a resident educator, you are also responsible for preparing students, rotators (anesthesia, neurosurgery and psychiatry interns, and internal medicine and family medicine rotators) to present to the attending physician. You are expected to provide third year medical students on their clerkship with daily formative feedback and to reply to the daily summative evaluations sent you via email.

You are responsible for signing out your patients in an efficient but effective manner at the end of your day, 5 pm. You will also take short call once or twice a week, in which case you will receive sign out from your colleagues on the Shands services starting at 5 pm, and be responsible for all Shands neurology patients, whether ward, consult, or ED, until you sign them out to the nightfloat at 8 pm. You will be responsible for seeing new ED and inpatient consults during short call.

During the weekend there will be times when you are called upon to cover the dayshift where you will be responsible for all neurology patients on the Shands stroke service and in the ED, as well as new ED consults. These shifts are from 8 am to either 5 pm or 8 pm, depending on whether you are on short call that weekend, when you will be relieved by the overnight resident or nightfloat. Sign out responsibilities are the same as during short call.

Therefore, in summary, as the Senior resident your main administrative responsibilities include:

- supervising the entire team in caring for all in-patients and consults on the stroke neurology service on the neurology floor, NICU and ER
- distributing patients and workload to your team
- ensuring that everyone is able to attend lectures, conferences and Grand Rounds
- ensuring that daily Morning Report and work rounds start and end on time.
- preparing your team to sign out to the night-call resident at 5pm on the weekends
- help attending field all requests for admission to the neurology service, including hospital to hospital transfers
- selecting cases to present at Grand Rounds, and preparing/supervising presentations
- preparing students, rotators, interns and junior residents in their case presentations to the attending physician.
- completing student evaluations daily, both formative and summative, for each student (student has formative feedback form and summative evaluation is sent daily in your email).

**Goals and Objectives:**

**Patient Care**

- You should consistently demonstrate the abilities achieved in the PGY-2 year to obtain accurate histories, perform accurate neurological examinations, localize lesions, and plan for effective diagnosis, management and rehabilitation.
- You should demonstrate proficiency in the neurological examination, and in the performance of routine neurological procedures such as lumbar punctures, operating EEG long term monitoring equipment, assessing brain death.
- You should demonstrate proficiency in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the inpatient setting, at the level of a junior attending.
- You should demonstrate proficiency in the care and management of patients with neurological emergencies such as acute strokes (including intravenous TPA administration and other interventional procedures), status epilepticus (including placing a patient on burst suppression), brain herniation.
- You should demonstrate proficiency in assessing the rehabilitation potential for each patient, and to make appropriate plans for rehabilitation, both during the hospital stay, and after discharge.

**Medical Knowledge**

- You should demonstrate basic knowledge acquired during the PGY-2 year about major stroke types that require inpatient care, and about specific neurovascular situations that require urgent or emergent responses
- You should demonstrate in-depth understanding of common and uncommon/rare stroke disorders, including basic mechanisms of disease, neuropathology, and current methods of diagnosis and treatment.

**Practice-based Learning**

- You should demonstrate proficiency in utilizing computerized and non-computerized information systems to facilitate patient care
and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.

- You should demonstrate proficiency in reviewing your own practice to guide learning.

- You should demonstrate the proficiency to extract information and salient features from the history, examination, and caregiver and paramedical personnel interview, and organize them to base your differential diagnosis and management.

- You should be able to use the review of your own practice to guide learning.

**Interpersonal and communication skills**

- You should demonstrate effective communication with patients, families in the inpatient setting.

- You should demonstrate effective communication with fellow residents, attending physicians, and other health care professionals; help junior residents to improve their communication skills.

- You should demonstrate team-work: Supervise and teach neurology Junior residents, and residents from other services. You should take a leading role in student teaching; ensure that ward responsibilities are effectively shared among rotating residents.

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

- You should demonstrate proficiency in discussing ethical issues of patient care with junior residents and students, and raise these issues on attending rounds. Be prepared to use selected ethical problems encountered on the ward as a focus for discussion in conferences devoted to ethical issues.

- You should make sure that your team is on time and prepared for Morning Report and daily work rounds.

- You should ensure that all your dictations are complete, accurate and on time.

**Systems-based practice**

- You should now always demonstrate awareness and careful consideration of the costs of the resources needed to care for your patients.

- You should demonstrate the ability to lead your team, work with social services to plan for the care of patients after discharge; You should be very familiar with the resources available in the patient’s community to promote the patient’s health. You should make junior residents aware of these issues and resources.

- You should demonstrate proficiency in utilizing resources in the hospital and in the community to foster the best quality care for all patients, including the poor and the uninsured.

- You should demonstrate the ability to suggest specific ways to improve the practice of stroke neurology at your institution.

**Suggested Textbooks/Reading Materials:**

- The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Widjicks ($108)

- Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)

- Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)

- Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)

- Emergency Neurology: Principles and Practice 2007 by John Wigenstein et al. ($83.60)

- AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

5. **VA In-patient/Consult Junior**

**Description:**

You will be expected to gain experience caring for patients on the neurology in-patient and consult service, and you will assist the attending physician in supervising students and rotating residents. You will also evaluate, treat, and make dispositions on patients in the Emergency Room. You are expected to fully evaluate each patient before conferring with the attending physician. Based on your evaluation, you should be able to comment upon localization and differential diagnosis, and you should have a plan for evaluation and treatment. You must confer with the attending prior to making important decisions in the management of cases; but you should not expect that the attending will do your thinking for you.
The socio-economic and emotional aspects of patient care are to be addressed, and you will be conferring with the social worker to make appropriate plans for your patients. The rehabilitation of every patient begins with admission, and you will be involved in the planning and execution of rehabilitation efforts in every patient.

Your day starts by doing your “pre rounds” from 8:00 to 9:00 am daily (except Thursdays), prior to Morning Report. Daily Morning Report is held at the VA Neurology Team Room from 9:00 to 9:30am. The post-call resident presents all admissions and consults to the neurology team. A concise but comprehensive presentation is given to the team on each patient admitted. The case, including differentials, diagnosis and management are discussed within the time allotted. Except on Thursdays, immediately following Morning Report, the in-patient and consult work rounds follow (work rounds on Thursdays occur in the afternoon after Neuro 1 clinic). The management of all new and old inpatients and consultations patients are discussed. The daily work rounds should not last longer than 3 hours. The rest of your day should be spent admitting new patients, discharging old patients, and attending all conferences during the day. As the Junior resident in this rotation, you may be assigned by your Senior resident to assess patients in the Emergency Room (ER) as promptly as possible.

You are responsible for entering each in-patient and consults seen on the in-patient admissions/consultation log in the Departmental offices.

As a resident educator, you are also responsible for preparing students, rotators in presenting their cases to the attending physician. At the end of each their rotation, each resident must complete their respective evaluation form and return it to the Neurology Office.

You are responsible for signing out your patients in an efficient but effective manner at the end of your day, 5 pm. You will also take short call several times a week, in which case you will receive sign out from your colleagues on the VA inpatient/consult service starting at 5 pm, and be responsible for all VA neurology patients, whether ward, consult, or ED, until you sign them out to the nightfloat at 8 pm. When the workload is light, this short call may be taken from home if you can be back at the VAMC within 15-20 minutes of being called. You will be responsible for seeing new ED and inpatient consults during short call.

During the weekend there will be times when you are called upon to cover the dayshift where you will be responsible for all neurology patients on the VA ward service and in the ED, as well as new Shands consults. These shifts are from 8 am to 8 pm, when you will be relieved by the overnight resident or nightfloat. When the workload is light, this short call may be taken from home if you can be back at the VAMC within 15-20 minutes of being called. Sign out responsibilities are the same as during short call.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate proficiency in obtaining a complete and accurate neurological history and perform a complete neurological examination
- You should be able to perform technical skills for neurological procedures such as lumbar puncture, assessment of brain death, operating EEG long term monitoring equipment.
- You should begin to demonstrate knowledge in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the VAMC inpatient setting.
- You should effectively carry out the management plans for all your patients in an organized and efficient manner.
- You should be able to adequately carry out the management of neurological emergencies such as acute stroke, status epilepticus, spinal cord compression, brain herniation, respiratory decompensation, etc under the supervision of your Senior resident or attending neurologist.
- You should demonstrate awareness in assessing the rehabilitation potential for each patient, and to make appropriate plans for rehabilitation, both during the hospital stay, and after discharge.

**Medical Knowledge**

- You should demonstrate knowledge about major neurological diseases affecting veterans that require inpatient care, including stroke, seizures, CNS infections, coma, dementia, common movement disorders, myelopathy, neuromuscular disorders, and specific neurological situations that require urgent or emergent responses.
You should demonstrate ability to localize disease in the nervous system, and formulate a complete differential diagnosis.

You should demonstrate knowledge about major neurological diseases that affect medical, surgical veteran patients.

**Practice-based Learning**
- You should demonstrate ability to use computerized and non-computerized information systems available at the veterans hospital to facilitate veterans care and to facilitate the development of techniques for life long learning.
- You should demonstrate the ability to extract information and salient features from the history, examination, and caregiver and paramedical personnel interview, and organize them to base your differential diagnosis and management.
- You should be able to use the review of your own practice to guide learning

**Interpersonal and communication skills**
- You should demonstrate the ability to communicate effectively with your veteran patients and their families in the inpatient setting.
- You should demonstrate the ability to efficiently and effectively present information about your veteran patients to fellow residents, attending physicians, and other health care professionals.
- You should demonstrate the ability to participate with other members of the veteran health care team (nurses, physical and occupational therapists, speech therapists, social workers and others) to promote the best care for your veteran patients (team-work).

**Professionalism**
- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the management of your patients.
- You should make sure you are on time and prepared for Morning Report and daily work rounds.
- Most importantly, you should do all dictations—admission notes and discharges comprehensively and in a timely manner.

**Systems-based practice**
- You should demonstrate consideration the costs of medical care, and learn about resources available to all veterans to cover these costs.
- You should demonstrate the ability to work with social services, allied health professionals and the Veterans Health Care system to plan for the care of veterans after discharge; and know about the resources available in the community to promote the veteran’s health.
- You should demonstrate the ability to consider and discuss ways to improve the practice of neurology at the VAMC.

**Suggested Textbooks/Reading Materials:**
- Localization in Neurology 2006 by Paul Brazis and Joseph Masdeu ($143.20)
- Technique of the Neurological Examination 2003 by William DeMyer ($64.76)
- The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Widjicks ($108)
- Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)
- Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)
- Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)
- AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

**6. VA In-patient/Consult Senior**

**Description:**
As the Senior in the in-patient and consult service, you are expected to act as the Junior Attending and you will play a supervisory role in addition to caring for patients on the neurology in-patient, consult services, and the Emergency Room. Your team will usually be comprised of 1 Junior Resident, 1 medical student and other rotators. As the team leader, you are expected to assist the attending physician in supervising students and rotators. You are expected to fully evaluate each veteran patient seen by your team before conferring with the attending physician. You also have the responsibility of distributing patients and
Information for Neurology Residents

workload to your team, making sure that everyone is able to attend lectures, conferences and Grand Rounds, and ensuring that daily Morning Report and work rounds start and end on time.

Your day starts at 8am as the Senior resident to familiarize yourself with the events from last night, update the in-patient and consult census and prepare the team for Morning Report. Daily Morning Report is held from 9:00 to 9:30 am (except Thursdays from 8:00 to 8:30) at the Neurology Team Room, followed by work rounds with the attending which should last no longer than 3 hours. On Thursdays, work rounds are held in the afternoon after Neuro I clinic. It is your responsibility to ensure that Morning Report and work rounds are organized and start and end on time. The rest of your day should be spent personally admitting new patients, discharging old patients, or supervising your team members, and attending all conferences during the day. You should prepare your team to sign out to the night-call resident at 5pm every day on the weekends.

Your team is also responsible for all neurology consultations from other services and the Emergency Room (ER), including the prompt assessment of all stroke patients and the administration of tPA. You should confer each case seen in the ER with your attending physician. As the Senior on service, you will also field all requests for admission to the neurology service, including hospital to hospital transfers from other Veterans Hospitals.

You are also responsible for selecting cases to present at Neurology Grand Rounds, and in preparing for the presentation.

As a resident educator, you are also responsible for preparing students, rotators, interns and junior residents in their case presentations to the attending physician. Therefore, in summary, as the Senior resident your main administrative responsibilities include:

- supervising the entire team in caring for all in-patients and consults
- distributing veteran patients and workload to your team
- ensuring that everyone is able to attend lectures, conferences and Grand Rounds
- ensuring that daily Morning Report and work rounds start and end on time.
- preparing your team to sign out to the night-call resident at 5pm on the weekends
- fielding all requests for admission to the neurology service, including hospital to hospital transfers from other Veteran Hospitals
- ensuring that each in-patient admission and consultation is entered in the admission log
- selecting cases to present at Grand Rounds, and preparing/supervising presentations
- preparing students, rotators, interns and junior residents in their case presentations to the attending physician.
- completing a student evaluation form for each student and rotator and returning it to the Neurology Office

**Goals and Objectives: **

**Patient Care**

- You should consistently demonstrate the abilities achieved in the PGY-2 year to obtain accurate histories, perform accurate neurological examinations, localize lesions, and plan for effective diagnosis, management and rehabilitation.
- You should demonstrate proficiency in the neurological examination, and in the performance of routine neurological procedures such as lumbar punctures, operating EEG long term monitoring equipment, assessing brain death, checking for the integrity of implanted devices such as baclofen pumps, deep brain stimulation and vagal nerve stimulation.
- You should demonstrate proficiency in
creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the inpatient setting at the level of a junior attending.

- You should demonstrate proficiency in the care and management of patients with neurological emergencies such as acute strokes (including intravenous TPA administration and other interventional procedures), status epilepticus (including placing a patient on burst suppression), brain herniation, spinal cord compression, neuroleptic malignant syndrome, and respiratory decompensation from myasthenia gravis and Guillain Barre syndrome.

- You should demonstrate proficiency in assessing the rehabilitation potential for each patient, and to make appropriate plans for rehabilitation, both during the hospital stay, and after discharge.

**Medical Knowledge**

- You should demonstrate basic knowledge acquired during the PGY-2 year about major neurological diseases that require inpatient care, and about specific neurological situations that require urgent or emergent responses.

- You should demonstrate in-depth understanding of important neurological disorders, including basic mechanisms of disease, neuropathology, and current methods of diagnosis and treatment.

- You should demonstrate knowledge about major neurological diseases that affect medical, surgical veteran patients in the hospital.

**Practice-based Learning**

- You should demonstrate proficiency in using computerized and non-computerized information systems at the Veterans Health Care system to facilitate veteran care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.

- You should demonstrate proficiency in extracting information and salient features from the history and examination of your veteran patient, and their caregivers upon which to base your differential diagnosis and management.

- You should be able to use the review of your own practice to guide learning

**Interpersonal and communication skills**

- You should demonstrate effective communication with veteran patients and their families in the inpatient setting.

- You should demonstrate effective communication with fellow residents, attending physicians, and other Veteran Health Care professionals; help Junior residents to improve their communication skills.

- You should demonstrate team-work: Supervise and teach PGY-2 residents, and residents from other services. You should take a leading role in student teaching; ensure that ward responsibilities are effectively shared among rotating residents.

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards veteran patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

- You should demonstrate the ability to discuss ethical issues of patient care with junior residents and students, and raise these issues on attending rounds. Be prepared to use selected ethical problems encountered on the ward as a focus for discussion in conferences devoted to ethical issues.

- You should make sure that your team is on time and prepared for Morning Report and daily work rounds.

- You should ensure that all your dictations are complete, accurate and on time.

**Systems-based practice**

- You should now always demonstrate awareness and careful consideration of the costs of the resources needed to care for your veteran patients.

- You should demonstrate the ability to lead your team, work with social services to plan for the care of patients after discharge. You should be very familiar with the resources available to the veteran community to promote your patient’s health. You should make junior residents aware of these issues and resources.

- You should demonstrate how to use what you have learned from caring for veterans in the Veteran Health Care system to plan your own practice of neurology after residency.
• You should demonstrate the ability to suggest specific ways to improve the practice of neurology at the VAMC.

**Suggested Textbooks/Reading Materials:**

• The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Widjicks ($108)
• Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)
• Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)
• Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)
• Emergency Neurology: Principles and Practice 2007 by John Wigenstein et al. ($83.60)

7. **Nightfloat Rotation - Shands**

*Description:*

You will be expected to gain experience in the solo practice of neurology during the nightfloat rotation. As the sole overnight coverage, Shands, and all late calls from Shands patients you will develop your independence as a practicing neurologist, learn to assess and triage cases in the inpatient setting. You will evaluate, treat, and make dispositions on patients in the Emergency Department as well as inpatient consultations from other services. You will be able to localize neurological complaints, determine acuity of problem, derive appropriate differential diagnoses, establish an appropriate course of evaluation, again making decisions as to level of urgency for said evaluation. You will determine appropriate management and treatment for all levels of neurology care from urgent care, brief emergency visit, inpatient, and neurointensive care patients. You will be responsible for directing care overnight on neurology ward patients in the unit and on the floor.

Nightfloat is in two week blocks of six days (Monday night to Saturday night) on from 8 pm to 8 am, and time off between from Sunday morning until Monday night. As nightfloat, you are expected to take report from the Short Call residents covering Shands and answer all calls to neurology overnight. At 8 am you attend Morning Report where you are expected to present cases from overnight and give updates on patients being followed by neurology.

You will start rotating through Nightfloat in your PGY2 year. At this stage in your training you will be expected to gather an initial H&P, provide evaluation and management plans for common neurological complaints, and identify patients in neurological emergencies and initiate immediate treatment. You will always have the inpatient attendings on Shands and the VA available via phone at any time to review your cases and give further education and advice. At need, attendings may come into the hospital to assist in your work-up and management for particularly challenging cases.

**Goals and Objectives:**

*Patient Care*

• You should demonstrate proficiency in obtaining a complete and accurate neurological history and perform a complete neurological examination.

• You should be able to perform technical skills for neurological procedures such as lumbar puncture, assessment of brain death, operating EEG long term monitoring equipment.

• You should begin to demonstrate knowledge in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the inpatient setting.

• You should effectively carry out the management plans for all your patients in an organized and efficient manner.

• You should be able to adequately carry out the management of neurological emergencies such as acute stroke, status epilepticus, spinal cord compression, brain herniation, respiratory decompensation, etc under the supervision of your attending neurologist.

*Medical Knowledge*

• You should demonstrate knowledge about major neurological diseases affecting veterans that require inpatient care, including stroke, seizures, CNS infections, coma, dementia, common movement disorders, myelopathy, neuromuscular disorders, and specific neurological situations that require urgent or emergent responses.
• You should demonstrate ability to localize disease in the nervous system, and formulate a complete differential diagnosis.

• You should demonstrate knowledge about major neurological diseases that affect medical, surgical patients.

**Practice-based Learning**

• You should demonstrate ability to use computerized and non-computerized information systems available at the hospital to facilitate patient care and to facilitate the development of techniques for life long learning.

• You should demonstrate the ability to extract information and salient features from the history, examination, and caregiver and paramedical personnel interview, and organize them to base your differential diagnosis and management.

• You should be able to use the review of your own practice to guide learning

**Interpersonal and communication skills**

• You should demonstrate the ability to communicate effectively with your patients and their families in the inpatient setting.

• You should demonstrate the ability to efficiently and effectively present information about your patients to fellow residents, attending physicians, and other health care professionals.

**Professionalism**

• You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

• You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the management of your patients.

• You should make sure you are on time and prepared for Sign Out rounds and at the end of your nightfloat shift, Morning Report.

• Most importantly, you should do all dictations—admission notes and discharges comprehensively and in a timely manner.

**Systems-based practice**

• You should demonstrate consideration the costs of medical care, and learn about resources available to all patients to cover these costs.

• You should demonstrate the ability to consider and discuss ways to improve the practice of neurology overnight in the inpatient setting.

**Suggested Textbooks/Reading Materials:**

• Localization in Neurology 2006 by Paul Brazis and Joseph Masdeu ($143.20)

• Technique of the Neurological Examination 2003 by William DeMyer ($64.76)

• The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Widjicks ($108)

• Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)

• Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)

• Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)

• AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

8. Nightfloat Rotation - VAMC

**Description:**

You will be expected to gain experience in the solo practice of neurology during the nightfloat rotation. As the sole overnight coverage for the VAMC, and all late calls from patients you will develop your independence as a practicing neurologist, learn to assess and triage cases in the inpatient setting. You will evaluate, treat, and make dispositions on patients in the Emergency Department as well as inpatient consultations from other services. You will be able to localize neurological complaints, determine acuity of problem, derive appropriate differential diagnoses, establish an appropriate course of evaluation, again making decisions as to level of urgency for said evaluation. You will determine appropriate management and treatment for all levels of neurology care from urgent care, brief emergency visit, inpatient, and neurointensive care patients. You will be responsible for directing care overnight on neurology ward patients in the unit and on the floor.

Nightfloat is in two week blocks of six days (Sunday night to Friday night) on from 8 pm to 8 am, and time off between from Saturday morning until Sunday night. As nightfloat, you are expected to take report from the Short Call
Residents covering VAMC and answer all calls to VAMC neurology overnight. At 8 am you attend Morning Report where you are expected to present cases from overnight and give updates on patients being followed by neurology.

You will start to rotate through nightfloat in your PGY3 year. At this point in your training it is anticipated that you will be able to independently assess neurology complaints for acuity and urgency, localize the neurologic complaint, develop well crafted differential diagnoses, and order and prioritize evaluation and initial management. While some of the more esoteric or complex diagnoses may still require mentorship, you should be able to identify the categories of problem in even these cases. While attendings at the VA remain available overnight via telephone for mentorship and back-up, it is anticipated that at this level of training this will be more of a formality rather than a necessity in all but the most vexing of cases.

Your last rotation on nightfloat will be in of your PGY4 year. By this point in your training it is anticipated that you are essentially practicing at the level of an independent neurologist. You have mastered localization, development of differential diagnosis, and evaluation and management of neurology patients. You should only need to call for attending assistance for multiple simultaneous emergencies requiring back-up. The rotation at this point should show that you are able to balance the many demands of independent solo neurological practice and can efficiently pass on information during transfer of care during Morning Report, when you should be leading the discussion of the academic points of the cases seen overnight.

Goals and Objectives:

Patient Care

• You should demonstrate proficiency in obtaining a complete and accurate neurological history and perform a complete neurological examination
• You should be able to perform technical skills for neurological procedures such as lumbar puncture, assessment of brain death, operating EEG long term monitoring equipment.
• You should begin to demonstrate knowledge in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies

Medical Knowledge

• You should demonstrate knowledge about major neurological diseases affecting veterans that require inpatient care, including stroke, seizures, CNS infections, coma, dementia, common movement disorders, myelopathy, neuromuscular disorders, and specific neurological situations that require urgent or emergent responses.
• You should demonstrate ability to localize disease in the nervous system, and formulate a complete differential diagnosis.
• You should demonstrate knowledge about major neurological diseases that affect medical, surgical patients.

Practice-based Learning

• You should demonstrate ability to use computerized and non-computerized information systems available at the hospital to facilitate patient care and to facilitate the development of techniques for life long learning.
• You should demonstrate the ability to extract information and salient features from the history, examination, and caregiver and paramedical personnel interview, and organize them to base your differential diagnosis and management.
• You should be able to use the review of your own practice to guide learning

Interpersonal and communication skills

• You should demonstrate the ability to communicate effectively with your patients and their families in the inpatient setting.
• You should demonstrate the ability to efficiently and effectively present information about your patients to fellow residents, attending physicians, and other health care professionals.

Professionalism
You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the management of your patients.

You should make sure you are on time and prepared for Sign Out rounds and at the end of your nightfloat shift, Morning Report.

Most importantly, you should do all dictations—admission notes and discharges comprehensively and in a timely manner.

**Systems-based practice**

You should demonstrate consideration the costs of medical care, and learn about resources available to all patients to cover these costs.

You should demonstrate the ability to consider and discuss ways to improve the practice of neurology overnight in the inpatient setting.

**Suggested Textbooks/Reading Materials:**

- Localization in Neurology 2006 by Paul Brazis and Joseph Masdeu ($143.20)
- Technique of the Neurological Examination 2003 by William DeMyer ($64.76)
- The Clinical Practice of Critical Care Neurology 2003 by Eelco F. M. Widjicks ($108)
- Textbook of Clinical Neurology 2007 by Christopher Goetz ($143.20)
- Adams and Victor’s Principles of Neurology 8th Edition 2005 ($111.75)
- Neurology in Clinical Practice e-dition: Text with continuously updated online reference, 2-volume set, 2007 by Walter Bradley, Robert Daroff et al. ($434.59)
- AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

9. **Pediatric Neurology Rotation**

**Description:**

You will do a total of 3 months of Pediatric Neurology during your residency. While on Pediatric Neurology you will make rounds on pediatric neurology in-patients and attend to pediatric neurology general and specialty clinics. You will admit selected patients to the service. A pediatric resident will have the responsibility of working up each patient, and writing orders. You will function more as a consultant or advisor. You will attend the pediatric neurology clinics every morning. You are expected to attend the Pediatric Neurology morning report on Mondays at 7:30am. You also expected to prepare and deliver one pediatric neurology lecture topic for pediatric interns, residents, and medical students. The following are your responsibilities while in this rotation:

1. You will be directly involved in the management of patients on the inpatient service. This includes:
   a. interviewing and examining every new admission/consult.
   b. composing an abbreviated admission note on your patients.
   c. reviewing, guiding and teaching the interns in their performance of a complete and accurate admission history and physical on every patient.
   d. leading work rounds with the intern and students.
   e. assuring that the team is prepared for rounds with the attending daily.
   f. personally reviewing all CT and MRI scans and other diagnostic tests of your patients admitted to the service and patients seen in consultation.

2. You must write a progress note on all your patients. Notes must be in "SOAP"-note format and must be written *in addition to* a medical student note.

3. You must review all student and pediatric intern notes for accuracy and correct/amend them if necessary. You are the primary teacher of the pediatric intern and students.

4. You will see consults in the ER or the general pediatric floors during daytime hours as directed by the pediatric neurology attending.

5. You will also be directly involved in the management of patients in the out-patient clinics.

**Goals & Objectives:**

**Patient Care**

- You should demonstrate the ability to obtain a history from a child’s family and, when appropriate, from the child.
Information for Neurology Residents

Page 35

- You should demonstrate the ability to distinguish those features of the neurological examination of the child from the neurological examination of the adult.
- You should be able to recognize when a child is normal or has a neuropathological condition.
- You should be able to recognize and manage neurological conditions that do not require a referral, and you should be able to initiate management of neurological conditions generally requiring referral.
- You should know the indications for neurological tests.
- You should know the uses, side effects, and mode of action of commonly used neurological drugs.

Medical Knowledge

- You should demonstrate knowledge of fetal development, and the susceptibility of the fetus to maternal disease, drugs, hypoxia, hyperbilirubinemia, and similar disorders.
- You should know the normal development of the infant and young child.
- You should demonstrate proficient knowledge of the common “bread and butter” problems of child neurology, including seizures, movement disorders, migraine, other headaches, developmental delay, sleep problems, and inflammatory conditions of the nervous system including meningitis, encephalitis, transverse myelitis, and Guillain-Barré syndrome.
- You should demonstrate adequate knowledge of less common problems, including leukoencephalopathies, progressive epilepsies, brain tumors, and muscular dystrophies. When appropriate, you should demonstrate the ability to review the genetic, molecular, and neuropathologic basis of the inherited neurological disorders of childhood.

Practice-based Learning

- You should be able to use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. You should be able to critically review the salient literature, and base treatment on the best medical evidence.
- You should demonstrate proficiency in extracting information and salient features from the history and examination of your pediatric patient, and their parents upon which to base your differential diagnosis and management.
- You should be able to use the review of your own practice to guide learning.

Interpersonal and communication skills

- You should demonstrate the ability to communicate with your patients’ families and with pediatric patients, when applicable.
- You should be able to communicate with clerks, secretaries, nursing staff, other residents, consulting residents and attendings, and neurology attending staff, and with referring physicians.
- You should demonstrate team-work skills, including the supervision of pediatric residents and students.

Professionalism

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate consideration of ethical issues that are germane to pediatric practice.
- You should be on time and prepared for weekly Morning Report and daily work rounds.
- You should ensure that all your dictations are complete, accurate and on time.

Systems-based practice

- You should demonstrate consideration of cost and appreciation of resources available to pediatric patients to cover the costs of medical care.
- You should demonstrate the ability to work with social services to plan for the care of patients after discharge; Learn about resources available in your patient’s community to promote your patient’s health.

Suggested Reading:

- Clinical Pediatric Neurology: A signs and symptoms approach 2005 by Gerald Fenichel ($92.00)
- Neurology of the Newborn 2008 by Joseph Volpe ($127)

10. Continuity Clinic Longitudinal Rotation

Description:
You will follow selected patients whom you have cared for on the wards, seen in consultation, or evaluated in the clinics, in a continuity clinic, held one half day each week, alternately at Shands or at the VA, regardless of your current block rotation/tour of duty with the exception of Nightfloat.

When you begin your residency, you will pick up patients from outgoing residents. In addition, you will also schedule all patients that you have seen in the in-patient who require out-patient follow-up in your return clinics. You may also schedule patients you have seen in the Emergency Room or on consults or some of the patients evaluated by rotating residents (e.g., neurosurgical residents on the VA ward service) that you have supervised. Remember, you need not follow these patients indefinitely. Discharge patients who do not require specialized neurological follow-up to the care of their primary physician. A dedicated attending is available during each of the resident continuity clinic days. Every patient must be staffed by the attending. It is necessary to learn how a disease process develops and to develop management strategies. This is something only learned from experience. But, just as importantly, once you have constructed an adequate treatment course and the patient will no longer benefit from your continued specialty care, you must also learn how to terminate follow-up. Do not hesitate to ask you attending for assistance. As a PGY 2, you are expected to see a patient every 60 minutes, as a PGY 3 every 45 minutes and as a PGY 4 every 30 minutes.

If you are unable to attend one of your return clinics because of vacation or unusual circumstances, you must cancel your clinic at least 60 days in advance. It places a considerable burden on secretarial staff to call patients and reschedule them, and it can be a major inconvenience to your patients. If you do cancel a clinic, be sure that patients are rescheduled on a timely basis. It may be necessary to schedule an extra clinic to avoid problems with patient care.

It is important that you follow patients at appropriate intervals. Since you will have a continuity clinic every other week at each institution, you should be able to accommodate most patients within an adequate time. If patients require more urgent evaluation, you can arrange to see them in clinic as “special patients” in one of the attending’s clinics. Emergent conditions can be referred to the Emergency Department, but you should continue to oversee the neurological care of these patients, or, if you cannot, at least remain informed about the patient’s condition and progress.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate the ability to obtain accurate histories, perform accurate neurological examinations, localize lesions, and plan for effective diagnosis, management and rehabilitation in patients with chronic neurological disorders.
- You should know the complications and course of neurologic illness, learn how to use medications and how to monitor and recognize side effects of medications; learn about the appropriate use of non-medication treatments and how and when to refer.
- You should be able to formulate an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the outpatient setting.
- You should be able to effectively carry out the out-patient management of common neurological disorders seen in the general neurology clinic.

**Medical Knowledge**

- You should demonstrate facility in discussing major neurological diseases that are managed in the out-patient setting, and mastery of current evidence from knowledge of the literature.
- You should demonstrate mastery in the understanding of common and adequate understanding of less common neurological disorders, including a thorough understanding of basic mechanisms of disease, neuropathology, and current methods of diagnosis and treatment.
- You should demonstrate proficiency in the diagnosis and management of neurological disorders seen in the general neurology clinics such as pain, headache, seizures, neuropathy, myasthenia gravis, Parkinson’s disease, Alzheimer’s disease, post-stroke, and multiple sclerosis.
- You should be familiar with common outpatient neurological procedures such as botulinum toxin injection, interrogation of devices such as deep brain stimulation and vagal nerve stimulation settings; and be fluent in the interpretation of EEG, evoked potentials, EMG, NCV, muscle biopsies, polysomnographies, neuropsychological reports, PET, SPECT, MRI and CT images.

**Practice-based Learning**
You should demonstrate the ability to use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for lifelong learning. You should be able to critically review the salient literature, and base treatment on the best medical evidence.

After your PGY-2 year, you should demonstrate the abilities similar to those of a junior attending physician to abstract from the history and examination the salient features upon which to base your differential diagnosis and management.

You should demonstrate the ability to use the review of your own practice to guide learning.

**Interpersonal and communication skills**

You should demonstrate effective communication with patients, families in the outpatient setting.

You should demonstrate effective communication with clinic staff (schedulers, nurses), and with patient’s referring physicians, other health professionals and health-related agencies to ensure proper delivery of care.

You should demonstrate the ability to orient, teach, and assist medical students, interns and other residents on their neurology out-patient rotation.

**Professionalism**

You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

You should demonstrate consideration of ethical issues.

You should ensure that all your dictations are complete, accurate and on time.

**Systems-based practice**

You should know when to refer and coordinate the care of your more complicated patients from your general neurology continuity clinic to subspecialty clinics such as Movement Disorders, Epilepsy, Behavioral Neurology, Multiple Sclerosis, Botulinum Toxin, and Neuromuscular clinics.

You should demonstrate knowledge of resources available in the patient’s community to promote the patient’s health.

You should demonstrate knowledge of Medicare billing and documentation requirements; about the variety of public and private insurance plans; and, about resources (or the lack of resources) for uninsured patients.

You should demonstrate the ability to use resources in the hospital and in the community to foster the best quality care for all patients, including the poor and the uninsured.

**Suggested Textbooks/Reading Materials:**

- Office Practice of Neurology 2003 by Martin Samuels and Steve Feske ($219)
- Differential Diagnosis in Neurology 2006 by Robert Schwartzman ($169)
- AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

**11. VA Neuro I Longitudinal Clinic Rotation**

**Description**

This is a weekly “new” clinic for veterans held every Thursday mornings from 8:00 to early afternoon. You must attend VA Neuro 1 clinic throughout your three years of residency regardless of your rotation/tour of duty except when you are on service at Shands or on Pediatric Neurology rotation. A neurology attending is always available for consultation. If you are unable to attend one of your return clinics because of vacation or unusual circumstances, you must cancel your clinic at least 60 days in advance. It places a considerable burden on secretarial staff to call veterans and reschedule them, and it can be a major inconvenience to your veteran patients.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate the ability to obtain accurate histories, perform accurate neurological examinations on your veteran patients, localize lesions, and plan for effective diagnosis, management and rehabilitation in patients with chronic neurological disorders.

- You should know the complications and course of neurologic illness, learn how to use medications and how to monitor and recognize side effects of medications; learn about the appropriate use of non-medication treatments and how and when to refer.

- You should be able to formulate an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of
laboratory, clinical neurophysiologic, and imaging studies in the outpatient VAMC setting.

- You should be able to effectively carry out the out-patient management of common neurological disorders seen in the general veterans neurology clinic.

**Medical Knowledge**

- You should demonstrate facility in discussing major neurological diseases that are managed in the out-patient setting, and mastery of current evidence from knowledge of the literature.

- You should demonstrate mastery in the understanding of common and adequate understanding of less common neurological disorders, including a thorough understanding of basic mechanisms of disease, neuropathology, and current methods of diagnosis and treatment.

- You should demonstrate proficiency in the diagnosis and management of neurological disorders seen among veterans such as pain, headache, seizures, neuropathy, myasthenia gravis, Parkinson’s disease, Alzheimer’s disease, post-stroke, multiple sclerosis, post-traumatic stress disorders, and agent orange syndrome.

- You should be familiar with common outpatient neurological procedures such as botulinum toxin injection, interrogation of devices such as deep brain stimulation and vagal nerve stimulation settings; and be fluent in the interpretation of EEG, evoked potentials, EMG, NCV, muscle biopsies, polysomnographies, neuropsychological reports, PET, SPECT, MRI and CT images.

**Practice-based Learning**

- You should demonstrate the ability to use computerized and non-computerized information systems to facilitate veteran patient care and to facilitate the development of techniques for life long learning.

- You should be able to critically review the salient literature, and base treatment on the best medical evidence.

- After your PGY-2 year, you should demonstrate the abilities similar to those of a junior attending physician to abstract from the history and examination the salient features upon which to base your differential diagnosis and management.

- You should demonstrate the ability to use the review of your own practice to guide learning

**Interpersonal and communication skills**

- You should demonstrate effective communication with your veteran patients and their families in the outpatient setting

- You should demonstrate effective communication with clinic staff (schedulers, nurses), and with patient’s referring physicians at the VAMC outpatient facilities.

- You should demonstrate the ability to orient, teach, and assist medical students, interns and other residents on their neurology out-patient rotation.

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

- You should demonstrate consideration of ethical issues

- You should ensure that all your dictations are complete, accurate and on time.

**Systems-based practice**

- You should know when to refer and coordinate the care of your more complicated patients from your general neurology continuity clinic to subspecialty clinics such as Movement Disorders, Epilepsy, Behavioral Neurology, Multiple Sclerosis, Botulinum Toxin, and Neuromuscular clinics.

- You should demonstrate knowledge of resources available in the veteran patient’s community to promote the patient’s health.

- You should demonstrate the ability to use resources at the VAMC and in the community to foster the best quality care for all veteran patients.

**Suggested Textbooks/Reading Materials:**

- Office Practice of Neurology 2003 by Martin Samuels and Steve Feske ($219)
- Differential Diagnosis in Neurology 2006 by Robert Schwartzman ($169)
- AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

**B) Selective Rotations:**

1. **General Neurology Clinic Block**
   
   **Description:**
   
   - You should demonstrate the ability to use the
The general neurology clinic rotation provides an opportunity to see patients with important and interesting disorders who do not qualify for admission to the hospital. You will work up new patients and see return patients with general neurologic complaints during each half-day clinic, under the supervision of one or more neurology attendings. You will discuss each case with the attending. For the more challenging patients, you should research the patients’ problems after the clinic visit, and discuss your assessment with an attending.

The clinic rotation will be comprised of 10 half-day blocks. The resident is typically expected to be at the general clinic from 8AM to 12 Noon and 1PM to 5PM, Monday to Friday, except holidays unless otherwise notified. However, 2 blocks are reserved for your own Continuity Clinic, for Neuro I Clinic at the VAMC and Tuesday am block should end early for attending the weekly Grand Rounds/Lectures. In addition to general neurology clinics, you will also have the opportunity depending on availability to rotate through an MS clinic and Headache clinic during this rotation.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate the ability to obtain a complete and accurate neurological history and examination
- You should demonstrate the ability to localize disease in the nervous system, and formulate a complete differential diagnosis.
- You should be able to formulate an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the outpatient setting.
- You should be able to carry out the out-patient management of common neurological disorders seen in the general neurology clinic; and assist in the delivery of out-patient care of patients seen in the general neurology clinics.

**Medical Knowledge**

- You should demonstrate knowledge about major neurological diseases that are diagnosed and managed in the out-patient setting.
- You should demonstrate in-depth understanding of important outpatient neurological disorders, including basic mechanisms of disease, neuropathology, and current methods of diagnosis and treatment.
- You should be familiar with common outpatient neurological procedures encountered in the outpatient setting and their interpretation including but not limited to botulinum toxin injection, interrogation of devices such as deep brain stimulation and vagal nerve stimulation settings; and be fluent in the interpretation of EEG, evoked potentials, EMG, NCV, muscle biopsies, polysomnographies, neuropsychological reports, PET, SPECT, MRI and CT images

**Practice-based Learning**

- You should demonstrate the ability to use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning.
- You should demonstrate ability in extracting information and salient features from the history and examination of your patient, and their caregivers upon which to base your differential diagnosis and management.
- You should be able to use the review of your own practice to guide learning.

**Interpersonal and communication skills**

- You should demonstrate your ability to communicate effectively with patients, families in the outpatient setting.
- You should demonstrate your ability to communicate with clinic staff (schedulers, nurses), and with patient’s referring physicians.
- You should demonstrate your ability to orient, teach, and assist the medicine resident and medical student on their neurology rotation.

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the management of your patients.
- You should ensure that all your dictations are complete, accurate and on time.

**Systems-based practice**

- You should demonstrate knowledge of resources available in the patient’s community to promote the patient’s health.
- You should demonstrate knowledge about Medicare billing and documentation requirements; about the variety of public and
private insurance plans; and about resources available for uninsured patients.

• You should demonstrate the ability to consider and discuss ways to improve communication between services and enhance the outpatient practice of neurology at your institution.

**Suggested Textbooks/Reading Materials:**

- Office Practice of Neurology 2003 by Martin Samuels and Steve Feske ($219)
- Differential Diagnosis in Neurology 2006 by Robert Schwartzman ($169)

### 2. Epilepsy I Rotation

**Description:**

You will spend 1 month during your PGY2 year in this selective rotation. You will round on the EMU service daily, and develop basic EEG reading and review skills. You will work with the EEG technicians to learn how to perform an EEG both at Shands and the VAMC. You will also watch the technicians perform evoked potential studies as available, and review these studies with the attending at Shands and the VAMC. You will become familiar with the EEG monitoring setup, and participate in the decision-making process in the evaluation of patients for seizures and seizure surgery.

You are expected to attend clinic with the attending of the week and evaluate both new and return patients. Friday mornings are generally spent at the VA reading available studies and participating in journal club.

You are expected to provide the routine care for patients admitted to the Epilepsy Monitoring Unit (EMU) at Shands as well as to be an emergency responder for the EEG technologists in conjunction with the epilepsy fellow in case of questions or emergencies such as status epilepticus. This includes the prompt performance of the admission history and examination, admitting orders, daily progress notes and discharge summaries. You will round daily on your EMU patient along with the EMU attending of the week. You will be responsible for signing out any pertinent information to the on-call resident at the end-of-day. You may also act as the liaison between the EMU attending and the Consult or Neurology Inpatient attending and assist in the management of patients in status epilepticus or in long-term EEG monitoring as well as any additional consultations performed by the EEG/EMU service.

As time permits, you are encouraged to read EEGs with the pediatric neurology attending in order to gain familiarity with the similarities and differences. You are not expected to round with them during this rotation.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate the ability to obtain accurate histories, perform accurate neurological examinations, localize lesions, and plan for effective diagnosis and management of patients admitted to the EMU and seen in the Epilepsy clinics.
- You should demonstrate proficiency in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies for your epileptic patients.
- You should demonstrate proficiency in the care and management of patients with epilepsy, including those in convulsive and non-convulsive status epilepticus. This includes a basic working knowledge of medications and both urgent and emergent care for seizing patients.

**Technical Knowledge**

- You should know the placement of EEG electrodes and methods of recording
- You should be able to describe problems associated with scalp electrodes and artifacts that may develop during recording
- You should know the ways in which age, level of consciousness, stage of sleep, systemic and neurological disorders, and epilepsy affect the EEG.
- You should know the physiology underlying clinical EEG; recognize the neuronal (i.e. microscopic) origin of macroscopic brain electrical activity and conceptualize neuronal synchronization as a consequence of the interconnectedness of brain circuitry
- You should be able to recognize and describe the common EEG patterns (alpha, beta, theta, and delta waves), what they represent, and where they are recorded
- You should be able to describe the two types of sleep (slow wave sleep and REM sleep)
- You should demonstrate knowledge of the
principles underlying evoked response testing (visual, auditory and somatosensory)

- You should be able to define epilepsy and describe the general classification of epileptic seizures with EEG correlation.

**Practice-Based Learning**

- Demonstrate the ability to use texts, on-line resources, and computerized databases to effectively research best medical practice; education and sharing of information with the team is expected.
- You should demonstrate proficiency in extracting information and salient features from the history and examination of your EMU patient, upon which to base your differential diagnosis and management.

**Interpersonal and communication skills**

- Develop the ability to present a history and physical examination for epilepsy patients and begin to develop care plans both for the short and long term.
- You should demonstrate the ability to communicate results of studies to physicians and patients and develop patient education skills for counseling epileptic patients and their families.

**Professionalism**

- You should demonstrate dedication to work, respect for the feelings of patients, and willingness to acknowledge mistakes, and dedication to improving performance.
- You should be on time and be prepared for all work rounds and EEG reading sessions.
- You should dictate all admission and discharge notes in the most comprehensive, accurate and timely manner as well as review them for prompt cosigning.

**Systems-based Practice**

- You should demonstrate knowledge of the cost-effective use of electrodiagnostic procedures; and, about the contribution of procedure-based billing to the economic health of neurologic practice.

**Suggested textbooks:**

- Handbook of EEG Interpretation 2007 by William Tatum ($44.96)
- Fisch and Spehlmann’s EEG Primer: Basic Principle of Digital and Analog EEG 1999 by B.J. Fisch
- An Atlas of EEG Patterns 2009 by John Stern and Robert Engel
- Epilepsy: A Cleveland Clinic Guide 2007 by Elaine Wyllie
- Handbook of Epilepsy 2008 by Thomas Browne and Gregory Holmes ($49.45)
- EEG Teaching files at Shands and the VAMC

**3. Behavioral Neurology Clinic Rotation**

**Description:**

Residents evaluate patients with neurobehavioral disorders in the Memory and Cognitive Disorders Clinics, Traumatic Brain Injury Clinic, and on rare occasion in consultation on the wards. They are supervised by attending faculty from neurology. Patients with the full spectrum of dementing diseases, traumatic brain injury, encephalopathies, plus patients with focal neurobehavioral syndromes such as aphasia, alexia, agnosia, or apraxia, are discussed in detail. Residents will observe and learn about neuropsychological testing used to assess specific disorders, such as disorders of language or memory. Residents attend all Memory and Cognitive Disorders Clinics, especially the Wednesday Memory Disorders Clinic with Dr. Heilman that begins at 11 am, during the week except for Fridays which are spent in the Traumatic Brain Injury Clinic at the VA. In addition, residents are expected to attend Tuesday Grand Rounds, weekly Dementia Consensus Conference (check with Dr. Finney for times and dates). Residents attend behavioral neurology conferences, including the weekly meetings of the Center for Neuropsychological Studies on Fridays from 1:30 – 2:30 in the VA 3rd floor conference room E-336 from Labor Day to Memorial Day, as well as monthly Language and Brain Group meetings from 2:30 – 3:30 pm (immediately following CNS lecture in same location). There is also the option to attend Dr. Heilman’s Friday noon lab meeting in lieu of Friday noon resident conference (prior permission required and attendance at one or the other is mandatory).

**Goals and Objectives:**

**Patient care**

- You should be proficient in performing a complete mental status examination. You should use the Florida Mental Status Examination as a guide.
- You should demonstrate the ability to develop hypotheses to explain specific behaviors, and how to examine the patient to test these hypotheses.
- You should demonstrate the ability to develop
differential diagnostic considerations, plans for assessment and for treatment of patients with behavioral disorders, including when to order and how to be guided by neuropsychological testing.

• You should demonstrate knowledge of how “neurologic” disorders produce “psychiatric” symptoms, and how to distinguish illnesses that are traditionally called psychiatric from degenerative and other neurological disorders.

Medical knowledge
• You should demonstrate knowledge of the anatomic basis of behavior, and about the lesions associated with specific behavioral disorders.
• You should demonstrate knowledge about dementia, its forms, and causes, including genetic and biochemical disorders.
• You should demonstrate knowledge about the effects of drugs on behavior, both toxic and therapeutic.

Practice-based Learning
• You should demonstrate the ability to computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.

Interpersonal and communication skills
• You should demonstrate the ability to communicate with patients who have behavioral disorders, and with their families.
• You should demonstrate the ability to work with behavioral neurology fellows to improve your knowledge of patient care and research in behavioral neurology.

Professionalism
• You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
• You should demonstrate consideration of ethical issues involved in the care of patients with behavioral disorders, including competency, and the appropriate use of surrogates to make medical decisions.

Systems-based practice
• You should demonstrate knowledge about resources available in the patient’s community to promote the patient’s health.
• You should demonstrate knowledge about the resources available to assist patient with behavioral disorders and to assist their families.

Suggested Textbooks:
• Mesulam’s *Principles of Behavioral Neurology*
• Cummings & Benson’s *Dementia: A Clinical Approach*
• Heilman and Valenstein’s *Clinical Neuropsychology*

4. Movement Disorders Clinic Rotation

Description:
During this selective you will learn how to identify the different types of hypo- and hyper-kinetic movement disorders. You will be familiar with the most common movement disorders (such as Parkinson’s disease, Essential Tremor and dystonia) and also have the opportunity to see rare movement disorders (such as neuroacanthocytosis, Lubag disease, spino cerebellar ataxias, dystonia-myoclonus syndrome, etc). You will learn how to manage these disorders in an interdisciplinary fashion. This rotation is predominantly outpatient based where you will join the Movement Disorders attendings in their clinic. In particular, you will join new and follow up general movement disorders clinics, botulinum toxin clinics, fast-track surgical screening clinics, DBS clinics, Huntington’s disease clinics, Parkinson Day Clinical and Educational programs, etc. You also have the option of observing DBS surgery while on this rotation. You are expected to attend the weekly alternating clinical and research Movement Disorders Conference every Tuesday from 8-9 am at the UF MBI, the monthly journal club from 10-11 am the first Tuesday each month, and the monthly video lecture series from 10-11am the fourth Tuesday each month.

Goals and Objectives:

Patient Care
• You should demonstrate the ability to examine for and recognize the variety of movement disorders encountered in clinical practice.
• You should demonstrate the knowledge of the optimal management of the movement disorders, specifically, the optimal management of patients with Parkinson’s disease in the early, middle and late stages of progression.
• You should demonstrate the knowledge of the pharmacologic agents used in treatment,
including the indications, side effects, and drug interactions of each, and have some understanding of non-pharmacologic treatments, including the importance of physical and occupational therapy, as well as the indications for surgical procedures such as DBS.

• You should demonstrate appreciation of the limits of medical therapy, and the need for developing strategies to assist the patient and family to cope with effects of the illness.

• You should be familiar with the proper administration of botulinum toxin therapy and its various neurological indications.

Medical Knowledge

• You should demonstrate the knowledge of relevant neuroanatomy, with particular attention to cortical motor systems, the basal ganglia, and brain stem and cerebellar systems involved in motor control. You should demonstrate the knowledge of the connectivity of these regions, including motor and supplementary motor cortex, neostriatum (caudate, putamen), globus pallidus, subthalamic nucleus, thalamus, substantia nigra, cerebellar hemispheres and nuclei, and red nucleus.

• You should demonstrate the knowledge of the neurochemistry of motor systems, with special attention to the dopaminergic system. Demonstrate the knowledge of the biochemical pathways of dopamine synthesis and degradation, and how toxins and pharmacologic agents influence these pathways.

• You should demonstrate the knowledge of the genetic basis and neurochemical pathogenesis of the movement disorders that have been related to specific mutations, including inherited forms of PD, the spinocerebellar degenerations, and the inherited dystonias. Demonstrate the knowledge of how the science of genetics informs clinical practice.

• You should demonstrate the knowledge of the clinical presentations of the disorders included among movement disorders.

• You should be familiar with the different types of botulinum toxins and their advantages and disadvantages, differences in their mechanism of action, and dosing in different muscle and age groups.

Practice-based Learning

• You should demonstrate the use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.

• You should demonstrate the ability to use the review of your own practice to guide learning

Interpersonal and communication skills

• You should demonstrate effective communication with patients with movement disorders and their families

• You should demonstrate effective communication with clinic staff (schedulers, nurses), and with patient’s referring physicians.

Professionalism

• You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

• You should demonstrate consideration of ethical issues in Movement Disorders, such as the weighing the risk-benefit ratio of a patient who is intent on having DBS surgery.

• You should ensure that office visit dictations for all patients seen are comprehensive, accurate and finished in a timely manner.

Systems-based practice

• You should demonstrate knowledge about resources available in the patient’s community to promote the patient’s health.

• You should demonstrate the knowledge about Medicare billing and documentation requirements; about the variety of public and private insurance plans; and, about resources (or the lack of resources) for uninsured patients.

• You should observe the interdisciplinary model used for the outpatient care of the movement disorders patients and realize its advantages and develop similar practices in the way you care for your own patients.

Suggested Reading:

• The Practical Approach to Movement Disorders: Diagnosis, Medical and Surgical Management 2007 by Hubert H. Fernandez, Michael S. Okun, Ramon L. Rodriguez, et al. (49.95)

• Video file/collection of the UF Movement Disorders Center
5. Neuromuscular Clinic Rotation

Description:
One block of this selective rotation is provided during your residency. You will learn the clinical approach to patients with neuromuscular problems, review EMG and biopsy results and other results with a view to correct diagnosis, and learn the basics of pharmacological and non-pharmacological therapy as it applies to neuromuscular disease. You will also learn the basics of nerve conduction and EMG, and the anatomy underlying these studies. You will learn how to use the equipment and to perform nerve conduction studies first on normal subjects, and then on patients, under the supervision of the EMG technician, the Clinical Neurophysiology Fellow, or the Attending Neurologist, and then more independently. You will also perform needle EMG examination under direct supervision. You will learn to analyze clinical situations, plan appropriate diagnostic studies, and begin to interpret results of nerve conduction studies and electrophysiological examination of patients with neuromuscular disorders. (Needle EMG studies are never to be done without direct attending supervision.) This rotation will take place both at Shands Medical Plaza and the VAMC clinic facility.

Goals and Objectives:

Patient Care
- You should demonstrate the ability to obtain a focused neurological history and neurological examination focusing on the peripheral nervous system.
- You should demonstrate knowledge of the technical basics of performing and interpreting the results of nerve conduction studies and electromyography.
- You should demonstrate the ability to use nerve conduction studies and electromyography to test hypotheses regarding patient differential diagnosis.
- You should demonstrate knowledge to use the results of nerve conduction studies and electromyography in planning appropriate treatment recommendations.

Medical Knowledge
- You should demonstrate knowledge on how to localize a patient’s problem in terms in terms of the anatomy and physiology of the peripheral nervous system.
- You should demonstrate knowledge about the specific categories of diseases that affect the peripheral neuromuscular system and to formulate testable hypotheses with respect to differential diagnosis.

Practice-Based Learning
- You should be able to use texts, on-line resources, and computerized databases to effectively research best medical practice

Interpersonal and Communication Skills
- You should demonstrate the ability to communicate the results of an electrophysiological consultation to patients and to referring physicians.

Professionalism
- You should demonstrate dedication to work, respect for the feelings of patients, and willingness to acknowledge mistakes, and dedication to improving performance
- You should dictate all EMG and NCS procedure notes in a timely manner and relay findings to the requesting primary service

Systems-based Practice
- You should demonstrate knowledge of the cost-effective use of electrophysiological procedures; and, about the contribution of procedure-based billing to the economic health of neurologic practice.

Suggested Textbook:
- Griggs and Mendell: Evaluation of myopathies (Contemporary Neurology series black book)
- Katirji: Neuromuscular Disorders in Clinical Practice
- Electromyography (Chapter Subramony and Carpenter: will make available)
6. Neuropsychiatry Rotation

**Description:**
During your selective month on neuropsychiatry, you will work on the geropsychiatry unit mainly at the VAMC. You will attend Memory Disorders Clinic, and you will attend psychiatry teaching conferences and the conference of the Center for Neuropsychological Studies. The psychiatry teaching conferences include the student lecture series, psychopharmacology lecture series, and a lecture series for neurology residents on psychiatric disorders that present with neurological symptoms. There may also be opportunities to participate in the Tourette’s/OCD clinic, and to visit the State Mental Hospital.

**Goals and Objectives:**

**Patient Care**
- You should demonstrate the ability to interview patients with behavioral disorders, and to acquire accurate histories from all available sources.
- You should demonstrate the ability to examine patients with behavioral disorders, and to formulate reasonable differential diagnoses.
- You should demonstrate the ability to formulate treatment plans, including behavioral strategies and pharmacologic treatments and carry them out in a compassionate and competent manner.

**Medical Knowledge**
- You should demonstrate knowledge about psychiatric disorders that manifest with neurological symptoms, such as somatiform disorder, factitious disorder, conversion disorder, and pain disorder.
- You should demonstrate knowledge of the psychiatric manifestations of neurological disease, and of drugs commonly used by neurologists
- You should know the neurobiologic basis of psychiatric disease, including neurotransmitter balance, and the effects of psychotherapeutic agents
- You should know the indications, side effects, interactions, and therapeutic doses of commonly used psychotherapeutic agents.

**Practice-based Learning**
- You should demonstrate the use of the computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.
- You should demonstrate the use the review of your own practice to guide learning

**Interpersonal and communication skills**
- You should demonstrate the ability to communicate with patients, families, staff, residents and attendings
- You should demonstrate team-work: work effectively with other members of the psychiatry team to ensure that patients get the best possible care.

**Professionalism**
- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate consideration of ethical issues in psychiatry.

**Systems-based practice**
- You should demonstrate consideration of the special problems entailed in obtaining and paying for psychiatric care;
- You should demonstrate appreciation of resources available to patients with behavioral and psychiatric disorders in the community.

**Suggested Textbooks:**
- Mesulam’s *Principles of Behavioral Neurology*
- Cummings & Benson’s *Dementia: A Clinical Approach*
- Heilman and Valenstein’s *Clinical Neuropsychology*.

7. Concentrated Study of Basic Science—Neuroscience Rotation

**Description:**
During your neurology residency, you will help teach the Neuroscience course to medical students. You will participate in laboratory exercises and attend course lectures. You will read all course material and should be available to tutor students. You will conduct clinical teaching exercises during this course. This rotation is 5 weeks in duration and is the longest block rotation during your residency training. The curriculum of this neuroscience course includes:
- Neuroanatomy: Major divisions, ventricular system, meninges, cortex, white matter, subcortical gray structures, diencephalon,
brain stem, cerebellum, spinal cord & spinal meninges.

- CNS vasculature, blood flow, and metabolism
- Neurohistology: cellular classes; blood brain barrier; cellular organization
- Chemical Neurotransmission: Synaptic transmission; glutamate, GABA, Glycine, the neuropeptides, the catecholamines, serotonin, acetylcholine
- Neurophysiology: The membrane potential, the action potential, the neuron as an integrative structure, axonal conduction and the role of myelin, maintenance of ionic gradients.
- The Motor System: the motor unit, segmental reflexes, spinal cord reflex systems, spinal cord motor systems, brainstem centers for tone, posture and movement, bladder & bowel control, corticospinal system, basal ganglia, cerebellum.
- Somethesis: peripheral afferents and receptors, CNS sensory pathways, somatosensory cortex, trigeminal system.
- Pain systems: CNS modulatory mechanisms, peripheral mechanisms, neurogenic pain, the generation of chronic pain states.
- Cranial nerves and Brainstem organization
- Vision: retinal organization, visual pathways neurophysiology and Processes underlying Feature Enhancement; pupillary responses to light; vascular supply of the eye
- Intracranial Pressure and papilledema
- Auditory and Vestibular systems: hearing (cochlea anatomy, transduction of the auditory signal, generation of the neural signal, central auditory pathways, signal processing in the auditory cortex
- Autonomic, neuroendocrine and regulatory functions: the hypothalamus, autonomic nervous system, neuroendocrine function, hypothalamic regulatory systems, hypothalamic drive systems, brainstem regulatory systems.
- Higher Neural Functions: cerebral cortical anatomy, functions of sensory association cortices, functions of polymodal and supramodal cortices, the limbic system, memory, frontal systems, arousal, attention and selective engagement, parallel distributed processing.

Goals and Objectives:

Patient Care
- Not applicable

Medical Knowledge
- By the end of the rotation, you are expected to demonstrate a good fund of knowledge of the biological bases of neurological disorders.
- You should be well-versed on neuroanatomy, neurohistology/pathology, neurophysiology, neurochemistry, genetics, and the principles of neuropharmacology.

Practice-based Learning
- You should demonstrate the ability to use the library and computer resources to find needed information and improve teaching skills

Interpersonal and communication skills
- You should demonstrate the ability to encourage medical students and teach them how to apply basic neuroscience knowledge in the clinical arena.

Professionalism
- You should demonstrate attitudes that foster the values of teaching, analytical thinking and need for lifelong learning.
- You should attend all lectures and exercises during this course and be on time.

Systems-based practice
- Not applicable

Suggested Textbooks:
- Basic Clinical Neuroscience 2007 by Paul Young and Daniel Tolbert ($44.96)
- Medical Neuroscience 2003 by Stephen Nadeau ($34.99)
- Manter and Gatz’s Essentials of Clinical Neuroanatomy and Neurophysiology 2002 by Sid Gilman, et al ($32.00)
- UF College of Medicine Neuroscience Course Syllabus

8. Concentrated Study of Basic Science—Neuropathology

Description:
You must take at least one month of Neuropathology. During this time you will work under Dr.Yachnis and other neuropathology attendings and fellows, and you will attend conferences in Neuropathology, including brain-cutting, pathology residents’ conferences, Pediatric and Adult Neuropathology conferences, and the weekly tumor board conference (see above).

Goals and Objectives:

Patient Care
- Not applicable

Medical Knowledge
• You should demonstrate the ability to handle gross brain and brain sections to further enhance their knowledge of neuroanatomy and further appreciate and correlate the clinical manifestations of neurological disorders
• You should demonstrate the ability to acquire a solid fund of knowledge of normal microscopic anatomy and become familiar with the pathologic features of common neurologic illnesses, most especially, brain tumors, infections, neurodegenerative disorders, muscle and nerve disorders.

**Practice-based Learning**

• You should demonstrate the ability to use the library and computer resources to find needed information.
• You should demonstrate the ability to gain a solid understanding of the clinical utility of neuropathology in the practice of neurology in the diagnosis and prognosis of specific neurologic disorders. In particular, the proper utility of brain, muscle and nerve biopsies

**Interpersonal and communication skills**

• You should demonstrate the ability to encourage effective teaching and communication to medical students, fellow residents and attendings through the responsibility of preparing the protocols for the weekly clinico-pathological conferences.

**Professionalism**

• You should demonstrate attitudes that foster the values of teaching, analytical thinking and need for lifelong learning.

**Systems-based practice**

• You should demonstrate knowledge of cost effective use of brain, muscle and nerve biopsies and the importance of autopsies.

**Suggested Textbooks:**

• Escourolle and Poirier’s Manual of Basic Neuropathology 2003 by Francois Gray et al ($67.50)
• Greenfield’s Neuropathology 8th Edition (2 Volume Set and CD ROM) by Seth Love et al ($599.00)
• Teaching file/slides of the UF Neuropathology Division

9. Epilepsy II Rotation

**Description:**

You will spend 1 months during your time as a senior resident in this selective rotation. While this rotation is similar to the Epilepsy I Rotation you had early in your PGY2 year, it greatly increases the amount of responsibility you have for more independent, less directly supervised, practice of Epilepsy subspecialty neurology. You are expected to take increasing responsibility for treatment plans in the clinical setting and will be expected to begin to dictate studies, independently reviewing them prior to reading sessions with the attending whenever time permits. You will also be responsible for article selection for journal club when applicable. You will round on the EMU service daily, and demonstrate EEG reading and review skills. You will work with the EEG technicians to demonstrate knowledge of how to perform an EEG both at Shands and the VAMC. You will also work with the technicians to perform evoked potential studies as available, and review these studies independently and present them to the attending for final review with the attending at Shands and the VAMC. You will show you are familiar with the EEG monitoring setup, and lead in the decision-making process in the evaluation of patients for seizures and seizure surgery.

You are expected to attend clinic with the attending of the week and evaluate both new and return patients. Friday mornings are generally spent at the VA reading available studies and participating in journal club.

You are expected to provide the routine care for patients admitted to the Epilepsy Monitoring Unit (EMU) at Shands as well as to be an emergency responder for the EEG technologists in conjunction with the epilepsy fellow in case of questions or emergencies such as status epilepticus. This includes the prompt performance of the admission history and examination, admitting orders, daily progress notes and discharge summaries. You will round daily on your EMU patient along with the EMU attending of the week. You will be responsible for signing out any pertinent information to the on-call resident at the end-of-day. You may also act as the liaison between the EMU attending and the Consult or Neurology In-patient attending and assist in the management of patients in status epilepticus or in long-term EEG monitoring as well as any additional consultations performed by the EEG/EMU service.

As time permits, you are encouraged to read EEGs with the pediatric neurology attending in order to gain familiarity with the similarities and differences. You are not expected to round with them during this rotation.
Goals and Objectives:

Patient Care
- You should demonstrate the ability to obtain accurate histories, perform accurate neurological examinations, localize lesions, and plan for effective diagnosis and management of patients admitted to the EMU and seen in the Epilepsy clinics.
- You should demonstrate proficiency in creating an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies for your epileptic patients.
- You should demonstrate proficiency in the care and management of patients with epilepsy, including those in convulsive and non-convulsive status epilepticus. This includes a basic working knowledge of medications and both urgent and emergent care for seizing patients.

Technical Knowledge
- You should know the placement of EEG electrodes and methods of recording
- You should be able to describe problems associated with scalp electrodes and artifacts that may develop during recording
- You should know the ways in which age, level of consciousness, stage of sleep, systemic and neurological disorders, and epilepsy affect the EEG.
- You should know the physiology underlying clinical EEG; recognize the neuronal (i.e. microscopic) origin of macroscopic brain electrical activity and conceptualize neuronal synchronization as a consequence of the interconnectedness of brain circuitry
- You should be able to recognize and describe the common EEG patterns (alpha, beta, theta, and delta waves), what they represent, and where they are recorded
- You should be able to describe the two types of sleep (slow wave sleep and REM sleep)
- You should demonstrate knowledge of the principles underlying evoked response testing (visual, auditory and somatosensory)
- You should be able to define epilepsy and describe the general classification of epileptic seizures with EEG correlation.

Practice-Based Learning
- Demonstrate the ability to use texts, on-line resources, and computerized databases to effectively research best medical practice; education and sharing of information with the team is expected.
- You should demonstrate proficiency in extracting information and salient features from the history and examination of your EMU patient, upon which to base your differential diagnosis and management.

Interpersonal and communication skills
- Develop the ability to present a history and physical examination for epilepsy patients and begin to develop care plans both for the short and long term.
- You should demonstrate the ability to communicate results of studies to physicians and patients and develop patient education skills for counseling epileptic patients and their families.

Professionalism
- You should demonstrate dedication to work, respect for the feelings of patients, and willingness to acknowledge mistakes, and dedication to improving performance.
- You should be on time and be prepared for all work rounds and EEG reading sessions.
- You should dictate all admission and discharge notes in the most comprehensive, accurate and timely manner as well as review them for prompt cosigning.

Systems-based Practice
- You should demonstrate knowledge of the cost-effective use of electrodiagnostic procedures; and, about the contribution of procedure-based billing to the economic health of neurologic practice

Suggested textbooks:
- Handbook of EEG Interpretation 2007 by William Tatum ($44.96)
- Fisch and Spehlmann’s EEG Primer: Basic Principle of Digital and Analog EEG 1999 by B.J. Fisch
- An Atlas of EEG Patterns 2009 by John Stern and Robert Engel
- Epilepsy: A Cleveland Clinic Guide 2007 by Elaine Wyllie
- Handbook of Epilepsy 2008 by Thomas Browne and Gregory Holmes ($49.45)
- EEG Teaching files at Shands and the VAMC
C. Elective Rotations:

1. **Out-patient Clinics Block Elective**

   **Description:**
   The clinic elective provides an opportunity to see patients with important and interesting disorders who do not qualify for admission to the hospital. You will review prospective patients with the clinic appointment secretary in the Neurology Office, and select those who appear to have interesting problems, especially those that you feel you need more experience seeing. You will work up two to four such patients during each half-day clinic, under the supervision of one or more neurology attendings. You will discuss each case with the attending. For the more challenging patients, you should research the patients’ problems after the clinic visit, and discuss your assessment with the attending. For these cases, it is expected that your letters will be well-referenced.

   The clinic rotation will be comprised of 10 half-day blocks. The resident is expected to be at the subspecialty clinic from 8AM to 12 Noon and 1PM to 5PM, Monday to Friday, except holidays. However, 2 blocks are reserved for your own Continuity Clinic, for Neuro I Clinic at the VAMC and Tuesday am block should end early for attending the weekly Grand Rounds/Lectures. You are required to select 5 blocks on the following clinics: Neuromuscular clinic; Movement Disorders or Botulinum toxin clinic; “Episodic” Disorders (Epilepsy, Pain, Multiple Sclerosis) clinic; General Adult or Pediatric Neurology clinic; and Memory Disorders Clinic. In addition, you may be assigned one or more Wednesday mornings to the Gait and Balance clinic at the VA. For the two remaining blocks, you may chose from any of the “optional” clinics. You may choose to do any these clinics at the Shands Medical Plaza, VAMC in Gainesville, VAMC in Lake City or the University Hospital at Jacksonville.

   The following clinics are **optional** and may be requested by the resident to fill in the remaining 2 blocks during his/her clinic rotation.
   a. Additional Neuromuscular clinic
   b. Additional Movement Dis. Clinic
   c. Additional Neuromuscular/MS Clinic
   d. Additional Epilepsy Clinic
   e. Additional General Neurology Clinic
   f. Additional Memory Disorders Clinic
   g. Additional Pedi Neurology Clinic
   h. Surgical/DBS Mov. Dis. Clinic
   i. Pain Clinic
   j. Neuro-ophthalmology clinic
   k. Speech/Swallowing Clinic
   l. Sleep Clinic
   m. Botulinum toxin Clinic

   n. Neuro-oncology Clinic

   Each rotating resident should fill out their chosen mandatory and optional clinic block form before the beginning of that academic year. You should review the schedule again a month prior to starting the rotation for any changes in schedule that is needed due to clinic cancellations. If the requested clinic is unable to accommodate the resident during the requested month, the resident is expected to find a substitute specialty clinic. In each clinic block, the resident, at a minimum, should see two new patients, or, a total of 3 patients (i.e., 1 new and 2 follow-up patients; or 3 follow-up patients).

   **Goals and Objectives:**

   **Patient Care**
   - You should demonstrate the ability to obtain a complete and accurate neurological history and examination.
   - You should demonstrate the ability to localize disease in the nervous system, and formulate a complete differential diagnosis.
   - You should be able to formulate an appropriate and cost-effective diagnostic and treatment plan, including appropriate use of laboratory, clinical neurophysiologic, and imaging studies in the outpatient setting.
   - You should be able to carry out the outpatient management of common neurological disorders seen in the general neurology clinic; and assist in the delivery of out-patient care of patients seen in the subspecialty clinics.

   **Medical Knowledge**
   - You should demonstrate knowledge about major neurological diseases that are diagnosed and managed in the out-patient setting.
   - You should demonstrate in-depth understanding of important outpatient neurological disorders, including basic mechanisms of disease, neuropathology, and current methods of diagnosis and treatment.
   - You should be familiar with common outpatient neurological procedures encountered in the outpatient setting such as botulinum toxin injection, interrogation of devices such as deep brain stimulation and vagal nerve stimulation settings; and be fluent in the interpretation of EEG, evoked potentials, EMG, NCV, muscle biopsies, polysomnographies, neuropsychological reports, PET, SPECT, MRI and CT images.
Practice-based Learning

- You should demonstrate the ability to use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for lifelong learning.
- You should demonstrate ability in extracting information and salient features from the history and examination of your patient, and their caregivers upon which to base your differential diagnosis and management.
- You should be able to use the review of your own practice to guide learning.

Interpersonal and communication skills

- You should demonstrate your ability to communicate effectively with patients, families in the outpatient setting.
- You should demonstrate your ability to communicate with clinic staff (schedulers, nurses), and with patient’s referring physicians.
- You should demonstrate your ability to orient, teach, and assist the medicine resident and medical student on their neurology rotation.

Professionalism

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the management of your patients.
- You should ensure that all your dictations are complete, accurate and on time.

Systems-based practice

- You should demonstrate knowledge of resources available in the patient’s community to promote the patient’s health.
- You should demonstrate knowledge about Medicare billing and documentation requirements; about the variety of public and private insurance plans; and about resources available for uninsured patients.
- You should demonstrate the ability to consider and discuss ways to improve communication between services and enhance the outpatient practice of neurology at your institution.

Suggested Textbooks/Reading Materials:

- Office Practice of Neurology 2003 by Martin Samuels and Steve Feske ($219)
- Differential Diagnosis in Neurology 2006 by Robert Schwartzman ($169)
- AAN practice guidelines (http://www.aan.com/go/practice/guidelines)

2. Neuroradiology Elective Rotation

Description:
You will sit in while the neuroradiology attending reads studies each morning and afternoon. You will attend neuroradiology teaching conferences (2nd and 4th Thursdays at noon, Shands Radiology Conference Room). You will have access to the neuroradiology teaching files, which include normal MRIs with anatomic details indicated and PowerPoint presentations on a broad range of neuroradiologic subjects. You will be able to interact with neuroradiology attendings and fellows, who can answer specific questions.

Goals and Objectives:

Patient Care

- You should know the indications for each of the neuroimaging techniques available (plain x-ray, tomography, CT, CT Angiograms, MRI, MRA, radionucleide studies, PET, SPECT scans, etc.)
- You should demonstrate the ability to look at an imaging study systematically and how to identify important normal structures.
- You should demonstrate knowledge of the appearance of pathology in the various imaging studies.

Medical Knowledge

- You should demonstrate knowledge of the principles underlying plain x-ray, x-ray tomographic studies, and CT studies and their clinical applications.
- You should demonstrate knowledge of various means of visualizing blood vessels including angiography, CT-angiography, MRA, and 3-D MRA, and their clinical applications.
- You should demonstrate knowledge of the principles underlying MR and how they are applied to clinical problems.
- You should demonstrate knowledge of the principles underlying functional neuroimaging, including fMRI and the use radionucleide agents in SPECT and PET, and
how these studies are applied to clinical problems.

**Practice-based Learning**

- You should demonstrate the ability to use computerized and non-computerized information systems to assist your learning of neuroimaging.
- You should demonstrate knowledge to use the review of your own practice to guide learning.

**Interpersonal and communication skills**

- You should demonstrate understanding on how clinicians can best address questions to radiologists.
- You should demonstrate understanding on how radiologists communicate their findings to clinicians.

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

**Systems-based practice**

- You should demonstrate consideration of cost, risks, and benefits of neuroimaging studies.

**Suggested Textbooks:**

- Neuroradiology: The Requisites 2003 by Robert Grossman and David Yousem ($102.00)
- Neuroradiology teaching files at Shands Hospital

3. *Movement Disorders Elective Rotation*

**Description:**

During this elective you will learn how to identify the different types of hypo- and hyper-kinetic movement disorders. You will be familiar with the most common movement disorders (such as Parkinson’s disease, Essential Tremor and dystonia) and also see rare movement disorders (such as neuroacanthocytosis, Lubag disease, painful legs moving toes syndrome, spinocerebellar ataxias, dystonia-myoclonus syndrome, etc). You will learn how to manage these disorders in an interdisciplinary fashion. This rotation is predominantly outpatient based where you will join the Movement Disorders attendings in their clinic. In particular, you will join new and follow up general movement disorders clinics, botulinum toxin clinics, fast-track surgical screening clinics, DBS clinics, Huntington’s disease clinics, Parkinson Day Clinical and educational programs, etc. You also have the option of observing DBS surgery while on this rotation every Wednesday. You are expected to attend the weekly alternating clinical and research Movement Disorders Conference every Thursday from 7-8 am at the UF MBI.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate the ability to examine for and recognize the variety of movement disorders encountered in clinical practice.
- You should demonstrate the knowledge of the optimal management of the movement disorders, specifically, the optimal management of patients with Parkinson’s disease in the early, middle and late stages of progression.
- You should demonstrate the knowledge of the pharmacologic agents used in treatment, including the indications, side effects, and drug interactions of each, and have some understanding of non-pharmacologic treatments, including the importance of physical and occupational therapy, as well as the indications for surgical procedures such as DBS.
- You should demonstrate appreciation of the limits of medical therapy, and the need for developing strategies to assist the patient and family to cope with effects of the illness.
- You should be familiar with the proper administration of botulinum toxin therapy and its various neurological indications.

**Medical Knowledge**

- You should demonstrate the knowledge of relevant neuroanatomy, with particular attention to cortical motor systems, the basal ganglia, and brain stem and cerebellar systems involved in motor control. You should demonstrate the knowledge of the connectivity of these regions, including motor and supplementary motor cortex, neostriatum (caudate, putamen), globus pallidus, subthalamic nucleus, thalamus, substantia nigra, cerebellar hemispheres and nuclei, and red nucleus.
- You should demonstrate the knowledge of the neurochemistry of motor systems, with special attention to the dopaminergic system. Demonstrate the knowledge of the biochemical pathways of dopamine synthesis and degradation, and how toxins and
pharmacologic agents influence these pathways.

- You should demonstrate the knowledge of the genetic basis and neurochemical pathogenesis of the movement disorders that have been related to specific mutations, including inherited forms of PD, the spinocerebellar degenerations, and the inherited dystonias. Demonstrate the knowledge of how the science of genetics informs clinical practice.
- You should demonstrate the knowledge of the clinical presentations of the disorders included among movement disorders.
- You should be familiar with the different types of botulinum toxins and their advantages and disadvantages, differences in their mechanism of action, and dosing in different muscle and age groups.

**Practice-based Learning**

- You should demonstrate the use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.
- You should demonstrate the ability to use the review of your own practice to guide learning.

**Interpersonal and communication skills**

- You should demonstrate effective communication with patients with movement disorders and their families.
- You should demonstrate effective communication with clinic staff (schedulers, nurses), and with patient’s referring physicians.

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate consideration of ethical issues in Movement Disorders, such as the weighing the risk-benefit ratio of a patient who is intent on having DBS surgery.
- You should ensure that office visit dictations for all patients seen are comprehensive, accurate and finished in a timely manner.

**Systems-based practice**

- You should demonstrate knowledge about resources available in the patient’s community to promote the patient’s health.
- You should demonstrate the knowledge about Medicare billing and documentation requirements; about the variety of public and private insurance plans; and, about resources (or the lack of resources) for uninsured patients.
- You should observe the interdisciplinary model used for the outpatient care of the movement disorders patients and realize its advantages and develop similar practices in the way you care for your own patients.

Suggested Reading:

- The Practical Approach to Movement Disorders: Diagnosis, Medical and Surgical Management 2007 by Hubert H. Fernandez, Michael S. Okun, Ramon L. Rodriguez, et al. ($49.95)
- Video file/collection of the UF Movement Disorders Center

4. Sleep Medicine Elective Rotation

**Description:**

During this rotation, you will join sleep disorders clinics at the VAMC and Shands and learn the approach, diagnosis and management of sleep disorders from the medical (pulmonary) and neurological perspective. You will be familiar with the indications, proper administration, and interpretation of polysomnography. Sleeps disorders faculty members from Internal Medicine and Neurology, along with the sleep disorders fellow will supervise you during this rotation.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate proper placement of scalp electrodes and recording devices
- You should also demonstrate proper methods of recording

**Medical Knowledge**

- You should demonstrate knowledge of the physiology underlying clinical polysomnography
- You should know the common EEG patterns (alpha, beta, theta, and delta waves), what they represent, and where they are recorded
- You should describe the two types of sleep (slow sleep and REM sleep)
- You should demonstrate familiarity with the ways in which age, level of consciousness, stage of sleep, systemic and neurological
disorders, pulmonary disorders, sleep disorders, and epilepsy affect the EEG during a sleep study.

- You should demonstrate the knowledge of problems associated with scalp electrodes and sleep recording devices and the possible artifacts that may develop during recording.
- You should demonstrate knowledge of the types of sleep disorders and how to clinically assess patients with sleep disorders.

**Practice-based Learning**

- You should demonstrate the use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for lifelong learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.
- You should demonstrate the ability to use the review of your own practice to guide learning.

**Interpersonal and communication skills**

- You should demonstrate effective communication with patients, families.
- You should demonstrate effective communication with clinic staff (schedulers, nurses), and with patient’s referring physicians.

**Professionalism**

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate consideration of ethical issues related to sleep disorders such as addressing driving competency.

**Systems-based practice**

- You should demonstrate knowledge about resources available in the patient’s community to promote the patient’s health.
- You should demonstrate knowledge about Medicare billing and documentation requirements; about the variety of public and private insurance plans; and, about resources (or the lack of resources) for uninsured patients.

**Suggested textbooks:**

- Sleep Disorders and Neurologic Diseases, Second Edition, 1997 by Antonio Culebras
- Sleep Medicine 2008 by Harold Smith, Cynthia Comella, and Birgit Hogl ($70)

### 5. Behavioral Neurology Elective Rotation

**Description:**

Residents evaluate patients with neurobehavioral disorders in the Memory and Cognitive Disorders Clinics, and in consultation on the wards. They are supervised by attending faculty from neurology. Patients with the full spectrum of dementing diseases, plus patients with focal neurobehavioral syndromes such as aphasia, alexia, agnosia, or apraxia, are discussed in detail. Residents will observe and learn about neuropsychological testing used to assess specific disorders, such as disorders of language or memory. Residents attend all Memory and Cognitive Disorders Clinics during the week, especially the Wednesday Memory Disorders Clinic with Dr. Heilman that begins at 11 am, unless they opt to take a mixed elective track with both clinics and behavioral neurology research combined (permission of course director required ahead of time for this option, and requires an IRB approved project and protocol). However, residents must be in clinic or conducting clinical research during the work-week. In addition, residents are expected to attend Tuesday Grand Rounds, weekly Dementia Consensus Conference (check with Dr. Finney for times and dates). Residents attend behavioral neurology conferences, including the weekly meetings of the Center for Neuropsychological Studies on Fridays from 1:30 – 2:30 in the VA 3rd floor conference room E-336 from Labor Day to Memorial Day, as well as monthly Language and Brain Group meetings from 2:30 – 3:30 pm (immediately following CNS lecture in same location). The option to attend Dr. Heilman’s noon research lab meeting in lieu of the neurology resident noon conference is available with permission of the program director, but it is mandatory that you attend one or the other.

**Goals and Objectives:**

**Patient care**

- You should be proficient in performing a complete mental status examination. You should use the Florida Mental Status Examination as a guide.
- You should demonstrate the ability to develop hypotheses to explain specific behaviors, and how to examine the patient to test these hypotheses.
- You should demonstrate the ability to develop differential diagnostic considerations, plans for assessment and for treatment of patients with behavioral disorders, including when to order and how to be guided by
neuropsychological testing.

- You should demonstrate knowledge of how “neurologic” disorders produce “psychiatric” symptoms, and how to distinguish illnesses that are traditionally called psychiatric from degenerative and other neurological disorders.

Medical knowledge

- You should demonstrate knowledge of the anatomic basis of behavior, and about the lesions associated with specific behavioral disorders.
- You should demonstrate knowledge about dementia, its forms, and causes, including genetic and biochemical disorders.
- You should demonstrate knowledge about the effects of drugs on behavior, both toxic and therapeutic.

Practice-based Learning

- You should demonstrate the ability to computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.

Interpersonal and communication skills

- You should demonstrate the ability to communicate with patients who have behavioral disorders, and with their families.
- You should demonstrate the ability to work with behavioral neurology fellows to improve your knowledge of patient care and research in behavioral neurology.

Professionalism

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate consideration of ethical issues involved in the care of patients with behavioral disorders, including competency, and the appropriate use of surrogates to make medical decisions.

Systems-based practice

- You should demonstrate knowledge about resources available in the patient’s community to promote the patient’s health.
- You should demonstrate knowledge about the resources available to assist patient with behavioral disorders and to assist their families.

Suggested Textbooks:

- Mesulam’s *Principles of Behavioral Neurology*
- Cummings & Benson’s *Dementia: A Clinical Approach*
- Heilman and Valenstein’s *Clinical Neuropsychology*

6. Neuro-Oncology Elective:

General Description:

In this elective, you will rotate with the Neuro-Oncology (NeuroOne) Team, which includes the NeuroOne attending, ARNP, Study Coordinator, and the inpatient care team. Specifically designed to immerse you in all aspects of NeuroOnc, you will be exposed to the unique presentations and management of NeuroOnc patients. During these clinical activities, you will be exposed to medical and surgical NeuroOne emergencies, participate in the administration of anti-neoplastic therapy and supportive therapy, and gain awareness of the unique challenges and resources found in NeuroOne. Patient experiences will be primarily focused on those with primary CNS malignancies or others with metastases to the brain or spinal column. Other uncommon tumor types (including peripheral nerve malignancies or benign tumors) that are occasionally cared for by Neuro-Oncologists (particularly in the surgically/radiographically refractory setting), may also be encountered.

During this rotation, you will participate in the full spectrum of patient care, including multidisciplinary clinics (majority), weekly tumor board & educational conferences, and when needed, inpatient consults & patient care. In addition, you will receive insights into clinical and translational research and participate to the degree that you desire and the rotation time-period facilitates.

An attending NeuroOnc faculty member provides immersion, education, mentorship, and opportunities for graduated responsibility. An attending NeuroOne faculty member attends clinic and rounds with the fellow to provide data, guidance, and education regarding decision making for the patients. In addition, academic opportunities exist, including conferences, case-reports, and clinical research participation. You are still responsible for attendance at mandatory division/program conferences and participation in your VA and UFSCC clinics. Conflict resolution will always favor the core program requirements. Notification of your NeuroOne faculty/team members of these obligations is expected.

Learning takes place during clinic encounters,
bedside rounds, didactic conferences, sit down teaching rounds related to the care of patients, and self study.

**Duration:** 2 week blocks. This is intended to be an outpatient immersion elective rotation. Thus, usual time-commitments include M-F, business hours. However, interested fellows are welcome to participate in additional educational opportunities.

**Location:** Shands NeuroOne Clinics and Inpatient Hospital Wards

**Evaluation:** Done by attending NeuroOne faculty member for the rotation and are both written and verbal.

Core Competencies:

**Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

- To evaluate and treat patients with primary central nervous system malignancies and others with CNS metastases.
- To apply the different uses of chemotherapy and biologic therapy for palliative treatment, curative treatment and adjuvant or neo-adjuvant treatment.
- To manage the common complications of treating patients with CNS malignancies including but not limited to neutropenic fever, mucositis, emesis, extravesation, spinal cord compression, acute neurologic deficits, seizure, increased intracranial pressure and cancer pain.
- To understand the indications for hospitalization for patients with CNS malignancies whether to facilitate staging, treatment or management of complications.
- To appropriately understand and implement supportive care agents in cancer therapies.
- To develop the skills of ordering and administering chemotherapeutic and biologic agents.
- To understand the appropriate role of surgical and radiation modalities.
- To understand the anatomy and pathophysiology of CNS radiographic imaging and laboratory testing as used in patient management including progression/recurrence, hemorrhage, hydrocephalus, neutropenic fever, and titration of anti-epileptics or anti-coagulation.
- To understand the indications for and process of pre and post-test genetic counseling for hereditary cancer syndromes.

**Interpersonal and Communication Skills** that result in

**Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

- To understand the evaluation and treatment of patients with primary central nervous system malignancies and others with CNS metastases.
- To understand the different uses of chemotherapy and biologic therapy for palliative treatment, curative treatment and adjuvant or neo-adjuvant treatment.
- To understand the common complications of treating patients with CNS malignancies including but not limited to neutropenic fever, mucositis, emesis, extravesation, spinal cord compression, acute neurologic deficits, seizure, increased intracranial pressure and cancer pain.
- To understand the indications for hospitalization for patients with CNS malignancies whether to facilitate staging, treatment or management of complications.
- To develop the skills of ordering and administering chemotherapeutic and biologic agents.
- To understand the appropriate role of surgical and radiation modalities.
- To understand the anatomy and pathophysiology of CNS radiographic imaging and laboratory testing as used in patient management including progression/recurrence, hemorrhage, hydrocephalus, neutropenic fever, and titration of anti-epileptics or anti-coagulation.
- To understand the process of clinical trial enrollment and patient monitoring.
- To understand the indications for and process of pre and post-test genetic counseling for hereditary cancer syndromes.
effective information exchange and teaming with patients, their families, and other health professionals.

- To understand the role of a consultant in assisting a primary team with the care of a patient.
- To develop the skills needed to interact with patients and their families in a manner that demonstrates compassion, competence and professionalism.
- To provide education to the residents and students working with their patients.
- To participate in multidisciplinary conferences for patients with CNS malignancies.
- To effectively initiate end of life discussions with patients with incurable malignancies.
- To refine peer-to-peer relationships and methods of handing off patient care responsibilities for safety and continuity of care.

**Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

- To develop the skills needed to interact with patients and their families in a manner that demonstrates compassion, competence and professionalism.
- To develop in the role of consultant for other services always keeping the patient’s best interest as the primary goal, and performing these duties in a professional and courteous manner.
- To develop communication skills with patients and their families with attention not just to the medical aspects of cancer care, but also to the psychological, social and spiritual dimensions as well.

**Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

- To coordinate the care of patients moving from the inpatient to the outpatient setting and thus learn the complexities of our health-care delivery system.
- To develop the skills necessary for leadership within a healthcare team.
- To appreciate the use of limited resources and rationale of cost-effective healthcare delivery.

7. Neurosurgery Elective

**Description:**

In this elective will rotate predominantly on the sections of neurosurgical service that concentrates on neurovascular and tumor cases, but you will also get exposure to patients with the full range of common neurosurgical problems. You will make rounds with the neurosurgical team, care for patients in the Neurological Intensive Care Unit and neurosurgical ward, and evaluate patients in the Emergency Room. You will have responsibility for daytime call (6am to 6pm) on a rotation basis, with the backup of neurosurgical residents and attendings. You will attend neurosurgery clinics, including neuron-oncology, where you will have the opportunity to evaluate new patients, and see the long-term benefits and complications of neurosurgical procedures, radiation and chemotherapy. You will attend neurosurgical conferences each morning and the tumor board meeting.

**Goals and Objectives:**

**Patient Care**

- You should demonstrate the ability to manage patients in an intensive care setting, including patients with subarachnoid hemorrhage, head trauma, and increased intracranial pressure.
- You should demonstrate the ability to judge the appropriate medical and surgical management of diseases of the spine and spinal cord.
- You should demonstrate knowledge about the appropriate surgical management of diseases affecting the extracranial arteries, and of vascular malformations of the brain and spinal cord.
- You should demonstrate knowledge about the presentation, diagnosis, and management of patients with primary and secondary brain neoplasm.
- You should demonstrate knowledge about the risks and complications of neurosurgical procedures, and the sequelae of surgery, and of head injury and subarachnoid hemorrhage, and of the treatment of brain tumors.

**Medical Knowledge**

- You should demonstrate knowledge about the neuroanatomic issues that concern surgical approaches to disease.
- You should demonstrate knowledge about the genetics of cancer and its bearing on treatment.
- You should demonstrate knowledge of the mechanisms that determine intracranial pressure in health and disease.
Practice-based Learning

- You should demonstrate the ability to use computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for lifelong learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.
- You should demonstrate the ability to use the review of your own practice to guide learning

Interpersonal and communication skills

- You should demonstrate effective communication with patients, families
- You should demonstrate effective communication with clerks, secretaries, nursing staff, other residents, consulting residents and attendings, and neurology and neurosurgery attending staff, and with the patient’s referring physicians.

Professionalism

- You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.
- You should demonstrate consideration of ethical issues in neurosurgery such as addressing surgical risks, complications, brain death, prognosis to patients and their families.

Systems-based practice

- You should demonstrate consideration of cost and appreciation of resources available to patients to cover the costs of surgical care
- You should demonstrate the ability to work with social services and other allied health professionals to plan for the care of surgical patients after discharge;
- You should be aware of the resources available in the patient’s community to promote the patient’s health.

Suggested Textbooks:

- Wilkins & Rengachary's Neurosurgery
- Youman's Neurological Surgery
- Greenburg's Handbook of Neurosurgery

1. Behavioral Neurology Mini-Fellowship

Program Director: Glen Finney, M.D.

Description:
At the beginning of the mini-fellowship, residents will meet with the behavioral neurology mini-fellowship program director to determine a research project that the resident will complete during the mini-fellowship. This project may serve as their senior research project or be an additional project. It is anticipated that by the end of the mini-fellowship the resident will prepare a presentation of the project to be given as a lecture and will submit a write up for submission as a poster/platform presentation at a scientific meeting and/or for publication in a peer reviewed journal. In addition, residents will be expected to write at least one case report on an interesting behavioral neurology patient which may be submitted for presentation or publication. Residents evaluate patients with neurobehavioral disorders in the Memory and Cognitive Disorders Clinics, and in consultation on the wards. They are supervised by attending faculty from behavioral neurology. Patients with the full spectrum of dementing diseases, plus patients with focal neurobehavioral syndromes such as aphasia, alexia, agnosia, or apraxia, are discussed in detail. Residents will observe, learn and perform neuropsychological testing used to assess specific disorders, such as disorders of language or memory. Residents attend all Memory and Cognitive Disorders Clinics during the week, especially the Wednesday Memory Disorders Clinic with Dr. Heilman that begins at 11 am. When Dr. Heilman’s clinic is cancelled for any given Wednesday, the resident will instead attend Dr. Burks’ Wednesday afternoon memory clinic. In addition, residents are expected to attend Tuesday Grand Rounds from 11:30 – 12:45, weekly Dementia Consensus Conference (check with Dr. Finney for times and dates, though typically on Tuesday afternoons). Residents attend behavioral neurology conferences, including the weekly meetings of the Center for Neuropsychological Studies on Fridays from 1:30 – 2:30 in the VA 3rd floor conference room E-336 from Labor Day to Memorial Day, as well as monthly Language and Brain Group meetings from 2:30 – 3:30 pm (immediately following CNS lecture in same location).

Residents also be expected to write at least one case report on an interesting behavioral neurology patient which may be submitted for presentation or publication. Residents attend all Memory and Cognitive Disorders Clinics during the week, especially the Wednesday Memory Disorders Clinic with Dr. Heilman that begins at 11 am. When Dr. Heilman’s clinic is cancelled for any given Wednesday, the resident will instead attend Dr. Burks’ Wednesday afternoon memory clinic. In addition, residents are expected to attend Tuesday Grand Rounds from 11:30 – 12:45, weekly Dementia Consensus Conference (check with Dr. Finney for times and dates, though typically on Tuesday afternoons). Residents attend behavioral neurology conferences, including the weekly meetings of the Center for Neuropsychological Studies on Fridays from 1:30 – 2:30 in the VA 3rd floor conference room E-336 from Labor Day to Memorial Day, as well as monthly Language and Brain Group meetings from 2:30 – 3:30 pm (immediately following CNS lecture in same location).

Residents will also be excused for regular Friday noon lectures to attend Dr. Heilman’s Friday noon lab meeting. On Fridays when Dr. Heilman’s lab meeting is cancelled, residents will instead resume attendance at the residents’ Friday noon lecture.

Goals and Objectives:

Patient care
• You should be proficient in performing a complete mental status examination and higher cortical function examination. You should use the Florida Mental Status Examination as a guide.

• You should demonstrate the ability to develop hypotheses to explain specific behaviors, and how to examine the patient to test these hypotheses.

• You should demonstrate the ability to develop differential diagnostic considerations, plans for assessment and for treatment of patients with behavioral disorders, including when to order and how to be guided by neuropsychological testing.

• You should demonstrate knowledge of how “neurologic” disorders produce “psychiatric” symptoms, and how to distinguish illnesses that are traditionally called psychiatric from degenerative and other neurological disorders.

**Medical knowledge**

• You should demonstrate knowledge of the anatomic basis of behavior, about the lesions associated with specific behavioral disorders, and about brain-behavior relationships.

• You should demonstrate knowledge about dementia and other neurodegenerative disorders that have cognitive sequelae, their forms, and causes, including genetic and biochemical disorders.

• You should demonstrate knowledge about the effects of drugs, both toxic and therapeutic, and cognitive rehabilitation and compensation on behavior.

**Practice-based Learning**

• You should demonstrate the ability to computerized and non-computerized information systems to facilitate patient care and to facilitate the development of techniques for life long learning. Be able to critically review the salient literature, and base treatment on the best medical evidence.

**Interpersonal and communication skills**

• You should demonstrate the ability to communicate with patients who have behavioral disorders, and with their families.

• You should demonstrate the ability to work with behavioral neurology fellows and faculty to improve your knowledge of patient care and research in behavioral neurology.

• You should demonstrate the ability during interdisciplinary conferences to discuss with professionals from different facets of health care research, diagnosis, treatment, and management of patients with behavioral neurology disorders.

**Professionalism**

• You should demonstrate attitudes that foster honesty, respectfulness towards patients and peers, dedication to patient care, and willingness to acknowledge mistakes.

• You should demonstrate consideration of ethical issues involved in the care of patients with behavioral disorders, including competency, capacity, and the appropriate use of surrogates to make medical decisions.

**Systems-based practice**

• You should demonstrate knowledge about resources available in the patient’s community to promote the patient’s health.

• You should demonstrate knowledge about the resources available to assist patient with behavioral disorders and to assist their families.

• You should demonstrate knowledge of the roles of different allied health professionals in the diagnosis, treatment, and management of patients with behavioral neurology dysfunction.

**Suggested Textbooks:**

- Mesulam’s *Principles of Behavioral Neurology*
- Cummings & Benson’s *Dementia: A Clinical Approach*
- Heilman and Valenstein’s *Clinical Neuropsychology*

**Neuromuscular Medicine Mini-Fellowship**

**Program Director: Dr. S.H. Subramony, MD**

**Description**

Neuromuscular Medicine Mini-Fellowship is provided during your PGY 4 year, prior to the completion of your residency training. It consists of five to six months of training in neuromuscular medicine with focus on EMG/NCS training. The goals of the mini-fellowship are to develop competence in the assessment and management of acquired and hereditary neuromuscular diseases. You will be involved in the multidisciplinary MDA clinic as well as the neuromuscular clinics attended by the faculty in the division. You will learn how to use clinical symptoms and signs to design studies in a logical and standardized way, interpret findings and further tailor the studies to collect
pertinent ancillary evidence for the diagnosis of neuromuscular diseases. You will participate in muscle biopsy conferences and be introduced the basics of muscle and nerve pathology. You will also learn the uses and pitfalls of currently available gene tests as they apply to neuromuscular diseases. You will also learn how to formulate reports and communicate with referring doctors. A clear, dedicated goal is to train you how to incorporate EMG/NCS into the diagnostic workup of neuromuscular diseases. You will learn the basic concepts of EMG/NCS and the anatomy underlying these studies. You will have enough hands-on opportunities to learn how to perform nerve conduction studies (motor, sensory, late responses, repetitive stimulation and blink reflex) under the supervision of our skilled technicians, the Clinical Neurophysiology Fellows and the attending neurologists. You will also perform needle EMG examination under direct supervision of our attendings. You will learn how to analyze spontaneous activities, motor unit potentials, recruitment patterns and interference patterns. You will learn the normal and common abnormal electrophysiological findings in neuromuscular diseases including neuronopathy, plexopathy, radiculopathy, peripheral neuropathy, neuromuscular junction diseases, myopathy, and entrapment syndromes. Upon successful completion of the course, you will be awarded a certificate from our program.

Goals and Objectives:

Patient care

• You should demonstrate the ability to obtain neurological history and neurological examination focusing on the neuromuscular system.
• You should demonstrate the ability to examine for and recognize the variety of neuromuscular diseases encountered in clinical practice.
• You should demonstrate knowledge of the technical basics of performing and interpreting the results of EMG/NCS.
• You should demonstrate the ability to use EMG/NCS to test hypotheses regarding patient differential diagnosis.
• You should demonstrate the ability to choose appropriate pharmacologic agents in the treatment of neuromuscular diseases, understanding the indications, side effects, and drug interactions. To have some understanding of non-pharmacologic treatments, including the importance of physical and occupational therapy, as well as the indications for surgical procedures.
• You should demonstrate the ability to predict the prognosis of common neuromuscular diseases and convey the information to patient, family and medical staffs.
• You should demonstrate appreciation of the limits of medical therapy, and the need for developing strategies to assist the patient and family to cope with effects of the illness.

• You should be familiar with the options in the management of severely disabled neuromuscular disease patients(PEG, CPAP, mechanical ventilation, alternative communication skills)
• You should demonstrate the ability to coordinate multidisciplinary approach in patients’ management.

Medical Knowledge

• You should demonstrate the knowledge of relevant neuroanatomy, with particular attention to motor neuron, peripheral nerves, neuromuscular junction and muscle system.
• You should demonstrate the knowledge in neurogenetics, especially genetics related to neuromuscular disease and its application in diagnosis, management and counseling.
• You should demonstrate the knowledge of clinical neurophysiology and its application in electrophysiological diagnosis.
• You should demonstrate the knowledge of the clinical presentations of the disorders included among neuromuscular diseases
• You should demonstrate knowledge on how to localize a patient’s problem in terms of the anatomy and physiology of the neuromuscular system.
• You should demonstrate knowledge about the specific categories of diseases that affect the neuromuscular system and to formulate hypotheses with respect to differential diagnosis.
• You should demonstrate knowledge about commonly accepted guideline (AAN and AANEM) and their limitations in the management of neuromuscular diseases.

Practice-based Learning

• You should be able to use textbooks, journals, on-line resources, and computerized databases to effectively research best medical practice.
• You should be able to critically review the computerized and non-computerized information to find the best medical evidence to facilitate patient care and to facilitate the development of techniques for life long learning.

Interpersonal and communication skills

• You should demonstrate effective communication with patients with neuromuscular diseases and their families. Appropriate communication with the patients coming for EMG/NCS is especially important. It is generally not appropriate to jump into a conclusion either for or against a diagnosis solely based on EMG/NCS. Always suggest
patient to follow with the referring doctor for future workup and management.  
• You should demonstrate effective communication with clinic staff (EMG/NCS technician, schedulers, nurses), and with patient’s referring physicians.  
• Always communicate with your mentor in designing EMG/NCS studies and formulating the official report.  
• For complicated neuromuscular disease (e.g. ALS, muscular dystrophy), prompt and sufficient communication and coordination with our multidisciplinary team is very important in improving patient’s long-term prognosis and quality of life.

Professionalism

• You should demonstrate attitudes that foster dedication to patient care, respect for the feelings of patients, and willingness to acknowledge mistakes, and dedication to improving performance  
• You should dictate all EMG/NCS procedure notes and make sure that it is uploaded to the EMR system in a timely manner. Communicate with requesting doctor directly if you need to make any suggestion. Professional respect in writing the report is always appreciated.  
• You should ensure that office visit dictations for all patients seen are comprehensive, accurate and finished in a timely manner.

System-based practice

• You should demonstrate knowledge of the cost-effective use of electrodiagnostic procedures.  
• You should demonstrate knowledge about resources available in the patient’s community to promote the patient’s health.  
• You should demonstrate the knowledge about Medicare billing and documentation requirements; about the variety of public and private insurance plans; and, about resources for uninsured patients.  
• You should observe the interdisciplinary model used for the outpatient care of the movement disorders patients and realize its advantages and develop similar practices in the way you care for your own patients.

Suggested Textbooks:

• Kimura's Electrodiagnosis in Diseases of Nerves and Muscle: Principals and Practice  
• Electromyography and Neuromuscular Disorder: Textbook and CD ROM 2005 by David Preston and Barbara Shapiro

• Diagnosis and management of peripheral nerve disorders by Mendell, Kissel and Cornblath, Oxford 2001  
• Evaluation and treatment of myopathies by Mendell, Griggs, Logigan and Kissel.  
• EMG Pearls by Dr. Greenberg and Amato.

3. Research Electives:

Description:
Each resident is required to carry on a scholarly project during their three years of residency under faculty supervision. On entry into the neurology program you will be assigned an initial faculty mentor for scholarly research, though you will likely choose another faculty member as your research mentor once your ideas develop in this area. During your PGY2 year you will have 0.5 - 1 month of Research selective. You will be expected to meet with your assigned faculty mentor to develop a plan of study and meetings during this time to explore areas of interest to you for research and identify potential faculty and projects with which and on which to work. By the end of the PGY2 research selective you should report to your faculty mentor your progress during the rotation. You should choose a research mentor by the end of your PGY2 year.

You will have an additional 1 - 2 months (depending on level of development of project) in your PGY3 year for working with your chosen project mentor on a protocol and any institutional review board submissions that are necessary for implementation of your project. You should meet with your faculty research mentor prior to this time to develop a timetable for project study and writing so that by the end of the first month you have the necessary protocol and if applicable IRB submission to move forward with your project. Advanced residents may go on to actual initiation of data collection in a second block depending on program director approval.

In the PGY4 year you will have time to complete data collection, analysis of data, and prepare presentation of your project at the end of the academic year. Typically this is done in conjunction with electives or a dedicated mini-fellowship track, though residents who did not use a second month in the PGY3 year for research may opt to do a pure research block to advance the project.

Written records of the progress of your research project become a part of your portfolio.

In addition, throughout your residency, you are
encouraged to write up cases or treatments of interest as case reports or short notices. This experience is valuable, as it allows you carefully to review a subject, learn how to evaluate the clinical literature, and enhance your writing skills under the supervision of a faculty member. Faculty are ready to assist you.

**Goals and Objectives:**

**Patient Care**
- When involved in clinical research, you should demonstrate the ability to incorporate research such as clinical trials in the care of the neurological patient.
- You should demonstrate the conduct of clinical research in the most compassionate manner.

**Medical Knowledge**
- You should demonstrate knowledge about good clinical practices (GCP), and human subjects protection in the conduct of clinical research.
- You should demonstrate in-depth understanding of the research you are conducting.

**Practice-based Learning**
- You should demonstrate the ability to use computerized and non-computerized information systems to facilitate research to instill the value of life long learning.
- You should demonstrate ability in extracting information and salient features from the history and examination of your patient, and their caregivers upon which to base your differential diagnosis and management.
- You should be able to use research to guide your own growth in neurology.

**Interpersonal and communication skills**
- You should demonstrate your ability to communicate effectively with research subjects and their families.
- You should demonstrate your ability to communicate with clinic and research staff (schedulers, nurses, coordinators), and with patient’s referring physicians.
- You should demonstrate your ability to communicate and interact with your research mentor and other research collaborators.

**Professionalism**
- You should demonstrate attitudes that foster honesty, respectfulness towards patients, good work ethic and willingness to acknowledge mistakes.
- You should demonstrate the ability to recognize and deal effectively with ethical issues that arise in the conduct of research.
- You should try to meet all your research timelines.

**Systems-based practice**
- You should demonstrate knowledge of how your research can improve the delivery of care for your patients and their communities.

**RESEARCH**

The following is an overview of some of the research directions of faculty in Neurology.

**Behavioral Neurology**

Dr. Kenneth M. Heilman joined the department in 1970. Dr. Robert T. Watson joined Dr. Heilman in his research when he began his neurology residency in 1970. Dr. Valenstein joined the behavioral neurology group in 1974. From their initial studies on the phenomenon of unilateral neglect in humans and primates, they developed a model of attention and intention, or preparation for and initiation of thought and movement. Over the years, many other investigators have joined this group of behavioral neurologists and have greatly expanded its field of interests. Dr. Eileen Fennell, Professor of Clinical and Health Psychology and Neurology is an expert in pediatric neuropsychology. Dr. Dawn Bowers, a neuropsychologist in the Department of Neurology, has published widely in the literature on neglect, memory, and emotion. Dr. Leslie Gonzalez-Rothi is a Speech/Language Pathologist in the Department of Neurology who is recognized nationally as a researcher in the diagnosis and treatment of language disorders, and has also written extensively on apraxia. Dr. Stephen E. Nadeau, Professor of Neurology, has particular interest in grammatical disorders, frontal lobe disturbances, PDP (parallel distributed processing) modelling of brain function, and functional neuroimaging. Dr. Russell Bauer (Professor and Chair of Clinical and Health Psychology and Neurology) is involved in research on agnosia and memory. Dr. Bruce Crosson, Professor of Clinical and Health Psychology and Neurology, has written authoritatively on the contribution of sub-cortical structures to behavior, and leads the Health Center initiative in functional neuroimaging.

Among current behavioral neurology research projects are investigations of attentional disorders in primates and humans, neuropsychological studies on memory and emotion, and neuroanatomic (MR imaging) studies of developmental disorders (dyslexia, emotional disorders), and creativity. Studies in functional neuroimaging of language and praxis in awake behaving humans are underway using SPECT scanning, and plans are being made for functional MR imaging.

**Epilepsy and Clinical Neurophysiology**

For more than twenty years, Dr. B. J. Wilder has studied epilepsy, first with pioneering physiological studies, and later on with extensive studies on the pharmacodynamics,
metabolism, and efficacy of anticonvulsant drugs. He has carried out or contributed to clinical trials of many of the recently developed anticonvulsants.

The Epilepsy Program is now headed by Dr. Stephen Eisenschenk. Dr. Eisenschenk is fellowship trained in neurophysiology in epilepsy and sleep medicine at the University of Florida. His services include diagnosis of both epileptic syndromes and sleep disorders. He evaluates patients seen in Neurology/Epilepsy clinic for both medical and surgical treatment of epilepsy. His role pertaining to the Comprehensive Epilepsy Program is to assist in electrographic localization of seizure origin for surgical resection, if possible. Dr. Eisenschenk also performs intraoperative and extraoperative testing of brain function to minimize the risk of secondary loss of motor, language, visual, etc., function following epilepsy surgery. Dr. Eisenschenk is the director of the program utilizing stereotactic radiosurgery for the noninvasive "surgical" treatment of epilepsy.

Dr. Paul Carney (Pediatrics) is a pediatric neurologist with clinical and research interests in epilepsy. He has developed a mouse model of epilepsy. Dr. Basim Uthman was fellow under Dr. Wilder. His principal interest is the treatment of epilepsy. He conducts clinical trials the efficacy, safety and pharmacokinetics of new and current antiepileptic drugs, and has completed more than thirty trials. His pilot and follow-up studies were a major contribution that led to FDA approval of vagus nerve stimulation as a treatment for epilepsy. Dr. Stephan Eisenschenk’s research has focused on assessment of neuronal cell densities within hippocampal subregions, propagation pathways of seizures based on intracranial videoEEG monitoring, and the development of LINAC stereotactic radiosurgery for non-invasive ‘surgical’ treatment of refractory focal epilepsy.

Motor Control and EMG

The study of central and peripheral mechanisms of motor control is a new area of research development within the Department of Neurology. Dr. William Triggs uses transcranial magnetic cortical stimulation in conjunction with assessment of spinal cord reflex excitability to clarify mechanisms of human motor control. Current interests include the study of corticospinal facilitatory and inhibitory mechanisms, and the exploration of physiological asymmetries in motor function associated with human handedness.

A fellowship in motor control and clinical EMG, under the directorship of Dr. Triggs, has been offered since 1992. Residents in neurology benefit from interaction with the EMG fellow. Residents may also contribute to investigations in motor control, as described above, or to ongoing clinical investigations (for example, electrophysiologic findings in demyelinating neuropathies; transcranial magnetic stimulation pre- and post-pallidotomy in patients with refractory Parkinson’s disease; and prospective assessment of neuropathy following cardiac transplantation). They may also collaborate in reporting patients of interest seen in the EMG laboratory or the neuromuscular clinics.

Neurorehabilitation

An exciting initiative studying mechanisms of recovery of function and new methods of rehabilitation for motor and cognitive deficits after stroke and other nervous system disorders has been generously funded by both the VA and NIH. Dr. Leslie Gonzalez Rothi is the principal investigator, and many faculty are involved, both in neurology and in other departments. The Brain Rehabilitation Research Center (BRRC), focuses on exciting research designed to improve the quality of life for individuals who have had a stroke, incomplete spinal cord injury or other neurological problems.

This Center of Excellence encourages, advises and supports researchers and clinicians who are interested in initiating clinically relevant research in rehabilitation of neurocognitive (the study of the process of knowing and, more precisely, the process of being aware, knowing, thinking, learning and judging) and neuromotor (the study of the process of the movement of a part of the body) impairments. The types of research currently being funded include:

- treatments using techniques in physical, speech, and cognitive therapies
- drug treatments that may improve recovery of brain functioning
- brain imaging techniques to study changes associated with treatment
- interventions to enhance the daily lives of patients with brain injuries
- telecommunication technology to evaluate treatments

Movement Disorders

The University of Florida Parkinson’s Disease and Movement Disorders Center (UFPDMDC), created in July 2002, is one of the youngest, and most rapidly growing Centers in the McKnight Brain Institute’s Department of Neurology. In its 12 years of existence, growth has been exponential. The center is now composed of 14 Full-time Staff Members, and 2 dozen inter-disciplinary faculty members (from 14 Departments) within the University of Florida, as well as numerous other international collaborators. The UFPDMDC is considered one of the leading National Parkinson Foundation (NPF) Centers of Excellence (COE). It has also designated by both makers of botulinum toxins (Allergan and Solstice Pharmaceuticals) as a Botulinum Toxin Center of Excellence.
The UFMDC has one of the most comprehensive research groups in the country. The majority of the Center’s research has been fueled by NPF’s initial support of the INFORM (Interdisciplinary Florida Registry and Movement Disorders) database. The database has supported the publication of over 30 abstracts and research papers, and provided the preliminary data for many grants and future projects. The UFPDMDC has been actively expanding its research program to include projects with basic science, translational initiatives, and clinical research. Basic science research at the center has included the development of genetic therapies and adult stem cell research for the treatment of PD and other movement disorders. Additionally, the Center has a large investment in the development of animal and laboratory models of PD and Huntington’s disease.

The UFPDMDC Surgical-Research Program, under the direction of Drs. Michael Okun and Kelly Foote, is one of the most respected in the nation, and includes research projects on accurate brain targeting, post-operative imaging, mood/cognitive effects of surgery, and the development of better surgical procedures for Deep Brain Stimulation (DBS) and other PD related surgical therapies. With 3 DBS surgeries per week, it is perhaps the busiest surgical program for Movement Disorders in the entire East Cost United States.

The Clinical Trials Center, under the direction of Dr. Michael Okun, is one of the nation’s busiest and most recognized. Currently, the center has close to 2 dozen ongoing/active single-center investigator-initiated and multi-center clinical trials in Parkinson’s disease, Huntington’s disease, dystonia and other movement disorders.

Stroke

Stroke research is a vital component for patients at the University of Florida’s Stroke Program. Director Michael F. Waters, MD, PhD and the Stroke Program’s staff are currently involved in National Institutes of Health (NIH)-funded clinical trials related to stroke prevention, acute stroke therapy and neuroimaging in stroke. Because of their active participation in these and other clinical stroke research trials, Dr. Waters and his staff remain up to the minute in knowledge of new stroke therapies and can discuss the best treatment options for stroke patients. In turn, their patients benefit by having the latest information on stroke prevention and treatment and, as appropriate, can participate in clinical research.

The Stroke Program at the University of Florida is currently participating in several clinical trials such as the Insulin Resistance Intervention after Stroke Trial (IRIS) and the Stenting vs. Aggressive Medical Management for Preventing Recurrent Stroke in Intracranial Stenosis (SAMMPRIS) trial.
FACULTY

DEPARTMENT OF NEUROLOGY

The Department of Neurology has 24 full-time, Board Eligible or Certified adult neurologists, while the Division of Pediatric Neurology has 5 faculty members. These comprise the core faculty of the UF Neurology Residency Training Program. In addition, there are 3 full-time non-neurologists in the faculty. Affiliate faculty include 5 Pediatric Neurologists, 18 full-time neurologists at the University Hospital in Jacksonville, and several full time faculty members from the Departments of Neurosurgery (13), Psychiatry (85); Division of Neuroradiology (11), Division of Neuropathology (2), and other allied health departments.

A) Core Neurology Faculty @ UF Gainesville

Tetsuo Ashizawa, M.D., Professor of Neurology, Chairman of Neurology. Dr. Ashizawa received his M.D. from Keio University School of Medicine in Tokyo, Japan and completed his Neurology residency training at Baylor College of Medicine where he was appointed Chief Neurology Resident. He then completed fellowship training in Neuromuscular Studies and Neurochemistry with the Muscular Dystrophy Association at Baylor. He joined the faculty of the University of Florida in April 2009 when he was selected as Chairman for the Department of Neurology.

His research interests include Spinocerebellar Ataxia Subtype 10, Myotonic Dystrophy Type 1, Huntington’s Disease, Friedreich’s Ataxia, Parkinson’s Disease, and Myasthenia Gravis. Role in residency training: Didactic lecturer in clinical neurology, ataxias, movement disorders, and neurogenetics. Member, Neurology Resident Oversight Committee, Discussant, Grand Rounds.

Lucas J. Beerepoot, M.D., Assistant Professor of Neurology. In addition to general neurology, Dr. Beerepoot specializes in neuro-oncology, epilepsy and palliative care. Dr. Beerepoot is board certified in neurology by the ABPN. Role in residency training: Didactic lecturer in general & clinical neurology, Shands attending, Discussant, Neurology Grand Rounds.

Jean Cibula, M.D., Assistant Professor of Neurology. Dr. Cibula obtained her MD degree from Case Western Reserve University in Cleveland, Ohio and completed her neurology residency at the University of Florida. She completed fellowships in Behavioral Neurology and Epilepsy at the University of Florida. Dr. Cibula joined the faculty of the University of Florida in 2008. She has interests in Women’s and Adolescent Issues in Epilepsy, Surgical Evaluation and Management of Epilepsy, and New Onset Seizures as well as medical education. Role in residency training: Didactic lecturer in EEG, epilepsy; Epilepsy monitoring unit attending; Epilepsy clinic attending; Epilepsy I & II rotation faculty; liaison for Epilepsy education to the UF Neurology Residency Program.

James Cook, M.D., Assistant Professor of Neurology. Role in residency training: Didactic lecturer in general & clinical neurology, Shands attending, Discussant, Neurology Grand Rounds.

Stephan Eisenschenk, M.D., Clinical Associate Professor; Clinical Director, Adult Neurology Comprehensive Epilepsy Program; Medical Director, UF & Shands Epilepsy Monitoring Unit. Dr. Eisenschenk was a Junior Honors student at UF, and completed his Neurology Residency here in 1997. He completed a fellowship in Clinical Neurophysiology with emphasis on EEG in 1998. He has maintained an interest in neurological research throughout his schooling and training, and has developed a special interest in epilepsy and sleep medicine. Role in residency training: Didactic lecturer in EEG, epilepsy and sleep disorders; Epilepsy monitoring unit attending; Epilepsy clinic attending; Introduction to EEG selective rotation faculty supervisor.

Adam D. Falchook, M.D., Assistant Professor. Dr. Falchook received his MD at the Mount Sinai School of Medicine and completed his residency training here, at the University of Florida. After residency training, Dr. Falchook completed a fellowship in Behavioral Neurology, also at the University of Florida.

Role in residency training: Didactic lecturer in clinical neurology, behavioral neurology and memory disorders; Discussant, Neurology Grand Rounds

David Burks, M.D., Assistant Professor of Neurology. Dr. Burks obtained his MD degree from the University of Texas at San Antonio and did his Neurology residency at Tulane. He completed fellowships in clinical neurophysiology (at Tulane) and behavioral neurology (at the University of Florida) and joined our faculty in 2000. Role in residency training: Didactic lecturer in clinical neurology, behavioral neurology; VA ward attending; Multiple Sclerosis and Memory Disorders clinic attending; Neuro I longitudinal rotation faculty supervisor; Member, Neurology Residency Oversight Committee; Discussant, Neurology Grand Rounds.

Glen R. Finney, M.D., Assistant Professor, Co-Director, Behavioral Neurology Fellowship, Co-Director, Memory and Cognitive Disorders Program, Co-Director, Center for Neuropsychological Studies. Dr. Finney received his MD at Temple University and finished his residency training at the University of Miami. He did a fellowship in Behavioral Neurology. His interests include memory disorders, behavioral neurology, neurobiology of creativity, resident and medical student education, and neurology advocacy. Role in residency training: residency Program Director, Didactic lecturer in clinical neurology, behavioral neurology and memory disorders; Shands attending; Memory and
cognitive disorders clinic attending; Member, Neurology Residency Oversight Committee; Discussant, Neurology Grand Rounds

David Fitzgerald, M.D., Assistant Professor  Dr. FitzGerald is a neurologist specializing in behavioral neurology using functional neuroimaging. He completed his medical internship at St. Elizabeth’s Medical Center in Brighton, MA in 2001. He subsequently completed his neurology residency at UMass Medical Center in 2004. Dr. FitzGerald joined the University of Florida community in 2004 as a Neurology Fellow under Kenneth M Heilman, MD. He has strong research interests in cognitive neuroscience and functional magnetic resonance imaging. His current functional imaging projects include: diffusion tensor imaging of traumatic brain injury; clinical trial investigation as to the effectiveness of Donepezil on Alzheimer’s disease; and pathological gambling behavior. Role in residency training: Didactic lecturer in clinical neurology, behavioral neurology and memory disorders; Shands ward attending; Discussant, Neurology Grand Rounds

Annet E. Har-el Falchuck, M.D., Assistant Professor  Dr. Har-el is a neurologist with clinical specialization in evaluation and treatment of neuromuscular diseases such as myopathy, myasthenia gravis, neuropathy, and motor neuron diseases including amyotrophic lateral sclerosis (ALS). Dr. Har-el performs electrodiagnostic studies (EMG/NCS), muscle and nerve biopsies and treats upper and lower extremity spasticity with botulinum toxin. Role in residency training: Didactic lecturer in clinical neurology; Shands ward attending; Discussant, Neurology Grand Rounds

Kenneth M. Heilman, M.D., Clinical Professor of Neurology and Clinical Psychology; Co-Director, Behavioral Neurology Fellowship, Co-Director, Memory and Cognitive Disorders Program, Co-Director, Center for Neuropsychological Studies. Dr. Heilman received his M.D. from the University of Virginia and did his neurology training at Boston City Hospital. He came to the University of Florida in 1970, where he continued research into the mechanisms of the neglect syndrome. His numerous publications include articles in all areas of behavioral neurology, and in other aspects of clinical neurology. He is a recognized authority in behavioral neurology, and was elected President of the International Neuropsychological Society in 1982. He is Director of the Center for Neuropsychological Studies at the University of Florida. Role in residency training: Didactic lecturer in clinical neurology, behavioral neurology and memory disorders; Shands ward attending; Memory disorders clinic attending; Neurology longitudinal rotation and Neuropsychiatry selective rotation faculty supervisor; Discussant, Neurology Grand Rounds; Research mentor

Maria Hella, M.D., Assistant Professor  Dr. Hella received her MD degree from the University of Miami, Miller School of Medicine. She then completed both her Neurology Residency and fellowship in Clinical Neuropsychiatry at the University of Florida. Role in residency training: Didactic lecturer in EEG, epilepsy; Epilepsy monitoring unit attending; Epilepsy clinic attending.

Anna Khanna, M.D. Assistant Professor  Dr. Khanna completed her Preliminary Internal Medicine residency year in the University of Medicine and Dentistry of New Jersey in 1999 and completed her neurology residency there in 2002. She was inspired to pursue an interest in vascular neurology and became UMDNJ’s first stroke fellow and completed the fellowship in 2003. She remained on faculty at UMDNJ as an Assistant Professor and stroke program director. Dr Khanna was the director of the outpatient stroke clinic. She introduced a comprehensive vascular ultrasound examination to the outpatient setting. She also was the director of the resident clinic. Dr Khanna then joined the faculty in Saint Barnabas University Hospital where she was the stroke program director. Dr Khanna moved to Florida after a search for warmer climate in 2007. She joined Neurological Associates, a private practice group headed by Dr Jay Rubin. She provided general neurology care to the community serving mainly as a neurohospitalist in Ocala Regional and West Marion hospitals. She decided to return to academics after her interest in vascular neurology was rekindled by the current director of the vascular division at University of Florida. She joined the faculty as an Assistant Professor in the vascular neurology division in the University of Florida in 2011. She is currently providing care to patients on the stroke service and in the outpatient clinic. Role in residency training: Didactic lecturer in neurogenetics and cerebrovascular disorders; Shands Neurovascular attending; Discussant, Neurology Grand Rounds

Irene Malaty, M.D., Assistant Professor  Dr. Malaty, M.D., studied microbiology and psychology at Indiana University in Bloomington, IN. She attended Indiana University School of Medicine on the Notre Dame campus and in Indianapolis, IN. After completing a transitional year of medicine at St. Vincent’s hospital in Indianapolis, she moved to Gainesville for neurology residency and served as chief resident. She completed a fellowship in movement disorders at the University of Florida and joined the faculty thereafter. She cares for patients with a variety of movement disorders at the Shands medical plaza and at the Malcolm Randall Veteran’s hospital. She serves on the executive board of the Florida Society of Neurology, and on the executive committee of the American Academy of Neurology Neuroendocrinology Section, as the Movement Disorder Subsection Chair. Dr. Malaty is committed to providing quality, state-of-the-art care for all movement disorders, but has specific interests in the non-motor aspects of Parkinson’s disease, and in compulsivity as it applies to
Tourette’s syndrome and other movement disorders. Role in residency training: Didactic lecturer in Movement Disorders; Shands ward attending; Movement Disorders clinic attending.

Stephen E. Nadeau, M.D., Professor of Neurology and Clinical & Health Psychology; Director, Gait and Balance Clinic. Dr. Nadeau received his M.D. from the University of Florida, where he also trained in neurology. He joined the Neurology staff in 1987 after having been on the faculty of the Department of Neurology of the University of Mississippi. He is a member of the Geriatric Research, Education and Clinical Center at the Gainesville VA Medical Center. He is a recognized authority on cerebrovascular disease and neurological aspects of collagen vascular disease, and pursues research interests in stroke, dementia, neurolinguistics, and other aspects of higher cortical function. Role in residency training: Didactic lecturer in clinical neurology, behavioral neurology and cerebrovascular disorders; VA ward attending; Stroke and Pain clinic attending; Neuro I clinic and Continuity clinic longitudinal rotation faculty supervisor; Discussant, Neurology Grand Rounds; Research mentor

Michael S. Okun, M.D., Adelaid Lachner Associate Professor of Neurology; Co-Director, Movement Disorders Center. Dr. Okun received his MD and did his residency at the University of Florida, and then completed two years of fellowship at Emory studying movement disorders and intraoperative physiology for deep brain stimulation (DBS). He is well published in Movement Disorders, especially in deep brain stimulation surgery and currently serves as the Medical Director of the National Parkinson Foundation. Role in residency training: Didactic lecturer in Movement Disorders; Movement Disorders and DBS clinic attending; Discussant, Neurology Grand Rounds; Research mentor

Nikolaus McFarland, M.D., Ph.D., Assistant Professor; Dr. McFarland’s research focuses on understanding the pathological mechanisms of Parkinson disease and related disorders (atypical parkinsonisms) and in particular the role of alpha-synuclein in cell toxicity and neurodegeneration. A major hallmark of neurodegenerative disorders, including Parkinson disease, is abnormal protein aggregation and deposition. In Parkinson disease and related disorders, intracellular inclusions called Lewy bodies are found. A principal component of these Lewy bodies is alpha-synuclein. Abnormal folding, aggregation, and deposition of alpha-synuclein are believed to be central to the development of neuronal dysfunction and degeneration. A primary goal of my research is thus to elucidate the mechanisms of alpha-synuclein toxicity and to characterize molecular mediators that may enhance or rescue its toxicity. Work involves use of cellular, neuronal, and animal models that employ alpha-synuclein overexpression and allow for testing of various genes, molecules, and compounds that may modify toxicity and have the potential for novel therapeutics. Role in residency training: Didactic lecturer in Movement Disorders; Movement Disorders clinic attending; Discussant, Shands ward attending, Neurology Grand Rounds discussant.

Ramon L. Rodriguez, M.D., Associate Professor; Director of Clinical Services. Dr. Rodriguez received his MD at the University of Puerto Rico. He finished residency training at the University of Texas Medical Branch in Galveston and movement disorders fellowship here at the University of Florida. Besides his interests in surgery for movement disorders, Dr. Rodriguez has special interest in the translation of the latest advances in movement disorders research and the application into clinical practice. He is also experienced in the administration of Botulinum toxin for dystonia and spasticity. The main goal in his practice is to provide the highest level of care and improve the quality of life of his patients. Dr. Rodriguez directs the Tyler’s Hope Dystonia Center at UF and the Huntington’s disease clinic. In addition to clinical care, Dr. Rodriguez is investigator in multiple clinical trials attempting to find ways to delay the progression of Parkinson’s disease as well as development of new therapies. He is also an Associate Professor at the Department of Neurology and is Board Certified in Neurology by the American Board of Psychiatry and Neurology. Role in residency training: Didactic lecturer in Movement Disorders; Shands ward attending; Movement Disorders and Botulinum toxin clinic attending; Continuity clinic longitudinal rotation faculty supervisor; Member, Neurology Residency Oversight Committee

Leslie A. Rudzinski, M.D.; Assistant Professor, Dr. Rudzinski is from Centerville, Ohio and received her B.S. in the Biological Sciences and M.D. from The Ohio State University. She completed her internship in preliminary medicine at Riverside Methodist Hospital in Columbus, Ohio and neurology residency at Mayo Clinic Florida in Jacksonville. She then completed a two-year fellowship in clinical neurophysiology/electroencephalography and epilepsy at Mayo Clinic Rochester. She is board certified by the American Board of Psychiatry and Neurology in Adult Neurology, Clinical Neurophysiology, and Epilepsy. She is a member of the American Academy of Neurology, American Epilepsy Society, and the American Clinical Neurophysiology Society. She is a current member of the Scientific Program Committee and Advocacy Committee of the American Epilepsy Society. She served on the Professional Advisory Board of the Epilepsy Foundation of Georgia and was a member of the Critical Care EEG Monitoring Research Consortium while at Emory University. Role in residency training: Didactic lecturer in EEG, epilepsy; Epilepsy monitoring unit attending; Epilepsy clinic attending.

J. Chris Sackella, M.D., Professor, VAMC. Dr. Sackella joined our faculty in 1993, after pursuing his
career in epilepsy and EEG on the faculty at the University of Michigan. He has investigated the biochemical and neurophysiological mechanisms of human temporal lobe epilepsy. He has conducted clinical trials of many of the newer anticonvulsants. He is currently engaged in the mathematical analysis of EEG in epilepsy, using chaos theory. Role in residency training: VA ward attending; Epilepsy clinic attending; Neuro I clinic and Continuity clinic longitudinal rotation faculty supervisor; Research mentor

S.H. Subramony, M.D., Professor, Program Director, Neurology Residency Program; Chief of the Neuromuscular Division Dr S. H. Subramony was trained in Neurology and Electromyography/ Neuromuscular diseases at the Cleveland Clinic, Cleveland, OH. Subsequent to that, he was on the faculty at the University of Mississippi Medical Center from (from 1980 to 2007 ), where he was named the Billy Guyton Distinguished Professor of Neurology. Later, at University of Texas Medical Branch in Galveston where he was appointed the Charlotte Warmoth Professor of Neurology (2007 to 2009 ), before coming to University of Florida in 2009. At the University of Mississippi Medical Center, he was the director of the Muscular Dystrophy Association (MDA) clinic and the Neuromuscular Division, in addition to directing a busy Ataxia Clinic. His investigative interests have been in the field of ataxias and he brings a wealth of experience in evaluating and managing patients with ataxias. At UF, he co-directs the Ataxia Clinic in the Movement Disorder Center with Dr Tetsuo Ashizawa, Chair of the Department of Neurology. In addition to patient management, this clinic will also be involved in many research projects.

His clinical experience includes the management of patients with all types of neuromuscular diseases including ALS, myasthenia gravis, polymyositis, neuropathies and muscular dystrophies. In the past he has participated in clinical trials in ALS and published in the field of neuromuscular genetics. His clinic at UF provides expert evaluation of patients with neuromuscular disorders and offers treatment that includes electromyography, muscle biopsy when appropriate, appropriate genetic testing and referral to ancillary services such as physical, occupational and speech therapy and evaluation for mobility aids. Role in residency training: Didactic lecturer in Neuromuscular disorders; Discussant, Neurology Grand Rounds.

William Triggs, M.D., Associate Professor of Neurology; Chief of Neurology VAMC
Dr. Triggs received MD at the University of Florida and his training in Neurology at the University of Texas in Houston, and has completed fellowships in Electromyography and Neuromuscular Disease and in Neurorhabilitation and Neurophysiology at Harvard Medical School. He joined the Department in July 1992. Dr. Triggs’ interests include application of neurophysiological techniques, including motor cortex stimulation, to clinical neurology. He assists in supervision of EMG training, and he teaches principles of neurorehabilitation to Neurology residents. Role in residency training: Didactic lecturer in clinical neurology and neuromuscular disorders; VA ward attending; Neuromuscular clinic attending; Discussant, Neurology Grand Rounds

Aparna Wagle Shukla, M.D., Assistant Professor of Neurology. Dr. Wagle Shukla is an Assistant Professor in Department of Neurology at University of Florida. She has an extensive clinical experience with double training in Neurology. She has undergone three years of Internal Medicine and 3 years of Neurology training in India, subsequently completed her second Neurology Residency from Little Rock, Arkansas. She did her movement disorders fellowship with special training in clinical electrophysiology from University of Toronto, Canada, a world renowned center for movement disorders. Her goal of practice is to provide highest level of quality care to her patients and she is also committed to pursue her research interests in movement disorders. Currently she is working on projects elucidating the underlying mechanisms of action for deep brain stimulation in DYT1 dystonia and the use of repetitive Transcranial Magnetic Stimulation as a treatment modality for symptoms of Parkinson’s disease, depression associated with Parkinson’s disease and apathy as a consequence of Deep Brain Stimulation therapy in Parkinson’s Disease. In addition she is a co-investigator on clinical trials focusing on improved therapies for motor fluctuations in Parkinson’s Disease. Role in residency training: Didactic lecturer in Movement Disorders; Shands ward attending; Movement Disorders clinic attending; Discussant, Neurology Grand Rounds; Research mentor

Vishnumurthy Shushrutha Hedna, MD Assistant Professor Dr. Hedna, M.D., is an assistant professor of neurology at the UF College of Medicine and is a key member of the only comprehensive stroke program in north central Florida.

Hedna obtained his medical degree at Karnataka University, India, and completed special training in internal medicine at Stanley Medical College in Chennai, India. Hedna received Distinction (first class) in his first and second year of medical school and a ‘Certificate of Merit’ in 2003 by the department of internal medicine. He then moved to the United Kingdom and completed residencies with a focus in elderly care in cardiology at Scunthorpe General Hospital; stroke at Doncaster Royal
Infirmary and pulmonary and cardiology at West Walkes General Hospital.

Hedna came to the United States in 2007 as an intern in internal medicine at North General Hospital in New York. While at North General, he was introduced to medical problems with patients who have social and economic issues, which furthered his interest in providing care for the elderly.

Hedna was accepted into the University of Florida neurology department’s residency program in 2008, which was followed by a neurovascular fellowship. Hedna joined the faculty as an assistant professor in 2012. He is board-certified in both neurology and vascular neurology.

His research interests include brain edema after stroke, young stroke including Takayasu’s Arteritis, and the role of neuro-inflammation in stroke and mechanisms of arm paresis in MCA stroke. He currently has publications pending on all three subjects and was awarded the Best Research Award for outgoing residents at UF in 2011.

**Role in residency training:** Didactic lecturer in cerebrovascular disorders; Shands Neurovascular attending; Discussant, Neurology Grand Rounds

**Michael F. Waters, M.D., Ph.D., Assistant Professor, Director, University of Florida Stroke Program.** Dr. Waters received his MD and PhD here at the University of Florida. He finished residency and neurogenetics fellowship at UCLA and served as the Director of the Stroke Program at Cedars Sinai before he moved back to the University of Florida in 2007. His special interests include stroke and neurogenetics, especially cerebellar ataxias. **Role in residency training:** Didactic lecturer in neurogenetics and cerebrovascular disorders; Shands Neurovascular attending; Discussant, Neurology Grand Rounds

**Meredith Wicklund, MD, Assistant Professor.** Dr. Wicklund is Assistant Professor in the Department of Neurology at the University of Florida. She completed a B.S. in Microbiology, graduating Magna Cum Laude from the University of Illinois at Urbana-Champaign. She obtained her M.D. from the University of Illinois College of Medicine at Rockford, where she graduated With Honors. Dr. Wicklund completed her internship at the University of Illinois in Urbana-Champaign and then residency in Neurology at Mayo Clinic in Rochester, MN. Following residency, she pursued fellowship training in Behavioral Neurology at Mayo Clinic in Rochester, MN.

Dr. Wicklund’s clinical practice is devoted to providing the highest level of neurologic care to a wide variety of neurologic disorders. She has a special interest in autoimmune, paraneoplastic and degenerative neurologic disorders and traumatic brain injury. Her research interests include developing a database and clinical trials in Alzheimer’s disease and other cognitive and degenerative brain conditions. Dr. Wicklund has made several presentations and been invited to speak at national and international meetings. **Role in residency training:** Didactic lecturer in general neurology; Shands ward attending; General clinic attending; Discussant, Neurology Grand Rounds

**Christina Wilson, MD, PhD** Assistant Professor Dr. Wilson received a PhD from the University of Pennsylvania in pharmacology. She then continued her studies at the same university earning her MD degree. Dr. Wicklund did both her Neurology Residency and a fellowship in Neurovascular Medicine at the University of Pennsylvania. **Role in residency training:** Didactic lecturer in vascular neurology; Shands Stroke attending; Vascular clinic attending; Discussant, Neurology Grand Rounds

**Guangbin Xia, M.D., Assistant Professor** Dr. Xia is a board-certified Neurologist and is also board-certified in Neuromuscular Medicine. He holds hospital privileges for EMG/NCS, muscle biopsy and skin biopsy. His clinical experience includes management of patients with motor neuron diseases, neuropathies, myasthenia gravis, myopathy/muscular dystrophies and other neuromuscular disorders. **Role in residency training:** Didactic lecturer in clinical neurology and neuromuscular disorders; Shands ward attending; Neuromuscular clinic attending; Discussant, Neurology Grand Rounds

**B) Core Pediatric Neurology Faculty**

**Edgard Andrade, M.D., Assistant Professor** **Role in residency training:** Didactic lecturer in Pediatric Neurology, EEG and epilepsy; Shands pediatric neurology ward attending; Pediatric neurology clinic attending; Pediatric neurology core rotation faculty supervisor; Discussant, Grand Rounds

**Paul Carney, M.D., Professor of Pediatrics and Neurology; Wilder Chair for Epilepsy Research; Director, Pediatric Epilepsy Program.** **Role in residency training:** Didactic lecturer in Pediatric Neurology, EEG and epilepsy; Shands pediatric neurology ward attending; Pediatric neurology clinic attending; Pediatric neurology core rotation faculty supervisor; Discussant, Grand Rounds

**Peter Kang, M.D., Associate Professor and Chief, Division of Pediatric Neurology** **Role in residency training:** Didactic lecturer in Pediatric Neurology, Shands pediatric neurology ward attending; Pediatric neurology clinic attending; Pediatric neurology core rotation faculty supervisor; Discussant, Grand Rounds

**Zhao Liu, M.D, PhD, Assistant Professor** **Role in residency training:** Didactic lecturer in Pediatric Neurology, EEG and
epilepsy; Shands pediatric neurology ward attending; Pediatric neurology clinic attending; Pediatric neurology core rotation faculty supervisor; Discussant, Grand Rounds

Anne-Marie Slinger-Constant, M.D., Clinical Assistant Professor; Director of the UF Multidisciplinary Diagnostic and Training Program. Role in residency training: Didactic lecturer in Pediatric Neurology, learning disorders, ADHD, autism, memory disorders; Shands pediatric neurology ward attending; Pediatric neurology clinic attending; Pediatric neurology core rotation faculty supervisor; Discussant, Grand Rounds

C) Non-Neurologist Faculty @ UF Gainesville

Janis Daly, Ph.D., M.S., Director, Brain Rehabilitation Research Center of Excellence, Professor of Neurology Dr. Daly is a Research Career Scientist from the Louis Stokes VA Medical Center (LS VAMC) in Cleveland, OH, where she has also been Director of the Cognitive and Motor Learning Research Program and Associate Director of the Functional Electrical Stimulation Center (FESC), an RR&D Center of Excellence similar to the BRRC. She also has been Professor of Neurology at Case Western Reserve University.

Leilani Doty, Ph.D., Associate Research Scientist; Administrator, University of Florida Cognitive and Memory Disorder Clinics Dr. Doty has a Ph.D. in Counselor Education with a Specialty in Gerontology. She has more than a decade of experience dealing with problems of the elderly, and especially those with Alzheimer’s disease. She is currently Administrator of the Memory Disorder Clinic. Her counseling skills and her encyclopedic knowledge of resources for the elderly are an invaluable resource for patients attending the clinic. Dr. Doty also carries on research in gerontological issues, and trains health-professionals in the care of the elderly.

Pedro Fernandez-Funez, Ph.D., Assistant Professor of Neurology Dr. Fernandez-Funez received his Ph.D in February 1998 from Universiadi Autonoma de Madrid, where he worked as a Postdoctoral Associate until October of 1998. In November 1998, he became a Postdoctoral Associate at Baylor College in Houston, Texas. In February 2004, he left Baylor and became an Assistant Professor for the Department of Neurology at UTMB. At UTMB, he worked in the George and Cynthia Mitchell Center for Neurodegenerative disorders. His research interests include Molecular mechanisms of neurodegeneration in Alzheimer’s disease & Prion disorders.

Yuqing Li, Ph.D. Professor, Dr. Li joined the Department of Neurology in November of 2010 as a Professor in the Center for Movement Disorders and Neurorestoration. Prior to the current position, Dr. Li served as Associate Professor of Neurology and Neurobiology in the Department of Neurology and Center for Neurodegeneration and Experimental Therapeutics, School of Medicine, University of Alabama at Birmingham. From 2001 to August of 2006, Dr. Li served as Assistant Professor with the Beckman Institute for Advanced Science and Technology at the University of Illinois at Urbana-Champaign with the focus of his research in genetic analysis of neural development and plasticity, animal models of neurodevelopmental disorders. From 1996 to 2000, he was appointed as Lucille P. Markey Assistant Professor of Molecular and Developmental Neuroscience in the Department of Molecular and Integrative Physiology and the Beckman Institute for Advanced Science and Technology at the University of Illinois at Urbana-Champaign. He received his Ph.D. in Biology from Nagoya University, Nagoya, Japan in 1991 and was a Postdoctoral Research Associate with the Center for Learning and Memory, Massachusetts Institute of Technology, Cambridge, Massachusetts from 1991 to 1996. He majored in Biology in 1991 from Nagoya University, Japan, in molecular biology from Fudan University, China in 1988, and majored in Biochemistry with a Bachelor of Science degree from Fudan University, China in 1984.

Diego Rincon-Limas, Ph.D., Assistant Professor of Neurology Dr. Rincon-Limas obtained a Master’s degree in Microbiology and a summa cum laude Ph.D. in Molecular Biology and Genetic Engineering at the Autonomous University of Nuevo Leon in Monterrey, Mexico. He then moved to Baylor College of Medicine in Houston to conduct his postdoctoral training in the Department of Human and Molecular Genetics, where he got training in Developmental Biology and Neurobiology. Later on, he got his first Faculty position in the Department of Neurology and the Mitchell Center for Neurodegenerative Disorders at the University of Texas Medical Branch in Galveston. He moved to the University of Florida in 2010 as an Assistant Professor in the Department of Neurology at the McKnight Brain Institute and is also a member of the UF Genetics Institute.

John Williamson, Ph.D. Assistant Professor

Fumaki Yokoi, Ph.D. Assistant Scientist

Lin Zhang, Ph.D. Assistant Scientist Dr. Zhang joined the Department of Neurology in March of 2011 as an Assistant Scientist for the Center for Movement Disorders and Neurorestoration. She received her Ph.D. in Psychiatry from Chiba University, in Chiba, Japan, and was a postdoc in Chiba Cancer Center Research Institute. In 2001, Dr. Zhang got her M.D. at Yanbian University Medical College in China. She did a residency in Neurology at Yanbian University Hospital in China the following year.

D) Neurology Faculty @ UF Jacksonville
Alan Berger, M.D., Professor and Department Chair
Nader M. Antonios, M.D., Assistant Professor, Assistant Program Director, Vascular Neurology Fellowship
Shachie V. Aranke, M.D., Assistant Professor
Ramon E. Bautista, M.D., Associate Professor, Associate Program Director, Neurology Residency; Clerkship Director
Stuart J. Glassner, D.O., Assistant Professor
Elizabeth T. Glen Keymer, Psy.D., Assistant Professor
Dale F. Kraemer, PhD Research Associate Professor
Suparna R. Krishnaiengar, M.B.B.S. Assistant Professor
Kerry A. Maher, MD, Courtesy Assistant Professor
Odinachi Oguh, M.D., Assistant Professor
Trevor H. Paris, MD, Courtesy Assistant Professor
Michael T. Pulley, M.D., Ph.D., Associate Professor
Louis S. Russo, M.D., Professor
Kalina Sanders, MD, Assistant Professor, Associate Clerkship Director
Sukhwinder J. Sandhu, M.D., Assistant Professor
Scott L. Silliman, M.D., Associate Professor; Director, Neurology Residency Program; and Director, Comprehensive Stroke Program
Edward S. Urban, M.D., Assistant Professor
Daniel R. Wilson, M.D., Ph.D., FANPA Professor; Vice President for Health Affairs; Dean, College of Medicine-Jacksonville

F) Faculty from Related Departments

These faculty in other departments of the medical center have clinical or research interests related to neurology.

Neurosurgery

William A. Friedman, MD, Professor & Chairman
Spiros Blackburn, MD, Assistant Professor
Jacques N. Farkus, MD, Associate Professor

Kelly D. Foote, MD, Associate Professor; Co-Director, Movement Disorders Center
Brian L. Hoh, MD, FACS, FAHA, FAANS Associate Professor
Daniel Hoh, MD, Assistant Professor
R. Patrick Jacob, MD, Professor
J. Richard Lister, MD, MBA, Professor; Associate Chairman
Gregory J.A. Murad, M.D., Assistant Professor
David W. Pincus, MD, PhD, Professor
Maryam Rahman, MD, MS, Assistant Professor
Albert L. Rhoton, Jr., MD, Professor & Chairman Emeritus
Steven N. Roper, MD, Professor

Neuro-Ophthalmology

Hazem Samy, M.D., Director of Neuro-Ophthalmology Service

Neuroradiology

Jeffrey Bennett, MD, Assistant Professor, Division Chief Neuroradiology
Sharatchandra Bidari, MD, Assistant Professor
Reordan O De Jesus, MD, Assistant Professor
Christopher Firment, MD Assistant Professor
James A. Johnson, III, MD Assistant Professor
Anthony Mancuso, M.D., Professor and Chairman
Tara Massini, MD, Assistant Professor
Sandip Patel, MD, Assistant Professor
Keith R. Peters, M.D., Associate Professor
Ronald Quisling, M.D., Professor and Chief, Neuroradiology
Ilona Schmalfuss, MD, Assistant Professor

Neuropathology

Anthony Yachnis, M.D., Professor, Director of Neuropathology; Chief of Anatomic Pathology
Marie Rivera Zengotita, MD, Staff Pathologist

Neuropsychology

Dawn Bowers, PhD, Professor of Clinical & Health Psychology and Neurology

Tim Conway, PhD, Research Assistant Professor of Clinical and Health Psychology and Pediatrics

Bruce Crosson, Ph.D., Professor

Duane E. Dede, Ph.D., Clinical Professor

Vonetta Dotson, PhD, Assistant Professor

Eileen Fennell, PhD, Professor of Clinical & Health Psychology, Psychology, and Neurology

Shelly Heaton, PhD, Assistant Professor of Clinical & Health Psychology

Michael Marsiske, PhD. Associate Professor of Health Policy and Epidemiology, Clinical and Health Psychology; Associate Director for Research, Institute of Aging

William M. Perlstein, PhD, Assistant Professor

Catherine Price, PhD, Assistant Professor

Psychology

Russell Bauer, Ph.D., Professor of Clinical & Health Psychology and Neurology

Neuroscience

Ana Tari Ashizawa, PhD, Associate Professor

Barbara Battelle, PhD, Professor

Jennifer Bizon, PhD, Associate Professor

Stephen J. Blackband, PhD, Professor

Steve Blackband, Ph.D., Professor

David Borchelt, PhD, Professor
Animal Models, Huntington’s disease and AD

Sara Burke, PhD, Assistant Professor

Eduardo Candelario-Jalil, PhD, Assistant Professor

Paramita Chakrabarty, PhD, Assistant Professor

Shawn Dotson, Ph.D., Assistant Professor of Neuroscience

Kevin Felsenstein, PhD, Associate Professor

Thomas Foster, Ph.D., Professor

Benoit Giasson, PhD, Associate Professor

Todd Golde, M.D., Ph.D., Professor of Neuroscience, Director for Translational Research in Neurodegenerative Disease

Marieta B. Heaton, Ph.D., Professor

Chris Janus, PhD, Assistant Professor

Habibeh Khoshbouei, PhD, Associate Professor

Ashok Kumar, PhD, Assistant Professor

Yona Levites, PhD, Assistant Professor

Jada Lewis, PhD, Associate Professor

Ron Mandel, Ph.D., Professor

Leonid Moroz, PhD, Professor

Harry Nick, Ph.D., Professor

Lucia Nottepek, Ph.D., Professor & Chair

Paul Reier, PhD, Professor & Eminent Scholar

Louis A. Ritz, Ph.D., Associate Professor

Matt Sarkisian, Ph.D., Assistant Professor

Sue Semple-Rowland, Ph.D., Professor

Wolfgang J. Streit, Ph.D., Professor

Psychiatry (MD Faculty)

Mark Gold, M.D., Distinguished Professor & Chair of Psychiatry

Jorge Avila, MD, Assistant Professor

Robert N. Averbuch, MD Associate Professor

Lewis R. Baxter, Jr., MD, Professor

Martha Brown, MD, Associate Professor
Adriaan Bruijnzeel, Ph.D., Assistant Professor
Dawn M. Bruijnzeel, MD Assistant Professor
Regina Bussing, MD, MSHS Professor
James C. Byrd, III, MD Assistant Professor
Hong Chen, MD, Assistant Professor
Josepha A. Cheong, MD, Professor
Richard Christensen, M.D., Professor, Chief of the Division of Public Psychiatry
Brian Cooke, MD, Assistant Professor
Wayne L. Creelman, MD, Professor
Ameila Davis, MD, Assistant Professor
Faraaz Fakih, MD, Adjunct Assistant Professor
Sarah Fayad, MD, Assistant Professor
Joel Fernandes, MD, Adjunct Assistant Professor
Brian Fuehrlein, MD, PhD, Assistant Professor
Gary R. Geffken, Ph.D., Associate Professor
Donna Giles, PhD, Professor
Almari Ginoy, DO, Assistant Professor
Peter A. Gold, Psy.D., Assistant Professor
Bruce Goldberger, PhD, Assistant Professor
Erik J. Gooch, D.O., Assistant Professor
Maria Grant, MD, Professor
William M. Greene, MD Assistant Professor
Michael J. Herkov, Ph.D., Associate Professor & Program Director
Jacqueline A. Hobbs, M.D., PhD
Jon D. Hodggin, MD Associate Professor
Richard C. Holbert, MD Assistant Professor
William Hollifield, MD, Assistant Professor
Timothy Huckaby, MD, Assistant Professor
Isaac Isaac, MD, Assistant Professor
Michelle Jacobs-Elliott, MD Assistant Professor
K. Ahmad Khurshid, MD, Associate Professor
Tessy Korah, M.D., Assistant Professor
Mark H. Lewis, Ph.D., Professor
Yijun Liu, Ph.D., Professor
Daniel Logan, MD, Assistant Professor
Ross A. McElroy, Jr, MD, Associate Professor
Joseph McNamara, PhD, Assistant Professor
Lisa Merlo, PhD, MPE Assistant Professor
Brooke Miller, PhD, Assistant Professor
Drake Morgan, PhD, Assistant Professor
Amber Muchlmann, PhD, Assistant Professor
Michael Nias, JD, MSW, Assistant Professor
Sara Jo Nixon, Ph.D., Professor
Benjamin Phalin, PhD, Assistant Professor
John M. Petitto, MD; Professor
Mariam Rahmani, MD, Assistant Professor
Babu Rankupali, MD, Assistant Professor
Gary Reisfield, MD, Assistant Professor
Judy Rivenbark, MD, Professor
Julie Rodriguez, MD, Assistant Professor
Leo Rodriguez, MD, Assistant Professor
William Rout, MD, Assistant Professor
Kevin Sabet, PhD, Assistant Professor
Barry Setlow, PhD, Associate Professor
Michael Shapiro, MD, Assistant Professor
Richard L. Shriner, M.D., Assistant Professor
Jamie Smolen, MD, Associate Professor
Natalie Colapelle-Snodgrass, MD, Assistant Professor
Professor

Lauren Solberg, JD, MTS, Assistant Professor

Louis Solomon, MD; Assistant Professor & Program Director

Uma Suryadevera, MD, Assistant Professor

Rajiv Tandon, M.D., Professor

John Tanner, DO, Assistant Professor

Scott A. Teitelbaum, MD; Associate Professor

Panayotis (Peter) Thaos, PhD

Joseph Thornton, MD, Clinical Assistant Professor

Michele Travers, MD, Assistant Professor

Daniel M. Tucker, M.D., Associate Professor & Chief

Michael Tueth, MD, Associate Professor

Jacob VanLandingham, PhD, Assistant Professor

Ashit K. Vijapura, MD, Assistant Professor

Kevin Wang, PhD

Herbert E. Ward, MD. Associate Professor

Michael Ware, MD, Associate Professor

Stephen Welch, MD, Assistant Professor

Tonia Werner, MD, Associate Professor

Kimberly A. White, MD; Assistant Professor

Lawrence Wilson, MD, MRO, Professor

William Yvorchuk, MD, Assistant Professor

Yi Zhang, PhD, Assistant Professor

Anesthesiaology:

Andrea Gabrielli, MD, Associate Professor (Critical Care)

A. Joseph Layon, MD, Professor (Critical Care)

Sleep Disorders

Richard Berry, MD (Sleep Medicine)

Stephan Eisenschenk, MD (Sleep Neurology/Neurophysiology)

Infectious Disease:

Ivan A. Guerrero, MD, Adjunct Assistant Professor

Bradley S. Bender, MD, Chief of Staff, VAMC

Nilmarie Guzman, M.D., Assistant Professor

Diana I. Mercado, MD, Assistant Professor

Wilfredo Sanchez, MD, Assistant Professor

Michael L. Sands, MD, MPH, and TM Professor

Neuro-otology:

Patrick J. Antonelli, MD, Professor and Chair

Matthew O’Malley, MD, Professor

Speech, Language and Swallow

Christine Sapienza, Professor and Chair, Department of Communication Science and Disorders

Michael Crary, Ph.D., Professor, Speech and Language Pathology, Department of Communicative Disorders

James W. Hall, PhD., Clinical Professor, Chief of Audiology

Jamie Reilly, Ph.D., Assistant Professor, Department of Communicative Disorders

John C. Rosenbeck, Ph.D., Professor

Rehabilitation

James W. Atchison, D.O. Distinguished Service Professor; Division of Physical Medicine and Rehabilitation

Krista Vandenborne, Ph.D. Assistant Professor Department of Physical Therapy

Carolyn Patten, PhD, Associate Professor, Department of Physical Therapy

Lisa Edmond, PhD, Assistant Professor, Department of Communication Science and Disorders

Lori J. P. Altman, PhD, Assistant Professor,
Department of Communication Science and Disorders

Lori Richards, PhD, Associate Professor, Department of Occupational Therapy
HOSPITAL, OUTPATIENT AND ADMINISTRATION FACILITIES

Shands HealthCare, affiliated with the University of Florida Health Science Center, is one of the Southeast's premier health systems. Shands includes eight hospitals: two academic medical centers; four community hospitals; and two specialty hospitals. The two primary teaching hospitals for the Neurology Residency Training Program are: Shands at UF and the Gainesville VAMC.

Shands at UF is the primary teaching hospital and assembles more than 500 physicians representing 110 medical specialties work with a team of healthcare professionals to provide quality care for patients Shands at the University of Florida was established in 1958. It is a 788-bed tertiary care center with 144 intensive care beds. Shands at UF features four Centers of Excellence including Cancer, Cardiovascular medicine, Neurological services, and Transplantation. Neurology shares a 34-bed ward with Neurosurgery. This includes six epilepsy monitoring unit beds. Cardiac telemetry is available for six or more patients.

Intensive care is provided in the newly opened Neurological Intensive Care Unit (Ward 82), Medicine Intensive Care Unit (Ward 52), Surgical Intensive Care Unit and the Intermediate Care Unit (Ward 94), with neurology residents serve as either primary caregivers or consultants. In addition, the hospital has been designated a Level 1 Trauma Center with its own Trauma Ward/Unit.

The Gainesville Veterans Administration Medical Center (VAMC) is a 473-bed tertiary care facility that is also an active teaching hospital, with an extensive array of specialty services. Gainesville VA Medical Center combines a full range of patient care services with state-of-the-art technology that is enhanced and supported through education and research. It has facilities that include CT and MR scanners. Neurology shares beds with Medicine on Ward 4A and 4B which has 40 beds, and patients needing telemetry are placed on Ward 3C. A 300-bed patient tower is also scheduled for completion in 2009.

Regarding Outpatient Clinics, Neurology is located in the third floor of the Shands Medical Plaza. The total space includes 36 examining rooms, two large conference rooms with view boxes and computers, four nurses stations with computers, six procedure rooms, offices for staff, check-in and check-out areas, and a large waiting room. Neurology uses from 10 to 20 rooms at any one time. In addition, Neurology has two rooms in this clinic dedicated for EMG. At the VA Medical Center, Neurology patients are seen in the Out-patient facility. Neurology uses six rooms.

The McKnight Brain Institute provides leadership for strong basic science and clinical programs in the Neurosciences, including Neuroscience, Neurology, Neurosurgery, and Psychiatry. It houses the administrative offices and research laboratories of the Department of Neurology and its Residency Training Program. It is one of the world's largest research institutions devoted to the challenges resulting from brain and nervous system disorders. The building opened in September of 1998 and provides world-class facilities for research including sophisticated brain imaging laboratories, a 15T research MR unit, and a state-of-the-art linear accelerator.

LIBRARY AND COMPUTER FACILITIES

Residents can access literature in many ways. At the VMAC and in the resident’s room, a small collection of reference books are available. The VAMC has a small but very useful medical library. The Greer Library in the departmental offices has a nice selection of neurology journals and texts, plus selected medicine and neurosurgery journals. Finally, the Health Center Library is conveniently located in the Communicore center. A Neurology and Sleep Medicine Board review course is currently being formulated, and will be available to incoming PGY-2 residents. This review database will be updated and modified yearly by faculty and residents to optimize educational resources to prepare neurology residents for written and oral examinations.

Computerized databases: There are currently many readily available databases that residents can easily search. The computer in the resident’s room can access the following:

Free Medline searches are available through the Health Center Library, which has Medline on CD ROM discs. It is accessible from the Informatics Laboratory on the 2nd floor of the Health Center Library, or from any of the departmental computers that are on the network, including the computers in the Residents’ Room. Medline, Toxline, and several other databases are available from the Health Center Library web-page.

The course syllabi from the latest American Academy of Neurology meetings are available on CD-ROM.

OTHER COMPUTER RESOURCES

Residents should be able to take advantage of the increasing resources available via computer. We expect residents to be computer-literate. If you are not, consult with your fellow residents or knowledgeable faculty. The residents have a Pentium computer running Windows 95. Some of the programs and facilities you may access include:

On the computer hard drive:
- Microsoft Word (word processor)
- Microsoft Excel (spreadsheet program)
Microsoft Access (database program)
Microsoft Powerpoint (presentation program)
Medlink Neurology (text-book of Neurology)

On the Local Network:
SMS (on-line clinical records, including web-based viewing of many notes, labs, and radiology reports).
Stentor: Web-based viewing of current imaging.
Health Center Library Medline searching (see above)
E-mail

On the Internet:
Web access to Shands Hospital Information System
Web access to electronic signature documents
UF facilities

---

BENEFITS

Compensation and benefits will be determined by the College of Medicine with the advice of the Graduate Medical Education Committee.

Financial Support: The College of Medicine sets the annual stipend for residents at each level. An attempt is made to bring this stipend to the 50 percentile of the College of Teaching Hospitals data for hospitals in the southern region. Exceptions to these stipend levels should be approved by the Graduate Medical Education Committee. The College of Medicine pays the employer contribution of FICA. The residents are also eligible for in the deferred compensation plan of the State of Florida.

Insurance: The College of Medicine recognizes the need to provide insurance coverage in a variety of different categories.

Health Insurance. Housestaff are eligible for "Gator Care" a new health insurance program created with your health and wellness needs in mind. Designed to promote improved health care access, quality of care and employee health, GatorCare is a consolidated group health insurance plan available to eligible employee groups associated with the University of Florida and its affiliates. GatorCare is a self-insured health plan. Both Florida Blue (formerly Blue Cross Blue Shield) and Magellan Pharmacy Solutions have partnered with UF to manage the plan’s administration. Each offer comprehensive provider networks within Florida and across the U.S. and has extensive experience with the processing of both medical and pharmacy claims for payment. You may choose between two plan options: Prime Plus or Premium. For plan details and the schedule of benefits visit the GatorCare website: http://gatorcare.org

GatorCare Prime Plus—More Options-If you want two network options, you may wish to consider this plan. The plan design offers two tiers. You receive the highest level of benefits when you receive services within the GatorCare Network. The GatorCare Network includes hospitals, physicians and providers in Gainesville and Jacksonville. Providers in both locations are available to you. You also have access to Florida Blue’s NetworkBlue participating providers for Tier 2. Higher deductibles, out of pocket costs and coinsurance typically apply for Tier 2 benefits.

GatorCare Premium—More Flexibility- If you are looking for the most flexibility, this plan may be an option for you. This plan offers you three network tier options. Tier 1 is the GatorCare Network and offers the best value with low deductibles, out-of-pocket and coinsurance amounts that you would pay. The GatorCare Network includes hospitals, physicians and providers in Gainesville and Jacksonville. Providers in both locations are available to you. Tier 2 applies when you receive services from physicians and providers in Florida Blue’s NetworkBlue. You will pay higher deductibles, out-of-pocket costs and coinsurance amounts when using Tier 2 providers. You can access services from an out-of-network provider and still have coverage; Tier 3 benefits would apply and you may be billed for the difference between the provider’s charge and the allowed amount.

Magellan Pharmacy Solutions - GatorCare has partnered with Magellan Pharmacy Solutions to provide the highest-quality prescription drug benefit program with safety and cost savings in mind. This program provides efficient electronic claims processing, as well as retail and mail order prescription drug services at a reduced rate through a national pharmacy network. You may speak with a customer service representative at 800-651-8921.

FloridaBlue.com is the Online Resource for GatorCare participants.
Florida Blue’s member website is your online resource to know more about your health plan. You can view benefits, check claims information, access monthly statements, research general health information and more. To create an online account on or after July 1, 2014, go to florida.blue.com, click on Login and then Register. You will need your member number (located on your ID card) and a valid email address. In all Plan Options, Pre-Certification is required for inpatient Inpatient Admissions. Prescriptions written by an insured for self or any family members will not be eligible for reimbursement through the prescription drug program or the health insurance plan.
It is your responsibility to notify the Fringe Benefit office of any changes in your family status.

**COBRA** *(Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985).* In the event of termination, under COBRA, residents have the option to continue their health insurance policy at the current premium plus 2% for a maximum of 18 months. Eighteen month continuation is also available in the event of reduction in hours or layoff. Thirty-six month continuation is available in the event of divorce, death, retirement and a dependent losing that status because of age. It is the resident's responsibility to notify the Fringe Benefits Office within 30 days of any of the above events.

**Life Insurance.** Level term group life insurance underwritten by The Standard Insurance Company provides $50,000 of life insurance for all eligible employees with an additional $10,000 in the event of accidental death and dismemberment. You will find the life insurance policy on the Administrative Affairs/Fringe Benefits website at: http://adminaffairs.med.ufl.edu/files/2013/01/Standard-Life-Policy.pdf.

**Long Term Disability Insurance.** All active full-time College of Medicine housestaff members working at least 30 hours a week are provided group Long Term Disability insurance. The policy is underwritten by The Standard Insurance Company. The monthly benefit is equal to 60% of the first $4167 of monthly salary to a maximum monthly benefit of $2,500 reduced by benefit offsets. The benefits as set forth under this policy will begin after the insured's sixth month of total disability. The maximum benefit period is determined by your age when disability begins. In order to make sure income replacement is maximized in the unfortunate event of a disability, the College of Medicine will gross-up the disability benefit of all residents. Grossing-up is a common method of income maximization used by employers to help their employees. The premium cost of the disability insurance is added to an employee’s earnings so that the employee pays taxes on this premium every paycheck. Paying taxes on the premium assures a tax-free disability benefit. You will find the disability policy on the Administrative Affairs/Fringe Benefits website at: http://adminaffairs.med.ufl.edu/files/2012/05/Faculty-Group-Long-Term-Disability-Policy.pdf.

**Leave of Absence:** If a leave of absence or unpaid leave is taken during the residency, insurance benefits will be covered by the department for up to two months; after two months, the resident will be responsible for payment of insurance premiums. For the specific guidelines concerning: Military Leave, FMLA and Medical Leave please review the specific documentation requirements, permission and eligibility for such leave.

Such leave includes Military Leave, Extended Medical Leave, FMLA and Medical Leave of Absence.

**FICA Alternative Program.** Employees will contribute 7.5% of their wages into an investment account in their name. Medicare contributions at 1.45% will continue to be withheld and matched by the employer. The plan is mandatory for eligible employees and employees will be automatically enrolled or un-enrolled based on their salary plan status during the affected pay period. There is no minimum age or service requirement. Once a contribution has been made to the plan, the employee will receive an Enrollment/Designation of Beneficiary form and an introduction letter from Bencor, the plan Administrator. They will also be available on the BENCOR web site. These forms will allow the employee to choose between a Guaranteed Pooled Fund (an interest bearing account) and a variable investment option. As a participant in the plan, you will have the option of investing in a mutual fund plan or a fixed account and will also be asked to identify a beneficiary. If an employee does not direct the investments of your funds, they will automatically be placed into the Guaranteed Pool fund. For information pertaining to enrollment please visit the website at www.bencor.com or contact BENCOR at (386) 755-9192 or WATS: 888-258-3422.

**UFSelect Voluntary Benefits Program.**
http://www.fbmlearningcenter.com/uf
The UFSelect offerings do not replace your College of Medicine benefit plans. Instead, the program offers additional financial protection with premiums payable through the convenience of payroll deduction. Because the plans are voluntary, you can customize your coverage by choosing from a range of plans that offer a combination of benefits and features that can help meet your personal and family insurance needs. Voluntary Benefits offered through the UF Select program include Dental Insurance, Accident Insurance, Vision Insurance, Life Insurance, Pet Insurance and Legal Services Insurance. For information about UF Select please call Health Center Personnel at 352-392-3786. You must sign up for these benefits during the first 60 calendar days of your employment at UF.

**Professional Liability.** Pursuant to Section 768.28, Florida Statutes, the University of Florida Board of Trustees is exclusively responsible for any civil claims or actions arising from the acts of its employees and agents. The UF BOT is protected for such liabilities by the J. Hillis Miller Health Center Self-Insurance Program (UF SIP), a self-insurance program managed by a governing council created by the Florida Board of Governors that is chaired by the Sr. Vice President for Health Affairs. As an employee of the University of Florida (UF), you are personally immune from civil liabilities which may arise from acts or omissions committed by you in the...
course of your employment. UF SIP affords you personal professional liability protection while you act as a Good Samaritan, while you are involved in community service work, which has been pre-approved by your college, or if you are on a job assignment outside of Florida. UF SIP also provides defense costs for certain licensure investigations by the Department of Health. If you have questions regarding professional liability, please contact the UF SIP Director at 352-273-7006.

**Vacation and Leave**

(http://housestaff.medinfo.ufl.edu/policy/benefits.shtml) Members of the housestaff shall be entitled to leave with pay for the purpose of annual and sick leave depending upon the length of appointment during the training period July 1 through June 30, as described in this section. Leave will be granted and charged in one-day increments for each workday of leave requested and approved. If specialty board regulations for annual and sick leave accrual and usage differ from that outlined in this rule, written notification of the board policy shall be completed by the program director and submitted to the Dean for approval. The total maximum time a housestaff member can be away from a program in any given year or for the duration of the residency program shall be determined by the requirements of the specialty board involved. All absences must be approved by the program director. For additional information, please refer to Graduate Medical Education website at http://housestaff.medinfo.ufl.edu/policy/benefits.shtml

The College of Medicine recognizes a variety of categories of leave:

**Vacation Leave:** Vacation leave shall be requested and approved by the program director prior to the date taken. Vacation leave should not be fragmented into less than one-week periods except under unusual circumstances and must be taken at the time approved by the program director. Vacation leave may be advanced to housestaff proportionate to expected service. This advance leave cannot exceed the amount of the leave accrual rate for a one-year period. The amount of advanced leave will not exceed that which can be earned during the remainder of the housestaff leave year. Sick leave which has been granted but not earned by the housestaff member at the time of separation from the academic department will require an appropriate reduction for the value thereof in the final stipend payment. Housestaff may be permitted to carry over sick leave to a new year, as consistent with department policy; however, carryover must be approved by the program director and an excess of fifteen days (15) work days cannot be accumulated. All unused leave is considered non-payable leave, and there is no entitlement for lump-sum payment for unused leave upon separation or completion of training.

**Sick Leave:** All housestaff shall accrue sick leave at the rate of 10 working days per year of full employment if consistent with board requirements Housestaff shall be entitled to utilize for special cases severe illness, in the immediate family (spouse, parents, brothers, sisters, children, grandparents, and grandchildren of both housestaff and spouse). The number of days allowed will be determined by the program director. Sick leave may be advanced to housestaff proportionate to expected service. This advance leave cannot exceed the amount of the leave accrual rate for a one-year period. The amount of advanced leave will not exceed that which can be earned during the remainder of the housestaff leave year. Sick leave which has been granted but not earned by the housestaff member at the time of separation from the academic department will require an appropriate reduction for the value thereof in the final stipend payment. Housestaff may be permitted to carry over sick leave to a new year, as consistent with department policy; however, carryover must be approved by the program director and an excess of fifteen days (15) work days cannot be accumulated. All unused leave is considered non-payable leave, and there is no entitlement for lump-sum payment for unused leave upon separation or completion of training.

**Parental Leave:** Housestaff may take up to 6 weeks paid leave using accrued sick leave and vacation leave to care for a new child by birth or adoption. Sick/Vacation leave may be advanced to housestaff proportionate to expected service. Please see above sick leave policy. The official parental leave period may begin two weeks before the expected date of the child’s arrival and must occur with the 12-month period beginning with that date. Residents that plan to utilize parental leave are expected to notify their Training Program Director as soon as they know they will need to use parental leave to facilitate appropriate scheduling. Complicated pregnancy or delivery will be handled through additional sick leave and disability policies. FMLA mandates that up to 12 workweeks may be taken for the birth of a biological child or placement of child pending adoption. If the housestaff member chooses to take more than the 6 weeks leave, he/she will be placed on unpaid leave the remaining 12 weeks. While on unpaid leave, housestaff’s insurance benefits will be covered by the academic department for up to two (2) months. After two (2) months, the house officer will be responsible for payment of insurance premiums. Such coverage may be purchased for a time period consistent with COBRA regulations.

The total time allowed away from a program in any given year or for the duration of the housestaff program will be determined by the requirements of the specialty board involved. Any absences must be made up in accordance with specialty board policy. The housestaff will be paid for makeup or extended time.
FMLA Entitlement

The Family and Medical Leave Act (FMLA) is federal legislation enacted to provide job protection for up to 12 weeks an entitlement year to an employee, or for an employee to care for his or her parent, spouse, or child who has a serious health condition determined to be FMLA-qualifying by the patient’s physician, or when an employee must be absent due to becoming a parent. Employers must approve leave for events that qualify under the FMLA. Employees hired into leave-accruing positions are eligible for FMLA leave upon hire at the University of Florida.

Twelve weeks of entitlement translates to 12 weeks of an employee’s regular schedule. The maximum entitlement for FMLA leave is 480 hours in the FMLA year for a full-time employee. The entitlement is prorated based on FTE, so an employee at .50 FTE would have a maximum entitlement of 240 hours in the FMLA entitlement year, which is from July 1 through June 30.

OPS employees (Staff, Academic Personnel and Graduate Assistants) who have been employed by the University of Florida at least 12 months (need not have been consecutive), and have worked a minimum of 1,250 hours during the 12 months immediately preceding the requested leave, are eligible for a total entitlement (not per event) of up to 12 workweeks of leave without pay in a fiscal year for events determined to be FMLA-qualifying. Residents are included in this group.

At the University of Florida, the leave benefits to which employees have access are frequently more generous than those provided by the FMLA. As a result, when granting appropriate leave in keeping with university policy, departments will likely meet the requirements of the FMLA as a matter of course.

Domestic Violence Leave: Housestaff are eligible up to 3 days leave in a twelve-month period if the housestaff member or a family or household member is a victim of domestic violence. The fiscal year of July 1 to June 30 will be considered the 12 month period. Except in case of imminent danger to the health or safety of a housestaff member, or the health or safety of a family or household member, a housestaff member seeking leave from work under this section must provide his or her program director advanced notice of the leave. The housestaff member is required to use accrued sick or annual leave. In the event that the employee does not have sufficient leave hours to cover the event, the leave that is not covered will be unpaid.

Bereavement Leave: Housestaff shall be granted, upon request to the program director, up to 5 days off for funeral of an immediate family member. Housestaff members are granted 2 days of bereavement pay and for the other 3 days, the resident may use their sick or annual leave time. Immediate family shall include spouse, cohabiters, registered same sex domestic partners, children, step children, parents, parents of spouse, and the stepparents, grandparents, grandchildren, brothers, and sisters.

Military Leave: Absences for temporary military duty (e.g. two-week annual training) will not be taken from sick or annual leave but will be considered leave with pay for up to 17 days. If activated from reserve to active duty status, the housestaff member will receive thirty (30) days full pay before going on leave without pay. Insurance policies will remain in effect for dependents during the period of active duty for one year. Additional extensions require special approval from the Dean of the College of Medicine.

Jury Duty Leave: Housestaff who are summoned to jury duty will be granted paid leave for all hours required for such duty. If jury duty does not require absence for the entire workday, the employee should return to work immediately upon release by the court. The university will not reimburse the employee for meals, lodging, and travel expense while as a juror. This type of leave must be approved by program director in advance. Any absences must be made up in accordance with specialty board policy. The housestaff will be paid for makeup or extended time.

Educational Assignment: Housestaff shall be eligible for absence pertaining to educational and training provided it is allowed by the appropriate board and agreed to, in writing, by the program director. This should not be charged as either annual or sick leave.

Licensure Examination Leave: Housestaff taking American specialty board and state licensure examinations will be authorized leave at the discretion of the program director. The amount of absence authorized will not exceed the time actually required for taking the examination and for travel to and from the place of examinations. Only one licensure and one specialty exam shall be authorized per housestaff member. Any additional absence will be charged to annual leave or leave without pay if annual leave is not available.

Holidays: Housestaff shall be entitled to observe all official holidays designated by the Department of Administration for state employees except when they are on call for clinical responsibilities. Housestaff on Veteran's Administration Medical Center (VAMC) rotations shall be entitled to observe all official holidays designated by the federal government for VAMC employees except when they are on call for clinical responsibilities. When on duty or call for clinical responsibilities on designated holidays, the assignment will be considered as part of the residency and will not result in extra remuneration.

**Baby Gator Child Development Center at Newell Drive** was established as a partnership with the Colleges of Medicine and Public Health and Health Professions. Faculty and Housestaff Members whose children are between the ages of 6 weeks and 5 years are eligible for enrollment at reduced tuition rates. A monthly tuition subsidy of $250.00 per child is paid directly to Baby Gator by the College of Medicine. Questions or comments about Baby Gator should be directed to babygator@admin.ufl.edu Phone: (352) 273-8000, Fax: (352) 273-8747. Baby Gator maintains a waiting list for all age groups. Please apply to the waiting list by visiting the website at www.babygator.ufl.edu. There is a $40.00 application fee that must be paid by either check or money order, after you have completed the application. Once the application and payment have been received, the enrollment coordinator will contact you with information regarding the enrollment.

**Gator Dental Care**-The UF College of Dentistry can provide all your oral health services. UF Resident's Priority Program. Contact: priority@dental.ufl.edu. Please include your name and the best number for daytime contact. We’ll respond within one business day. Initial screening appointments scheduled within two weeks. Emergency appointments scheduled within 24 hours. Extended hours are available in some clinics for convenient scheduling. Professional discounts available in the Faculty Practice and some graduate clinics. This program is also available for spouse and dependents. Services: cleanings & preventive care, fillings, braces & Invisalign, crowns, dentures, bridges, whitening & aesthetic care, children's care, implant dentistry, root canals and, extractions.

**Resident Assistance Program (RAP)** is designed to help residents and their families with concerns or problems that may be troubling them. The mission of the program is to develop and maintain a positive and productive work environment. The program helps by providing a system of short-term, confidential, professional counseling and referral services to residents and their families. Counselors from the program teach residents how to manage their problems when their job is affected. The RAP addresses Stress, Adjustment to life changes, Marital or relationship difficulties, Parenting issues, Family illness, Job burnout, Anger, Depression, Anxiety, Gambling, Alcohol or chemical Dependency. If any of the above or other concerns have adversely affected your job performance or personal life, you may consider assistance from the RAP to help you identify and resolve the problem. Benefits-eligible residents, interns, and fellows and their legal spouses, and other eligible dependents all qualify for RAP benefits. There are two different ways to obtain help from your RAP:

1. **Self-Referral** – This is a completely confidential method of getting help for yourself by simply calling the RAP 24-hour, Shands Vista number 352.265.5493 or toll free 866.643.9375.
2. **Employer Referral** – if your problems visibly affect your job performance, your training director, faculty advisor or GME dean may recommend that you access the RAP for an evaluation. Your supervisor will not have access to your records. Participation in the RAP is not included in your personnel files. The UF College of Medicine pays for the basic services of the RAP and regards the program as a fringe benefit. Up to the first three visits to a provider are free. If more services are needed, the counselor will coordinate continued care with your health benefits plan. All discussions with RAP counselors, records of treatment or assistance, and all follow-up care are strictly confidential. Counselors follow professional standards and a strict code of ethics, which includes a firm commitment to protect and uphold privacy and confidentiality. To arrange an appointment, please call 352.265.5493 or toll free 866.643.9375, 24 hours a day, seven days a week. Simply state that you need an RAP appointment. RAP has flexible hours and a convenient location to accommodate the needs of you and your family.

**Needlestick Hotline**-866-477-6824. The needlestick hotline will ensure that all UF employees with an exposure have immediate access to a medical provider in a timely manner. During regular work hours, an operator from the Occupational Medicine clinic at the Student Health Care Center will answer the line and put the caller in contact with a skilled and knowledgeable provider. After hours and on weekends, the injured employee calls the hotline (866-477-6824) and an operator will take necessary demographic data. The employee will be directed to the Needlestick website where thorough instructions are given to obtain source testing. The employee will be contacted the following business day to finish any necessary testing or follow up. Whether during normal working hours or after hours, the provider will collect the exposure and source history, arrange for laboratory work to be drawn, decide on post exposure treatment if necessary, and recommend follow-up as appropriate. All follow-up laboratory work and counseling will continue to be conducted at the SHCC at Shands 352-392-0627, Room D2-52. Immediately after you have been evaluated/treated, contact the University of Florida Workers' Compensation Office (UFWC) at 392-4940 to report your injury. Failure to contact UFWC is a violation of university policy.

**Job-related Employee Injuries** Job-related employee injuries are also covered under the Occupational Medicine Program. The University must provide medical attention for employees injured in the line of duty.
Primary cost recovery is obtained from the state Worker's Compensation Program. Contact the University of Florida Workers' Compensation Office (UFWC) at 392-4940 to report your injury. Failure to contact UFWC is a violation of university policy.

**Meals**
Meals for overnight Shands call residents are provided by the hospital to which the residents rotate. As a general rule residents who do not appear as on overnight call on the call schedule are not entitled to meals. Residents on a Night Float rotation do not receive meals.

**On-Call Quarters/Work Room**
The Neurology Work Room at Shands is located at Ward 65. It has 3 computers, 2 printers, a bookshelf with general neurology and subspecialty text books, lockers, a refrigerator, white board, round table for discussion and a couch. A similar but smaller Work Room at the VA is located at 4B. On-Call Quarters for the resident on night call is located at ward 54. As a general rule, living quarters and laundry, other than on-call, are not provided by the institution. Some departmental exceptions to this may exist for residents who are sent to specific rotations outside of the immediate home area. Departmental policies will govern provision of living quarters at these sites.

The Department does provide 2 lab coats for each resident, and also provides laundering for these.

**Book allowance**
A book allowance of up to $500.00 per year are provided for each resident.

**Miscellaneous benefits**
- The resident chosen to be Chief Resident during the final year of residency receives an additional stipend.
- Low-interest loans are sometimes available through the Resident Loan Assistance Program.
- Lab coats and laundry (for lab coats) are provided.

**Working environment**
The institution is required to provide adequate patient support services (such as intravenous services, phlebotomy services and laboratory services, as well as messenger and transporter services). An effective laboratory, medical records, and radiologic information retrieval system must be in place to provide for appropriate conduct of the educational programs and quality and timely patient care. Also, appropriate security measures must be provided to residents in all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities. If you perceive that the working environment does not meet these and other reasonable requirements, please report the perceived deficiency to the Program Director or to the Office for Housestaff Affairs.

**AWARDS**
During the residency graduation ceremonies, the following awards are given by the faculty to the residents:

1. **Robert H. Watson Resident Teacher of the Year Award**: this award is given to the resident with the best evaluation from the medical students rotating in neurology.

2. **Kenneth Heilman Award for the Best Research Presentation**: this award is given to the graduating resident with the best research presentation.

3. **Chairman’s Award for Excellence in Patient Care**: This is award is voted by the PGY2 and 3 residents and awarded to the graduating senior deemed as providing the most compassionate and comprehensive care to patients.

4. **Program Director’s Scholastic Achievement Award**: this award is given to the resident with the highest in-service examination score at the year’s in-service examination.

The following awards are given by the residents to the faculty:

1. **Didactic Teacher of the Year Award**: the award is given by the graduating residents for the outstanding achievement in didactic teaching of neurology and neuroscience to one faculty member.

2. **Clinical Teacher of the Year Award**: this award is given by the graduating seniors for the outstanding achievement in bedside teaching of the art and science of clinical neurology to one faculty member.

All graduating residents and fellows are also inducted to the **Melvin Greer Society**—the University of Florida Residency and Fellowship Alumni Association.

**IF THERE ARE PROBLEMS**
We hope that you will feel free to call upon any of the Neurology faculty or on the Program Director at any time. Stress that results from program requirements should be
discussed with fellow residents and faculty, so that adjustments can be made in the program to eliminate unwarranted stress.

There are several mechanisms to deal with personal stress, whether related to the reasonable demands of residency or to factors outside of the residency, such as family problems, parenting issues, family illness, depression, anger, anxiety, or other issues. Neurology faculty members are always available to counsel you. It is understandable, however, that you may not wish to confide in faculty within the Department. The Office of House Staff Affairs, under the direction of Dr. Timothy Flynn, is available to all residents. This office can assist residents obtain counseling, housing, financial planning, spouse employment, child care and provides other benefits. Sharon Wallace in that office has years of experience. Third, if you want completely confidential assistance to deal with stress, you may avail yourself of the Resident Assistance Program (RAP), which provides short-term counseling (3 visits) free of charge to residents and their families, funded by the College of Medicine. Neither your Program Director nor the Office of Housestaff Affairs has any knowledge of these visits. The RAP counselor may arrange referrals for longer-term care (not covered financially under this plan). To arrange an appointment, please call (352) 265-5493 or (866) 643-9375, 24 hours per day, seven days a week.

Please see the attachments 1 and 5 for institutional policies on discipline and substance abuse. The Department is obligated to follow these policies.

TECHNICAL REQUIREMENTS FOR RESIDENTS

The Neurology Program has the right not to accept residents into the program who do not meet minimum technical requirements. These are the same as requirements of the institution for admission to medical school, and are stated as follows:

1) Observation: The candidate must be able to observe demonstrations and experiments in the basic sciences, including but not limited to physiologic and pharmacologic demonstrations in animals, microbiologic cultures, and microscopic studies of microorganisms and tissues in normal and pathologic states. A candidate must be able to observe a patient accurately at a distance and close at hand. In detail, observation necessitates the functional use of the sense of vision and other sensory modalities.

2) Communication: A candidate must be able to speak, to hear, and to observe patients in order to elicit information, describe changes in mood, activity, and posture, and perceive nonverbal communications. A candidate must be able to communicate effectively and sensitively with patients. Communication includes not only speech but reading and writing. The candidate must be able to communicate rapidly, effectively and efficiently in oral and written form with all members of the healthcare team.

3) Motor: Candidates must have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. A candidate must be able to execute motor movements reasonably required to provide general care and emergency treatment to patients. Examples of emergency treatment reasonably required of physicians are: The administration of intravenous medication, the application of pressure to stop bleeding and the opening of obstructed airways. Such actions require coordination of both gross and fine muscular movements, equilibrium, and functional use of the senses of touch and vision.

4) Intellectual-Conceptual, Integrative, and Quantitative Abilities: These abilities include measurement, calculation, reasoning, analysis and synthesis of complex information.

5) Behavioral and Social Attributes: A candidate must possess the emotional health required for full utilization of his or her intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients. Candidates must be able to tolerate physically taxing workloads and to function effectively under stress. They must be able to adapt to changing environments, to display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of many patients. Compassion, integrity, interpersonal skills, interest and motivation are all personal qualities that are assessed during the admission and education processes.

GAINESVILLE AND ENVIRONS

HOUSING

Information about housing can be obtained from the Office of Housestaff Affairs, the Neurology Office, and (most critically) from your fellow residents. These is an abundance of attractive apartment complexes, many with swimming pools, some with tennis, within a short distance of the Medical Center.
PLEASURE

**Exercise & fun:** Within Gainesville, there are many places to walk, jog, or bike. You have access to facilities at The University tennis, racquetball, swimming, and golf, among other sports. Gainesville is just a little over one hour's drive from the Gulf (Cedar Key), and about 2 hours from the beaches of the East Coast. North and mid-Florida cities are easily accessible: Jacksonville (90 minutes), St. Augustine (2 hours), Orlando (2 hours -- with Walt Disney World and other "attractions"), Tampa (2.5 hours) and Sarasota (3 hours). The Gainesville Health & Fitness Center offers discounts through the House Staff Office.

**Culture:** The Performing Arts Center, opened in 1992, provides a world-class concert hall that has hosted many fine performers, including the New York City Opera, the Royal Philharmonic Orchestra, the Beaux Arts Trio, Branford Marsalis, Russian National Orchestra, The Czech Philharmonic Orchestra, and David Copperfield Broadway shows such as Miss Saigon, Mama Mia, Annie are often featured at the Performing Arts Center. In addition, Rock and Country Stars such as Sir Elton John, Cher, David Benoit; Manhattan Transfer, Rascal Flat, etc have concerts at the O'Connell Center or Performing Arts Center. The Harn Art Museum, and the Florida Museum of Natural History (containing the largest butterfly exhibit) are free to the public and they also provide an attractive setting for varied exhibits. Gainesville has an active community of artists and writers, and exhibits take place both on campus and at various festivals in Gainesville and surrounding communities.

**Sports entertainment:** The University of Florida has one of the finest and most competitive undergraduate athletic programs. Football, basketball, baseball, volleyball, tennis, golf, track, swimming and gymnastics are all nationally competitive. Athletic facilities are first-rate, and with the exception of football, tickets are usually not difficult to obtain.

**Restaurants.** Numerous restaurant "chains" are represented in Gainesville. You may wish to try one-of-a-kind local restaurants:

- **Oriental:** Szechuan Palace, Dragonfly, Liquid Ginger, Bento’s Café, Taste of Saigon II, Indian Cuisine, Maui Terriyaki, Chop Stix Café, Miya Sushi (Korean and Japanese)

- **Italian/Mediterranean:** Napolitano's, Amelia's, Carrabba’s Italian Grill, Manuel’s Vintage Room, Pomadoro Café

- **Seafood:** Cedar River; Bonefish Grill, Northwest Grille, Ballyhoo Grill, Blue Water Bay Restaurant

**Cuban/Latin/New Orleans:** Emilano’s Café, Mi Apa, Green Plantain, Harry’s, Flaco’s

**Upscale Continental:** Leonardos 706, Mildreds, Ivey’s Grill, Paramount Grill; 101 Downtown

**Steak and Seafood:** Mark’s Prime

**Sushi:** Dragonfly, Fuji Sushi, Ichiban Sushi, Miya Sushi, Bento’s, Sushi Matsuri, Miraku, Yamato

**Specialty pizza:** Satchel’s, Leonardos Pizza of Millhopper

**Specialty burger/BBQ:** Copper Monkey, The Top, Ruby Tuesdays

**Brunch:** Ivey’s Grill, Ivy House, Paramount Grill, Leonardos 706, Emiliano’s, Best Western Grand; 101 Downtown

**Bistro:** Bistro 1245; Harvest Thyme Café; New Deal Cafe, Tapas 12 West; Panache Wine and Cheese

**Ice cream/gelato/desserts:** Gelato Di Prata, D’Lites , The Gelato Company, Uppercrust, Flour Pot
Attachment 1: Neurology Milestones

History — Patient Care
• Level 1 - Obtains a neurologic history
• Level 2 - Obtains a complete and relevant neurologic history
• Level 3 - Obtains a complete, relevant, and organized neurologic history
• Level 4 - Efficiently obtains a complete, relevant, and organized neurologic history
• Level 5 - Efficiently obtains a complete, relevant, and organized neurologic history incorporating subtle verbal and non-verbal cues

Neurological Exam—Patient Care
• Level 1 - Performs complete neurological exam
• Level 2 - Performs complete neurological exam accurately
• Level 3 - Performs a relevant neurological exam incorporating some additional appropriate maneuvers. Visualizes papilledema. Accurately performs a neurological exam on the comatose patient.
• Level 4 - Efficiently performs a relevant neurological exam accurately incorporating all additional appropriate maneuvers. Accurately performs a brain death examination
• Level 5 - Consistently demonstrates mastery in performing a complete, relevant, and organized neurological exam.

Management/Treatment—Patient Care
• Level 1 - Demonstrates basic knowledge of management of patients with neurologic disease.
• Level 2 - Discusses general approach to initial treatment of common neurologic disorders, including risks and benefits of treatment. Identifies neurologic emergencies.
• Level 3 - Individualizes treatment for specific patients. Initiates management for neurologic emergencies and triages patient to appropriate level of care. Appropriately requests consultations from non-neurologic care providers for additional evaluation and management.
• Level 4 - Adapts treatment based on patient response. Identifies and manages complications of therapy. Independently directs management of patients with neurologic emergencies. Appropriately requests consultations from a neurologic subspecialist for additional evaluation or management.
• Level 5 - Demonstrates sophisticated knowledge of treatment subtleties and controversies.

Movement Disorders—Patient Care
• Level 1 – Recognizes when a patient may have a movement disorder.
• Level 2 – Identifies movement disorder phenomenology and categories (hypokinetic and hyperkinetic).
• Level 3 - Diagnoses and manages common movement disorders. Identifies movement disorder emergencies.
• Level 4 – Diagnoses uncommon movement disorders. Appropriately refers a movement disorder patient for a surgical evaluation or other interventional therapies. Manages movement disorders emergencies.
• Level 5 – Manages uncommon movement disorders. Engages in scholarly activity in movement disorders (e.g. teaching, research).

Neuromuscular Disorders — Patient Care
• Level 1 - Recognizes when a patient may have a neuromuscular disorder.
• Level 2 – Identifies patterns of neuromuscular disease (e.g. anterior horn cell disease, nerve root, plexus, peripheral nerve, neuromuscular junction, muscle). Identifies neuromuscular disorder emergencies. Orders NCS (nerve conductive study)/EMG (electromyography) testing appropriately.
• Level 3 - Diagnoses and manages common neuromuscular disorders. Manages neuromuscular disorder emergencies. Interprets results of NCS/EMG testing in context of clinical presentation.
• Level 4 – Diagnoses uncommon neuromuscular disorders. Recognizes when tissue biopsy is warranted.
• Level 5 - Manages uncommon neuromuscular disorders. Engages in scholarly activity in neuromuscular disorders (e.g., teaching, research).
Cerebrovascular Disorders—Patient Care
- Level 1 - Recognizes when a patient may have a cerebrovascular disorder
- Level 2 - Describes strokes syndromes and etiologic subtypes. Identifies cerebrovascular emergencies. Lists indications and contraindications for intravenous thrombolytic therapy.
- Level 3 - Identifies specific mechanism of patient’s cerebrovascular disorder. Appropriately refers for interventional or surgical evaluation. Manages common cerebrovascular disorders including appropriate use of thrombolytics.
- Level 4 – Diagnoses uncommon cerebrovascular disorders.
- Level 5 - Manages uncommon cerebrovascular disorders. Engages in scholarly activity in cerebrovascular disorders (e.g. teaching, research)

Cognitive/Behavioral Disorders—Patient Care
- Level 1 - Recognizes when a patient may have a cognitive/behavioral disorder
- Level 2 – Identifies common cognitive/behavioral disorders
- Level 3 - Diagnoses and manages common cognitive/behavioral disorders, including cognitive effects of traumatic brain injury. Manages behavioral complications of cognitive/behavioral disorders. Appropriately refers for neuropsychological testing in evaluating patients with cognitive/behavioral disorders
- Level 4 - Diagnoses and manages uncommon cognitive/behavioral disorders
- Level 5 - Engages in scholarly activity in cognitive/behavioral disorders (e.g., teaching, research). Demonstrates sophisticated knowledge of advanced diagnostic testing and controversies.

Demyelinating Disorders—Patient Care
- Level 1 - Recognizes when a patient may have a demyelinating disorder.
- Level 2 - Diagnoses and manages common demyelinating disorders.
- Level 3 - Recognizes uncommon demyelinating disorders. Manages acute presentations of demyelinating disorders.
- Level 4 - Diagnoses uncommon demyelinating disorders.
- Level 5 - Manages uncommon demyelinating disorders. Engages in scholarly activity in demyelinating disorders (e.g., teaching, research)

Epilepsy—Patient Care
- Level 1 - Recognizes when a patient may have had a seizure.
- Level 2 - Identifies epilepsy phenomenology, and classification of seizures and epilepsies. Diagnoses convulsive status epilepticus.
- Level 3 - Diagnoses and manages common seizure disorders and provides antiepileptic drug treatment. Diagnoses non-convulsive status epilepticus. Manages convulsive and non-convulsive status epilepticus.
- Level 4 – Diagnoses uncommon seizure disorders. Appropriately refers an epilepsy patient for surgical evaluation or other interventional therapies.
- Level 5 - Manages uncommon seizure disorders. Engages in scholarly activity in epilepsy (e.g., teaching, research).

Headache Syndromes—Patient Care
- Level 1 - Recognizes common headache syndromes.
- Level 2 - Diagnoses and manages common headache syndromes. Identifies headache emergencies.
- Level 3 - Recognizes uncommon headache syndromes. Diagnoses and manages headache emergencies.
- Level 4 – Diagnoses and manages uncommon headache syndromes.
- Level 5 - Engages in scholarly activity in headache syndromes (e.g., teaching, research).

Neurologic Manifestations of Systemic Disease—Patient Care
- Level 1 - Recognizes when a patient’s neurologic symptoms may be due to systemic illness. Identifies neurologic emergencies due to systemic disease.
- Level 2 - Diagnoses and manages common neurologic manifestations of systemic diseases. Diagnoses and manages neurologic emergencies due to systemic disease.
- Level 3 - Recognizes uncommon neurologic manifestations of systemic disease.
- Level 4 – Diagnoses and manages uncommon neurologic manifestations of systemic disease.
- Level 5 - Engages in scholarly activity in neurologic manifestations of systemic disease (e.g., teaching, research).
Child Neurology for the Adult Neurologist—Patient Care

- Level 1 - Obtains basic neurologic history of infants and children
- Level 3 - Obtains a complete and age-appropriate neurologic history of infants and children. Performs a complete and age-appropriate neurological examination of infants and children. Diagnoses common child neurologic disorders.
- Level 4 - Initiates management of common childhood neurologic disorders. Initiates management of common neurologic emergencies in infants and children.
- Level 5 - Diagnoses uncommon childhood neurologic disorders

Neuro-Oncology—Patient Care

- Level 1 - Recognizes common clinical presentations of a brain or spine mass.
- Level 2 - Identifies neuro-oncological emergencies and initiates management.
- Level 3 - Provides differential diagnosis of brain or spine mass. Identifies neurologic complications due to cancer or the treatment of cancer.
- Level 4 - Appropriately refers for advanced testing, including biopsy. Manages neurologic complications due to cancer or the treatment of cancer.
- Level 5 - Engages in scholarly activity in neuro-oncology (e.g., teaching, research).

Psychiatry for the Adult Neurologist—Patient Care

- Level 1 - Recognizes when a patient may have a psychiatric disorder. Obtains an appropriate psychiatric history.
- Level 2 – Identifies common psychiatric disorders. Identifies psychiatric comorbidities in patients with a neurologic disease.
- Level 3 - Recognizes when a patient’s neurological symptoms are of psychiatric origin. Recognizes when a patient’s psychiatric symptoms are of neurologic origin. Identifies major side effects of psychiatric medications.
- Level 4 - Diagnoses common psychiatric disorders. Initiates management of psychiatric comorbidities in patients with a neurologic disease.
- Level 5 - Engages in scholarly activity in psychiatric disorders (e.g., teaching, research).

Neuroimaging—Patient Care

- Level 1 - Identifies basic neuroanatomy on brain magnetic resonance (MR) and computerized tomography (CT).
- Level 2 - Recognizes emergent imaging findings on brain MR and CT. Identifies basic neuroanatomy on spine MR and CT.
- Level 3 – Identifies major vascular anatomy on angiography.
- Level 4 - Interprets MR and CT neuroimaging of brain and spine.
- Level 5 - Identifies subtle abnormalities on angiography. Interprets carotid and transcranial ultrasound

Electroencephalogram (EEG)—Patient Care

- Level 1 - Explains an EEG procedure in non-technical terms.
- Level 2 - Uses appropriate terminology related to EEG (e.g., montage, amplitude, frequency).
- Level 3 - Describes normal EEG features of wake and sleep states. Recognizes EEG patterns of status epilepticus. Recognizes common EEG artifacts.
- Level 4 - Interprets common EEG abnormalities and creates a report. Recognizes normal EEG variants.
- Level 5 - Interprets uncommon EEG abnormalities. Describes normal and some abnormal EEG features of wake and sleep states in children.

Nerve Conduction Studies (NCS)/Electromyography (EMG)—Patient Care

- Level 1 - Explains an NCS/EMG procedure in nontechnical terms.
- Level 2 - Uses appropriate terminology related to NCS/EMG.
- Level 3 - Describes NCS/EMG data. Lists NCS/EMG findings in common disorders.
- Level 4 - Interprets NCS/EMG data in common disorders. Describes common pitfalls of NCS/EMG.
- Level 5 - Performs, interprets, and creates a report for NCS/EMG.
Lumbar Puncture—Patient Care
- Level 1 - Lists the indications and contraindications for lumbar puncture.
- Level 2 - Lists the complications of lumbar puncture and their management.
- Level 3 - Performs lumbar puncture under direct supervision.
- Level 4 - Performs lumbar puncture without direct supervision.
- Level 5 - Performs lumbar puncture on patients with challenging anatomy.

Localization—Medical Knowledge
- Level 1 - Attempts to localize lesions within the nervous system. Describes basic neuroanatomy.
- Level 2 - Localizes lesions to general regions of the nervous system.
- Level 3 - Accurately localizes lesions to specific regions of the nervous system.
- Level 4 - Efficiently and accurately localizes lesions to specific regions of the nervous system. Describes advanced neuroanatomy.
- Level 5 - Consistently demonstrates sophisticated and detailed knowledge of neuroanatomy in localizing lesions.

Formulation—Medical Knowledge
- Level 1 - Summarizes history and exam findings.
- Level 2 - Summarizes key elements of history and exam findings. Identifies relevant pathophysiologic categories to generate a broad differential diagnosis.
- Level 3 - Synthesizes information to focus and prioritize diagnostic possibilities. Correlates the clinical presentation with basic anatomy of the disorder.
- Level 5 - Consistently demonstrates sophisticated and detailed knowledge of pathophysiology in diagnosis. Effectively educates others about diagnostic reasoning.

Diagnostic Investigation — Medical Knowledge
- Level 1 - Demonstrates general knowledge of diagnostic tests in neurology.
- Level 2 - Discusses general diagnostic approach appropriate to clinical presentation. Lists risks and benefits of tests to patient.
- Level 3 - Individualizes diagnostic approach to the specific patient. Accurately interprets results of common diagnostic tests.
- Level 4 - Explains diagnostic yield and cost-effectiveness of testing. Accurately interprets results of less common diagnostic testing. Recognizes indications and implications of genetic testing. Recognizes indications of advanced imaging and other diagnostic studies.
- Level 5 - Demonstrates sophisticated knowledge of diagnostic testing and controversies.

Systems thinking, including cost and risk effective practice — Systems-based Practice
- Level 1 - Describes basic cost and risk implications of care.
- Level 2 - Describes cost and risk benefit ratios in patient care.
- Level 3 - Makes clinical decisions that balance cost and risk benefit ratios.
- Level 4 - Incorporates available quality measures in patient care.
- Level 5 - Engages in scholarly activity regarding cost-and risk-effective practice.

Work in inter-professional teams to enhance patient safety—Systems-based Practice
- Level 1 - Describes team members’ roles in maintaining patient safety.
- Level 2 - Identifies and reports errors and near-misses.
- Level 3 – Describes potential sources of system failure in clinical care such as minor, major, and sentinel events.
- Level 4 - Participates in a team-based approach to medical error analysis.
- Level 5 - Engages in scholarly activity regarding error analysis and patient safety.
Self-directed learning — Practice-based Learning and Improvement
- Identify strengths, deficiencies, and limits in one’s knowledge and expertise
- Set learning and improvement goals
- Identify and perform appropriate learning activities
- Use information technology to optimize learning
  - Level 1 - Acknowledges gaps in knowledge and expertise.
  - Level 2 - Incorporates feedback.
  - Level 3 - Develops an appropriate learning plan based upon clinical experience.
  - Level 4 – Completes an appropriate learning plan based upon clinical experience.
  - Level 5 - Engages in scholarly activity regarding practice-based learning and improvement.

Locate, appraise, and assimilate evidence from scientific studies related to the patient’s health problems — Practice-based Learning and Improvement
- Level 1 - Uses information technology to search and access relevant medical information.
- Level 2 - Uses scholarly articles and guidelines to answer patient care issues.
- Level 3 - Critically evaluates scientific literature.
- Level 4 - Incorporates appropriate evidence-based information into patient care. Understands the limits of evidence-based medicine in patient care.
- Level 5 - Engages in scholarly activity regarding evidence-based medicine.

Compassion, integrity, accountability, and respect for self and others — Professionalism
- Level 1 - Demonstrates compassion, sensitivity, and responsiveness to patients and families. Demonstrates non-discriminatory behavior in all interactions, including diverse and vulnerable populations. Describes effects of sleep deprivation and substance abuse on performance.
- Level 2 - Demonstrates appropriate steps to address impairment in self. Consistently demonstrates professional behavior, including dress and timeliness.
- Level 3 - Demonstrates compassionate practice of medicine, even in context of disagreement with patient beliefs. Incorporates patients’ socio-cultural needs and beliefs into patient care. Demonstrates appropriate steps to address impairment in colleagues.
- Level 4 - Mentors others in the compassionate practice of medicine, even in context of disagreement with patient beliefs. Mentors others in sensitivity and responsiveness to diverse and vulnerable populations. Advocates for quality patient care.
- Level 5 - Engages in scholarly activity regarding professionalism.

Knowledge about, respect for, and adherence to the ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice — Professionalism
- Level 1 – Describes basic ethical principles.
- Level 2 - Determines presence of ethical issues in practice.
- Level 3 - Analyzes and manages ethical issues in straightforward clinical situations.
- Level 4 - Analyzes and manages ethical issues in complex clinical situations.
- Level 5 - Demonstrates leadership and mentorship on applying ethical principles.

Relationship development, teamwork, and managing conflict — Interpersonal and Communication Skills
- Level 1 - Develops a positive relationship with patients in uncomplicated situations. Actively participates in team-based care
- Level 2 - Manages simple patient/family-related conflicts. Engages patients in shared decision-making.
- Level 3 - Manages conflict in complex situations. Uses easy-to-understand language in all phases of communication.
- Level 4 - Manages conflict across specialties and systems of care. Leads team-based patient care activities.
- Level 5 - Engages in scholarly activity regarding teamwork and conflict management.
Information sharing, gathering, and technology—Interpersonal and Communication Skills

- **Level 1** - Effectively communicates during patient hand-overs using a structured communication tool. Completes documentation in a timely fashion. Accurately documents transitions of care.
- **Level 2** - Effectively communicates during team meetings, discharge planning, and other transitions of care. Educates patients about their disease and management, including risks and benefits of treatment options. Completes all documentation accurately, including use of EHR, to promote patient safety.
- **Level 3** - Effectively communicates the results of a neurologic consultation in a timely manner. Effectively gathers information from collateral sources when necessary. Demonstrates synthesis, formulation, and thought process in documentation.
- **Level 4** - Effectively leads family meetings. Effectively and ethically uses all forms of communication. Mentors colleagues in timely, accurate, and efficient documentation.
- **Level 5** - Develops patient education materials. Engages in scholarly activity regarding interpersonal communication.
A) UF Neurology Resident’s Clinical Skills Assessment Rules and Regulations:

In accordance with the standards set by the ABPN Neurology Council, the residents of the UF Neurology Residency Training Program who are in their PGY-3 and PGY-4 year of training will participate in four to five encounters. These encounters will be in the areas of 1) Child Neurology, 2) Critical Care, 3) Neuromuscular, 4) Episodic (headache, seizure), and 5) Neurodegenerative/ Movement/ Inflammatory. All PGY-3 residents will need to take the 4 Adult Clinical Skills Evaluation; and all PGY-4 residents will need to take Pediatric Neurology and four Adult Clinical Skills Evaluation.

A) Preparation: Starting school year 2007-2008, an assignment list will be posted by the Program Director for each PGY 3 and 4 resident, matching him/her with faculty members in each of the four (for PGY 3 & 4) Adult Neurology areas and Pediatric Neurology (for PGY 4 only). The resident will have two months to contact each faculty member in his/her list and make arrangements for a live patient clinical skills evaluation.

B) Examination: The patient chosen should not be familiar to the resident and can be an in-patient or out-patient at either Shands at UF or the Veterans Affairs Medical Center. The timed patient encounter should be no longer than 45 minutes in length and will be observed by one of the UF neurology faculty members assigned to that resident. During this time, the resident is expected to take an appropriate history, perform all relevant physical/neurological examinations, have a working diagnosis and treatment plan, and counsel the patient accordingly. After the form has been completed it should be handed over to the Residency Coordinator, Jennifer Shipley AND NOT to the resident. At least five minutes should be spent providing feedback/constructive criticisms to the resident without providing the final evaluation. Thus, the entire clinical skills evaluation should take not longer than 50 minutes.

C) Evaluation: It will be clear to both attendings and the residents being evaluated that the evaluation will be completed with the expectations being a performance equal to that of an independent neurologist and the attending should NOT adjust for residency level. The verbal feedback provided to the resident at the end of the examination by the faculty member will be written along with the faculty member’s final evaluation in each criterion. The faculty members will use two scales: a) the UF Neurology Residency four point scale used in all other residency evaluations; and b) the standardized/Neurology RRC/ACGME-Approved eight point scale for the Major Neurology Clinical Evaluation Examination. The UF four point scale is as follows:

1. Unsatisfactory: The history, examination, assessment or counseling is substandard and the resident is not yet ready to function as a competent and humanistic independent neurologist in the area being assessed.
2. Satisfactory: The history, examination, assessment and counseling performed by the resident is satisfactory and s/he meets the minimum standards of functioning as a safe and independent neurologist.
3. Very Good: The entire patient assessment was comprehensive and performed in a compassionate manner. The resident is comfortable with the area being assessed and is clearly ready to function as an independent neurologist.
4. Exemplary performance: The resident showed mastery in the patient assessment and counseling and performed like a seasoned neurologist.

The RRC/ACGME-Approved 8-point scales is as follows:

1. Very Poor
2. Poor
3. Unsatisfactory
4. Borderline but Unacceptable
5. Borderline but Acceptable
6. Very Good
7. Excellent
8. Outstanding

These two scales will be placed next to each other on each area to be evaluated to guide the faculty member of the equivalence of each scale.

D) Passing/Failing: The UF four point grading system will be used to determine the final grade that will assess resident competency in each of the four or five clinical skill areas. Two criteria must be met in each of the five areas of evaluation to achieve competency and will be
or higher and \(^2\) there must not be more than one score of “1” (unacceptable/needs Remediation) in any of the subcategories.

E) Remediation procedures: If the resident fails to achieve a passing score, the resident will have the opportunity to review his/her evaluation and feedback provided by the attending, reflect on possible shortcomings, and participate in a remediation with the same attending. Should the resident fail on the second attempt, the resident will need to remediate again but with a different attending. The resident will need to pass all four or five Clinical Skills Evaluation prior to promotion to the next PGY level or graduation to the Residency Training Program.

---

### NEUROLOGY CLINICAL EVALUATION EXERCISE (NEX v.2)

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Evaluator Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Case Scenario** (please check one):
- Critical Care
- Ambulatory/neurological, etc.
- Child Neurology for Adult Neurology Resident
- Neurovascular
- Neurodegenerative
- Adult Neurology for Child Neurology Resident

<table>
<thead>
<tr>
<th>Unacceptable</th>
<th>Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Very Poor</td>
<td>5 Acceptable</td>
</tr>
<tr>
<td>2 Poor</td>
<td>6 Very Good</td>
</tr>
<tr>
<td>3 Unsatisfactory</td>
<td>7 Excellent</td>
</tr>
<tr>
<td>4 Borderline but Unacceptable</td>
<td>8 Outstanding</td>
</tr>
</tbody>
</table>

**Level of Training PGY**

**Age of Patient (Pediatric)**

**A. Medical Interviewing Skills (score 1 - 8)**

- 1. Did the resident introduce himself/herself appropriately to the patient and others accompanying patient? *
- 2. Did the resident display appropriate listening skills? *
- 3. Presenting complaint (s)? *
- 4. History of Present Illness: *
- 5. Past History: *
- 6. Social History: *
- 7. Family History: *
- 8. Review of Systems: *
- 9. Medications: *
- 10. Allergies: *

**B. Evaluation of Neurological Examination Skills (score 1 - 8)**

- 1. Mental Status: *
- 2. Cranial Nerves: *
- 3. Sensory: *
- 4. Motor Exam: *
- 5. Reflexes: *
- 6. Coordination: *
- 7. Station and Gait: *

**C. Humanistic Qualities, Professionalism, and Counseling Skills (score 1 - 8)**

- 1. Did the resident demonstrate appropriate humanistic qualities and professionalism? *
- 2. Did the resident adequately counsel the patient in the nature of their diagnosis and evaluation approach? *
- 3. Is the patient/family provided an opportunity to ask questions? *
- 4. Does the patient/family appropriately care for themselves? *

**D. Oral Evaluation (score 1 - 8)**

- 1. Unacceptable
- 2. Acceptable

**E. Presentation / Formulation (score 1 - 8)**

Evaluator’s Comments (comments are used to focus staff performance)

<table>
<thead>
<tr>
<th>Resident Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Evaluator’s Signature

<table>
<thead>
<tr>
<th>FACULTY SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ATTACHMENT 3: Neurology Faculty Evaluation of Residents per Rotation (Base Questionnaire)

Name of Resident:

Evaluation Dates:

Rotation:

Please evaluate each housestaff that you worked with on a separate form. Leave blank if not applicable or not observed. Comments under each question are optional but help give feedback to residents and the Clinical Competency Committee. Explanations and expectations of each level are given under each evaluation criteria. Please select the level at which you feel the resident performed at during your rotation with them. Low scores (Level 1) and high scores (Level 5) will require a comment. Evaluations should be completed no later than one week after the rotation ends.

PC1 History — Patient Care
Level 1 - Obtains a neurologic history
Level 2 - Obtains a complete and relevant neurologic history
Level 3 - Obtains a complete, relevant, and organized neurologic history
Level 4 - Efficiently obtains a complete, relevant, and organized neurologic history
Level 5 - Efficiently obtains a complete, relevant, and organized neurologic history incorporating subtle verbal and non-verbal cues

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

PC2 Neurological Exam—Patient Care
Level 1 - Performs complete neurological exam
Level 2 - Performs complete neurological exam accurately
Level 3 - Performs a relevant neurological exam incorporating some additional appropriate maneuvers. Visualizes papilledema. Accurately performs a neurological exam on the comatose patient.
Level 4 - Efficiently performs a relevant neurological exam accurately incorporating all additional appropriate maneuvers. Accurately performs a brain death examination.
Level 5 - Consistently demonstrates mastery in performing a complete, relevant, and organized neurological exam.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comments
PC3 Management/Treatment—Patient Care
Level 1 - Demonstrates basic knowledge of management of patients with neurologic disease
Level 2 - Discusses general approach to initial treatment of common neurologic disorders, including risks and benefits of treatment. Identifies neurologic emergencies.
Level 3 - Individualizes treatment for specific patients. Initiates management for neurologic emergencies and triages patient to appropriate level of care. Appropriately requests consultations from non-neurologic care providers for additional evaluation and management.
Level 4 - Adapts treatment based on patient response. Identifies and manages complications of therapy. Independently directs management of patients with neurologic emergencies. Appropriately requests consultations from a neurologic subspecialist for additional evaluation or management.
Level 5 - Demonstrates sophisticated knowledge of treatment subtleties and controversies.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments

PC15 Neuroimaging—Patient Care
Level 1 - Identifies basic neuroanatomy on brain magnetic resonance (MR) and computerized tomography (CT).
Level 2 - Recognizes emergent imaging findings on brain MR and CT. Identifies basic neuroanatomy on spine MR and CT.
Level 3 – Identifies major vascular anatomy on angiography.
Level 4 - Interprets MR and CT neuroimaging of brain and spine.
Level 5 - Identifies subtle abnormalities on angiography. Interprets carotid and transtranscranial ultrasound.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments
Level 1 - Attempts to localize lesions within the nervous system. Describes basic neuroanatomy.
Level 2 - Localizes lesions to general regions of the nervous system.
Level 3 - Accurately localizes lesions to specific regions of the nervous system.
Level 4 - Efficiently and accurately localizes lesions to specific regions of the nervous system. Describes advanced neuroanatomy.
Level 5 - Consistently demonstrates sophisticated and detailed knowledge of neuroanatomy in localizing lesions.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

MK2 Formulation—Medical Knowledge
Level 1 - Summarizes history and exam findings.
Level 2 - Summarizes key elements of history and exam findings. Identifies relevant pathophysiologic categories to generate a broad differential diagnosis.
Level 3 - Synthesizes information to focus and prioritize diagnostic possibilities. Correlates the clinical presentation with basic anatomy of the disorder.
Level 4 - Efficiently synthesizes information to focus and prioritize diagnostic possibilities. Accurately correlates the clinical presentation with detailed anatomy of the disorder. Continuously reconsiders diagnostic differential in response to changes in clinical circumstances. Diagnoses brain death.
Level 5 - Consistently demonstrates sophisticated and detailed knowledge of pathophysiology in diagnosis. Effectively educates others about diagnostic reasoning.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

MK3 Diagnostic Investigation — Medical Knowledge
Level 1 - Demonstrates general knowledge of diagnostic tests in neurology.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000
indications of advanced imaging and other diagnostic studies.

Level 5 - Demonstrates sophisticated knowledge of diagnostic testing and controversies.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

——

SBP1 Systems thinking, including cost and risk effective practice —Systems-based Practice

Level 1 - Describes basic cost and risk implications of care.
Level 2 - Describes cost and risk benefit ratios in patient care.
Level 3 - Makes clinical decisions that balance cost and risk benefit ratios.
Level 4 - Incorporates available quality measures in patient care.
Level 5 - Engages in scholarly activity regarding cost-and risk-effective practice.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

——

SBP2 Work in inter-professional teams to enhance patient safety—Systems-based Practice

Level 1 - Describes team members’ roles in maintaining patient safety.
Level 2 - Identifies and reports errors and near-misses.
Level 3 – Describes potential sources of system failure in clinical care such as minor, major, and sentinel events.
Level 4 - Participates in a team-based approach to medical error analysis.
Level 5 - Engages in scholarly activity regarding error analysis and patient safety.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000
* Identify strengths, deficiencies, and limits in one’s knowledge and expertise
* Set learning and improvement goals
* Identify and perform appropriate learning activities
* Use information technology to optimize learning

Level 1 - Acknowledges gaps in knowledge and expertise.
Level 2 - Incorporates feedback
Level 3 - Develops an appropriate learning plan based upon clinical experience.
Level 4 - Completes an appropriate learning plan based upon clinical experience.
Level 5 - Engages in scholarly activity regarding practice-based learning and improvement

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

PBL12 Locate, appraise, and assimilate evidence from scientific studies related to the patient’s health problems — Practice-based Learning and Improvement
Level 1 - Uses information technology to search and access relevant medical information.
Level 2 - Uses scholarly articles and guidelines to answer patient care issues.
Level 3 - Critically evaluates scientific literature
Level 4 - Incorporates appropriate evidence-based information into patient care. Understands the limits of evidence-based medicine in patient care.
Level 5 - Engages in scholarly activity regarding evidence-based medicine.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Comments

Remaining Characters: 5,000

P1 Compassion, integrity, accountability, and respect for self and others — Professionalism
Level 1 - Demonstrates compassion, sensitivity, and responsiveness to patients and families. Demonstrates non-discriminatory behavior in all interactions, including diverse and vulnerable populations. Describes effects of sleep deprivation and substance abuse on performance.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Comments
Level 4 - Mentors others in the compassionate practice of medicine, even in context of disagreement with patient beliefs. Mentors others in sensitivity and responsiveness to diverse and vulnerable populations. Advocates for quality patient care.
Level 5 - Engages in scholarly activity regarding professionalism.

<table>
<thead>
<tr>
<th>Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

P2 Knowledge about, respect for, and adherence to the ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice — Professionalism
Level 1 - Describes basic ethical principles.
Level 2 - Determines presence of ethical issues in practice.
Level 3 - Analyzes and manages ethical issues in straightforward clinical situations.
Level 4 - Analyzes and manages ethical issues in complex clinical situations.
Level 5 - Demonstrates leadership and mentorship on applying ethical principles.

<table>
<thead>
<tr>
<th>Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

ICS1 Relationship development, teamwork, and managing conflict—Interpersonal and Communication Skills
Level 1 - Develops a positive relationship with patients in uncomplicated situations. Actively participates in team-based care.
Level 2 - Manages simple patient/family-related conflicts. Engages patients in shared decision-making.
Level 3 - Manages conflict in complex situations. Uses easy-to-understand language in all phases of communication.
Level 4 - Manages conflict across specialties and systems of care. Leads team-based patient care activities.
Level 5 - Engages in scholarly activity regarding teamwork and conflict management.

<table>
<thead>
<tr>
<th>Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Comments
ICS2 Information sharing, gathering, and technology—Interpersonal and Communication Skills
Level 2 - Effectively communicates during team meetings, discharge planning, and other transitions of care. Educates patients about their disease and management, including risks and benefits of treatment options. Completes all documentation accurately, including use of EHR, to promote patient safety.
Level 3 - Effectively communicates the results of a neurologic consultation in a timely manner. Effectively gathers information from collateral sources when necessary. Demonstrates synthesis, formulation, and thought process in documentation.
Level 4 - Effectively leads family meetings. Effectively and ethically uses all forms of communication. Mentors colleagues in timely, accurate, and efficient documentation.
Level 5 - Develops patient education materials. Engages in scholarly activity regarding interpersonal communication.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

Comments

Subcompetency questions are generated based on the resident's rotation.
ATTACHMENT 4: Criteria for Advancing from One Year to the Next

The decision to promote a resident from PGY II \( \rightarrow \) PGY III \( \rightarrow \) PGY IV \( \rightarrow \) graduation shall be determined by the Chairman of the Department and the Residency Program Director based upon the advice of the faculty of the department. The Residency Program Director will review the performance of each resident and make a recommendation to the Chairman as to the advisability of promoting the house officer to the next year of training or graduating that resident from the program.

The criteria for advancement shall be based upon the 6 core competencies:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health,
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care,
3. **Practice-Based Learning and Improvement** that involves the investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care,
4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals,
5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population, and
6. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context of health care and the ability to effectively call on system resources to provide care that is of optimal value.

The resident must demonstrate competency in **all six areas**.

The methods of evaluation shall include direct observation of the resident, indirect observations through rotation evaluations and 360 degree evaluations, self-evaluations, examinations such as the in-service exams and clinical skills assessments, and assessment of the resident’s attention to required duties, including attendance and participation at required conferences, timely review of dictations, timely completion of evaluations of students, faculty, and educational experiences, completion of patient and duty hours logs, and compliance with other administrative requirements.

**Introduction**

The residents will be evaluated by faculty on a monthly basis on each rotation. In addition, a summary evaluation shall occur every six months in the fall and spring. An end of the year evaluation will be completed in June at which time the resident will be promoted or graduate from the program. Residents not meeting expectations for performance will be counseled at the time of the unfavorable evaluation as well as during the semi-annual evaluations and appropriate measures for remediation will be instituted. At the end of the year, the Residency Program Director will make a recommendation to the Chairman of the Department regarding the advisability of promoting the house officer to the next year's training or regarding the graduation of that resident from our program.

**SUMMARY of METHODS of EVALUATION**

**Rotation Evaluations**

The basic method of evaluating house staff consists of the monthly rotation evaluations completed by all faculty for residents rotating with them. These are the fundamental tools for monitoring the progress of the resident. These summary evaluations shall be written by the Program Director and reviewed with each resident during their 6-month reviews. The evaluation forms are based on the ACGME Neurology Milestones.

The format for all rotation evaluations is similar and rate the resident's performance regarding the core competencies on a 5 point scale:

- **Level 1 = Novice (Medical Student level / intern)**
- **Level 2 = Competent (Beginning Neurology resident)**
- **Level 3 = Proficient (Advanced Resident)**
- **Level 4 = Expert (Resident who is ready to about complete training)**
- **Level 5 = Master (Experienced Physician)**
The evaluations are based upon expectations of a resident at that particular point in his or her training.

The resident and faculty evaluators should have a face to face meeting to discuss the evaluation.

The criteria for failing a rotation are as follows:

- The 'core' rotations are designated as all of the Adult VA and Shands In-patient and Consult Rotations, the Out-Patient Rotations and the Pediatric Neurology Rotations, all of which consist of multiple months for the resident to become competent in those areas.

- A one-time evaluation with 3 or more competencies evaluated as "Level 1"; or repeated (2 or more) evaluations with 1 or 2 competencies evaluated as "Level 1" will constitute failure of that rotation. The resident will be placed on probation.

- A one-time evaluation consisting of 1 or 2 competencies being judged as "Level 1" will constitute a 'provisional' pass for that rotation. The resident will be given a warning.

- A resident who fails a 'core' rotation/on probation must perform a remedial month of that rotation in lieu of an elective and must pass that rotation in order to be promoted or to graduate. A resident who fails a core rotation near the end of an academic year may be passed on probation to the next year, pending successful completion of the remedial rotation. Failure of the remedial month of a core rotation is grounds for dismissal of the resident from the program.

- A resident who 'fails' an elective rotation will be given a warning and must re-take that rotation in lieu of another elective. Failure to pass the repeat elective would constitute grounds for dismissal from the program after review by the Residency Program Director and Chairman.

- Two 'provisional' passes/warnings in the same 'core' rotation shall be considered as if the resident had failed a rotation and that resident must perform a remedial month in lieu of an elective and must pass that rotation in order to be promoted or to graduate.

- At each 6-month review, any areas in which the resident is below expectations shall be addressed with a plan of action for improvement.

- If a resident receives a score of Level 1 on any monthly evaluation, then a conference with that resident, the program director and preferably the staff who identified the deficiency shall be arranged to discuss the problems and means to correct this. This will not wait until the 6-month review.

The In-Service Examination

This will serve as an objective measure of the resident's academic/didactic knowledge. The in-service scores shall be reviewed with each resident in an individual conference with the Program Director, and shall be reviewed critically with the residents at the following 6-month review.

- Residents scoring < 50 percentile on major sub-categories of neurological knowledge will develop an individualized plan to improve this deficiency. The resident will review this plan at the time of the next meeting with the Program Director when the RITE scores are returned.

- Residents with an overall score < 25th percentile will be asked to use up one of his/her Electives for 'Board Review'. The resident needs to take a written examination given by the Program Director at the end of the Board Review Elective Month as a means of assessing competency in Medical Knowledge.

Student Evaluations of Residents

- Student evaluations of residents are considered an independent marker of the resident's interpersonal and teaching skills. All problems identified by the students will be addressed with the resident in question during the 6-month evaluation, or sooner if need be upon the discretion of the Program Director.

Monitoring patient contact and review/interpretation of diagnostic testing and performance of diagnostic tests

- All residents must maintain the ACGME patient case log as mandated by the neurology RRC. The program director and coordinator shall monitor the patient encounter data base to ensure compliance.

Clinical Skills Assessment

The American Board of Psychiatry and Neurology (ABPN) Neurology Council has recently shifted the evaluation of resident clinical skills into the residency years rather than by oral examination (Part II of the ABPN Board Certification in Neurology) after completion of residency. The resident must display competence in 5 areas (Emergency/Critical Care, Neuromuscular, Neurodegenerative (including Movement Disorders and Multiple Sclerosis), Episodic (such as epilepsy, headache) and Pediatric Neurology through live patient encounters. Along
• All PGY 4 residents will need to pass all 5 areas (including Pediatric Neurology) for graduation

Resident self-assessments
• Residents should provide a self-assessment at time of each 6 month review giving their own perspective of their strengths and weaknesses as well as areas that they identify as needing more work.

Professional Development
• Ongoing research projects - Residents should provide a brief summary of any research projects with which they are involved and status reports at each 6 month evaluation.
• Yearly update of CV with any meetings attended, presentations made, professional society memberships and ongoing research.
• Grand Rounds Presentation- the feedback from the audience goes into the resident's file.
• Complaints or disciplinary actions pertaining to residents should be summarized and evaluated at each 6 month review.
• Compliments shall also become a permanent part of file
• Summary of medical records proficiency or deficiencies

Duties and Requirements for Promotion:

The PGY-2 resident should complete the following requirements prior to transition to the PGY-3 year:

1. Have successfully completed all core rotations for the year, as demonstrated by the evaluation forms for each rotation and the semiannual 6-month summary evaluations. Failure of a core rotation or 2 provisional passes in core rotations as described above mandate a remedial month on that rotation. The resident is then placed on probation. Failure to satisfactorily complete the remedial core rotation is grounds for dismissal prior to promotion. If a core rotation is failed near the end of an academic year, then the resident may be provisionally promoted under a probationary arrangement to repeat the failed rotation within the first 3 months of the next academic year. Again, failure of the remedial month is grounds for immediate dismissal. Failure of a non-core rotation requires remediation of that rotation, and repeat failure may constitute grounds for dismissal after review by the Program Director and Chairman.
2. All medical records documentation, including dictation and review of discharge summaries and outpatient charts, must be up to date or with a planned date of completion within 30 days of matriculation into the PGY-3 year.
3. Documentation of all patient encounters and procedures performed and diagnostic studies must be logged.
4. Have satisfied all requirements of any disciplinary action.
5. Must have attended 75% of all required conferences (Grand Rounds, Neuropathology conferences and resident conferences) when not on vacation or ill.
6. The following global assessment will be made at each semiannual evaluation and must be satisfactory in order for the resident to be promoted. If resident is judged to have unsatisfactory performance, then a remedial plan to address the deficiencies will be instituted:

By the end of the PGY-2 year, residents should have the ability to recognize and manage "new" clinical problems, understand neurological localization, develop core differential diagnosis, execute proper workup and evaluation, lead and teach Neurosurgery and Anesthesia interns, and medical students, interact professionally with patients, staff, and colleagues.

- Needs Remediation lacks insight and judgment in clinical situations
- Acceptable recognizes most new clinical situations and seeks appropriate consultation; performing at expected level
- Very Good recognizes difficult/complicated clinical situations and seeks appropriate consultation; performing
○ **Exemplary** recognizes and manages new clinical situations skillfully; performing at a PGY-4 level

The PGY-3 resident should complete the following requirements prior to transition to the PGY-4 year:

1. Have successfully completed all core rotations for the year, as demonstrated by the evaluation forms for each rotation and the semiannual six-month summary evaluations. Failure of a core rotation or 2 provisional passes in core rotations as described above mandate a remedial month on that rotation. Failure to satisfactorily complete the remedial core rotation is grounds for dismissal prior to promotion. If a core rotation is failed near the end of an academic year, then the resident may be provisionally promoted under a probationary arrangement to repeat the failed rotation within the first 3 months of the next academic year. Again, failure of the remedial month is grounds for immediate dismissal. Failure of a non-core rotation requires repeat and repeat failure may constitute grounds for dismissal after review by the Residency Advisory Committee.

2. The resident must successfully complete the four adult Clinic Skills Evaluation/Assessments.

3. All medical records documentation, including dictation and review of discharge summaries and outpatient charts, must be up to date or with a planned date of completion within 30 days of matriculation into the PGY-4 year.

4. Documentation of all patient encounters and procedures performed and diagnostic studies reviewed/interpreted must be logged.

5. Have satisfied all requirements of any disciplinary action.

6. The resident must have attended 75% of all required conferences (Grand Rounds, Neuropathology conferences and resident conferences) when not on vacation or ill.

7. The following global assessment will be made at each semiannual evaluation and must be satisfactory in order for the resident to be promoted. If resident is judged to have unsatisfactory performance, then a remedial plan to address the deficiencies will be instituted:

   ○ **Needs Remediation** not yet capable of practicing at the expected level
   ○ **Acceptable** performing at the expected level
   ○ **Very Good** performing at or near a PGY-4 level already
   ○ **Exemplary** performing beyond a PGY-4 level

**By the end of the PGY-3 year, residents should demonstrate mastery of a large set of skills in neurological subspecialty areas, demonstrate efficiency of clinical triage and decision-making, mastery of handling of neurological emergencies, and continued professional interactions with patients, staff and colleagues.**

   ○ **Needs Remediation** not yet capable of practicing at the expected level
   ○ **Acceptable** performing at the expected level
   ○ **Very Good** performing at or near a PGY-4 level already
   ○ **Exemplary** performing beyond a PGY-4 level

Criteria required for graduation:

1. Have successfully completed all core rotations for the year, as demonstrated by the evaluation forms for each rotation and the semiannual six-month summary evaluations. Failure of a core rotation or 2 provisional passes in core rotations as described above mandate a remedial month on that rotation. Failure to satisfactorily complete the remedial core rotation is grounds for dismissal prior to graduation. Failure of a non-core rotation requires repeat and repeat failure may constitute grounds for dismissal prior to graduating after review by the Residency Advisory Committee.

2. The resident must successfully complete and pass all 5 areas of the Clinical Skills Evaluation/Assessment.

3. The house officer must have satisfactorily completed all of the requirements for the previous years, as given above.

4. The PGY-4 must have given a presentation of a scholarly activity (prospective/retrospective study, case series, or case report with review of literature).

5. The resident must have attended 75% of all required conferences (Grand Rounds, Neuropathology conferences and resident conferences) when not on vacation or ill.

6. Documentation of all patient encounters and procedures performed and diagnostic studies reviewed/interpreted must be logged into the ACGME website

7. Have satisfied all requirements of any disciplinary action.

8. Dictation of discharge summaries and outpatient charts must be up to date.

9. Must complete all portions of the Common Curriculum appropriate for this year’s training, as recommended by the Graduate Medical Education Committee of the Medical Center.
10. The following global assessment will be made at each semiannual evaluation and must be satisfactory in order for the resident to be promoted. If resident is judged to have unsatisfactory performance, then a remedial plan to address the deficiencies will be instituted:

**By the end of the PGY-4 year, residents should demonstrate leadership skills** to head a neurology consult team or ward team, and be fully prepared to practice the specialty of neurology independently

- **Unsatisfactory:** not yet capable of practicing as an independent neurologist
- **Satisfactory:** capable of practicing as an independent neurologist

**General criteria:**

The Program Director and Chairman anticipate that each house officer would not have disciplinary issues that would prevent them from graduating from the program or transitioning from one year to the next. However, if such a disciplinary issue should arise, the house officer is encouraged to meet all obligations as soon as possible. Discipline may be given by informal meeting or communication with the Chairman or Program Director or discipline may be given by written reprimand, written probation, or loss of other privileges.

If a house officer is placed on probationary status, specific criteria will be given to that house officer that must be met before the probation can be lifted. If those requirements are not completed satisfactorily, then immediate dismissal may occur.

Different violations of hospital or departmental policy may invoke different levels of discipline. Some disciplinary issues may lead to immediate dismissal without prior reprimand or probation.

The resident's performance of the six core competencies must be deemed adequate and appropriate to that resident’s level of training to be promoted or graduated. This recommendation will be made by the Program Director to the Chairman after assessing the information in the resident’s file with specific attention paid to items outlined above and upon overall assessment of the faculty as a whole. In order to graduate from the program, the resident must be deemed to be able to practice neurology competently as judged by the faculty.

**In the event of suspension, non-renewal or dismissal of a resident from the program, the UF Procedure for Grievance, Suspension, Non-Renewal or Dismissal shall be followed (see Attachment 5).**
ATTACHMENT 5: Procedure for Grievance, Suspension, Nonrenewal or Dismissal

INTENT: Each training program is responsible for the conduct of that training program and for the policy on defining satisfactory performance of the resident as a student. The sponsoring institution wishes to ensure that the application of such policies are not arbitrarily illegal, unjust or create unnecessary hardship. Therefore, a policy and procedure for addressing resident dissatisfaction is established.

POLICY STATEMENT:
Context of the institutional and program requirements. Each program must develop fair and consistent standards for the residents. If a resident feels that a decision by the program violates standards of fairness then the resident is afforded a process whereby individuals outside the program may review such decisions.

DESCRIPTION:
The position of the resident presents the dual aspect of a student in graduate training while participating in the delivery of patient care. For purposes of this policy, the term “resident” applies residents, fellows, and adjunct clinical post-doctoral associates in training programs recognized and approved by the Graduate Medical Education Committee at the University of Florida College of Medicine. These training programs may be either ACGME Accredited Programs or non-accredited programs formally approved by the GMEC.

The University of Florida College of Medicine is committed to the maintenance of a supportive educational environment in which residents are given the opportunity to learn and grow. Inappropriate behavior in any form in this professional setting is not permissible. A resident's continuation in the training program is dependent upon satisfactory performance as a student, including the maintenance of satisfactory professional standards in the care of patients and interactions with others on the health care team. The resident's academic evaluation will include assessment of behavioral components, including conduct that reflects poorly on professional standards, ethics, and collegiality. Disqualification of a resident as a student or as a member of the health care team from patient care duties disqualifies the resident from further continuation in the program.

Grievances: A grievance is defined as dissatisfaction when a resident believes that any decision, act or condition affecting his or her program of study is arbitrary, illegal, unjust or creates unnecessary hardship. Such grievance may concern, but is not limited to, the following: academic progress, mistreatment by any University employee or student, wrongful assessment of fees, records and registration errors, discipline (other than nonrenewal or dismissal) and discrimination because of race, national origin, gender, marital status, religion, age or disability, subject to the exception that complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida College of Medicine.

Prior to invoking the grievance procedures described herein, the resident is strongly encouraged to discuss his or her grievance with the person(s) alleged to have caused the grievance. The discussion should be held as soon as the resident becomes aware of the act or condition that is the basis for the grievance. In addition, or alternatively, the resident may wish to present his or her grievance in writing to the person(s) alleged to have caused the grievance. In either situation, the person(s) alleged to have caused the grievance may respond orally or in writing to the resident.

If a resident decides against discussing the grievance with the person(s) alleged to have caused such, or if the resident is not satisfied with the response, he or she may present the grievance to the Chair. If, after discussion, the grievances cannot be resolved, the resident may contact the Associate Dean of Graduate Medical Education (ADGME). The ADGME will meet with the resident and will review the grievance. The decision of the ADGME will be communicated in writing to the resident and constitute the final action of the University.

Suspension: The Chief of Staff of a participating and/or affiliated hospital where the resident is assigned, the Dean, the President of the Hospital, the Chair, or Program Director may at any time suspend a resident from patient care responsibilities. The resident will be informed of the reasons for the suspension and will be given an opportunity to provide information in response.
The resident suspended from patient care may be assigned to other duties as determined and approved by the Chair. The resident will either be reinstated (with or without the imposition of academic probation or other conditions) or dismissal proceedings will commence by the University against the resident within thirty (30) days of the date of suspension.

Any suspension and reassignment of the resident to other duties may continue until final conclusion of the decision-making or appeal process. The resident will be afforded due process and may appeal to the ADGME for resolution, as set forth below.

**Nonrenewal**: In the event that the Program Director decides not to renew a resident's appointment, the resident will be provided written notice which will include a statement specifying the reason(s) for nonrenewal. This should be done at least 4 months prior to the end of the resident's current agreement.

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed nonrenewal decision. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that nonrenewal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

**Dismissal**: In the event the Program Director of a training program concludes a resident should be dismissed prior to completion of the program, the Program Director will inform the Chair in writing of this decision and the reason(s) for the decision. The resident will be notified and provided a copy of the letter of proposed dismissal; and, upon request, will be provided previous evaluations, complaints, counseling, letters and other documents that relate to the decision to dismiss the resident.

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed dismissal. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that dismissal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the ADGME as described below.

**Appeal**: If the resident appeals a decision for suspension, nonrenewal or dismissal, this appeal must be made in writing to the ADGME within 10 working days from the resident's receipt of the decision of the person suspending the resident or the Chair. Failure to file such an appeal within 10 working days will render the decision of the person suspending the resident or the Chair the final agency action of the University.

The ADGME will conduct a review of the action and may review documents or any other information relevant to the decision. The resident will be notified of the date of the meeting with the ADGME; it should occur within 15 working days of the ADGME’s receipt of the appeal. The ADGME may conduct an investigation and uphold, modify or reverse the recommendation for suspension, nonrenewal or dismissal. The ADGME will notify the resident in writing of the ADGME's decision. If the decision is to uphold a suspension, the decision of the ADGME is the final agency action of the University. If the decision is to uphold the nonrenewal or dismissal, the resident may file within 10 working days a written appeal to the Dean of the College of Medicine. Failure to file such an appeal within 10 working days will render the decision of the ADGME the final action of the University.

The Dean will inform the ADGME of the appeal. The ADGME will provide the Dean a copy of the decision and accompanying documents and any other material submitted by the resident or considered in the appeal process. The Dean will use his or her best efforts to render a decision within 15 working days, but failure to do so is not grounds for reversal of the decision under appeal. The Dean will notify in writing the Chair, the ADGME, the Program Director and resident of the decision. The decision of the Dean will be the final agency action of the University. The resident will be informed of the steps necessary for the resident to further challenge the action of the University.
ATTACHMENT 6: Sample Resident's Evaluation of Faculty

EDUCATION FACULTY EVALUATION (BY RESIDENTS)

Evaluator:
Rotation:
Subject:

The following are important characteristics of good instruction. Using a scale of Poor-Excellent, please assess your instructor's performance on the following items. Please respond to all statements; if you cannot, leave blank.

**PART I INSTRUCTOR**

1.) Description of rotation objectives and assignments
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

2.) Communication of ideas and information
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

3.) Expression of expectations for performance
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

4.) Availability to assist residents in or out of class
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

5.) Respect and concern for residents
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

6.) Stimulation of interest in course
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

7.) Facilitation of learning
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

8.) Showed enthusiasm for the subject
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

9.) Encouraged residents to think independently, creatively, critically
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

10.) Overall rating of instructor
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

**PART II OPTIONAL QUESTIONS**

11.) Provided direction and feedback effectively
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

12.) Provided conscientious supervision of resident care for patients
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

13.) Reliably responded to pages and messages from residents
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

14.) Provided instruction to students on the service
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

15.) Effectively taught to the level of the residents on service
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A
16.) Promoted regular review of cost containment issues
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

17.) Promoted regular review of ethical, socioeconomic, and medical-legal issues in the care of patients
1= Needs Remediation  2= Acceptable  3=Very Good  4= Exemplary  N/A

**PART III COMMENTS**

18.) What were the strengths of this instructor's teaching?

19.) What were the weaknesses of this instructor's teaching?

20.) What teaching improvements would you suggest to the instructor?
ATTACHMENT 7: Sample Resident's Evaluation of each Rotation

Resident’s Evaluation of Neurology Rotations

Name of Resident: 

Month of Rotation: 

Name of Rotation: 

1. Adequacy of resources and case material during the rotation
   - Poor
   - Fair
   - Good
   - Very good
   - Excellent

2. Conduciveness of the environment and organization to meeting all applicable competencies
   - Poor
   - Fair
   - Good
   - Very good
   - Excellent

3. Ability to meet all applicable competencies at the end of the rotation
   - Poor
   - Fair
   - Good
   - Very good
   - Excellent

Over-all Comment (this is a required response):

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

____
## ATTACHMENT 8: SUMMARY OF MEDICARE REQUIREMENTS FOR DOCUMENTATION OF BILLING

***This attachment has been removed because residents all get handouts prepared by Medicare of Florida as part of their general orientation. You will be reminded of requirements and advised about any changes in requirements periodically during your residency.***

<table>
<thead>
<tr>
<th>ICD-9 code</th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>335</td>
<td>Anterior horn cell diseases including ALS</td>
</tr>
<tr>
<td>334</td>
<td>Ataxia, including spinocerebellar disorders</td>
</tr>
<tr>
<td>430-438</td>
<td>Cerebrovascular disorders</td>
</tr>
<tr>
<td>362.34</td>
<td>Amaurosis fugax</td>
</tr>
<tr>
<td>785.9</td>
<td>Asymptomatic bruit</td>
</tr>
<tr>
<td>747.81</td>
<td>Vascular malformation</td>
</tr>
<tr>
<td></td>
<td>Congenital disorders &amp; degenerative disorders of childhood</td>
</tr>
<tr>
<td>343</td>
<td>Cerebral palsy</td>
</tr>
<tr>
<td>330</td>
<td>Degenerative diseases pediatrics</td>
</tr>
<tr>
<td></td>
<td>Cognitive disorders</td>
</tr>
<tr>
<td>331</td>
<td>Alzheimer’s, Pick’s</td>
</tr>
<tr>
<td>437</td>
<td>Dementia, unspecified</td>
</tr>
<tr>
<td>350-352</td>
<td>Cranial nerve disorders</td>
</tr>
<tr>
<td>388</td>
<td>VIIth nerve</td>
</tr>
<tr>
<td>378</td>
<td>III, IV, VI nerves</td>
</tr>
<tr>
<td>377</td>
<td>II nerve</td>
</tr>
<tr>
<td>374.30</td>
<td>Ptosis</td>
</tr>
<tr>
<td>340-341</td>
<td>Demyelinating disorders</td>
</tr>
<tr>
<td>340</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>377.80</td>
<td>Optic neuritis</td>
</tr>
<tr>
<td>135</td>
<td>Sarcoi</td>
</tr>
<tr>
<td>088.81</td>
<td>Lyme</td>
</tr>
<tr>
<td></td>
<td>Encephalopathy</td>
</tr>
<tr>
<td>348.3</td>
<td>Unspecified</td>
</tr>
<tr>
<td>310.3</td>
<td>Post-concussive</td>
</tr>
<tr>
<td>349.82</td>
<td>Toxic</td>
</tr>
<tr>
<td>348.1</td>
<td>Hypoxic</td>
</tr>
<tr>
<td>320-326</td>
<td>Infections</td>
</tr>
<tr>
<td>042</td>
<td>AIDS</td>
</tr>
<tr>
<td>047.9</td>
<td>Aseptic meningitis</td>
</tr>
<tr>
<td>094.9</td>
<td>Neurosyphilis</td>
</tr>
<tr>
<td>046.1</td>
<td>CJD</td>
</tr>
<tr>
<td>054.3</td>
<td>HSV</td>
</tr>
<tr>
<td>053.9</td>
<td>H. zoster</td>
</tr>
<tr>
<td>088.81</td>
<td>Lyme</td>
</tr>
<tr>
<td></td>
<td>Intracranial pressure</td>
</tr>
<tr>
<td>742.3</td>
<td>Congenital hydrocephalus</td>
</tr>
<tr>
<td>331.3</td>
<td>Communicating hydrocephalus</td>
</tr>
<tr>
<td>331.4</td>
<td>Obstructive hydrocephalus</td>
</tr>
<tr>
<td>348.4</td>
<td>Cerebral herniation</td>
</tr>
<tr>
<td>348.2</td>
<td>Pseudotumor cerebri</td>
</tr>
<tr>
<td>332-333</td>
<td>Movement disorders:</td>
</tr>
<tr>
<td></td>
<td>Dystonia</td>
</tr>
<tr>
<td></td>
<td>Huntington’s</td>
</tr>
<tr>
<td></td>
<td>Parkinson’s</td>
</tr>
<tr>
<td></td>
<td>Tremor</td>
</tr>
<tr>
<td></td>
<td>Myelopathy</td>
</tr>
<tr>
<td>191-192</td>
<td>Brain and other CNS malignancy</td>
</tr>
<tr>
<td>198.3</td>
<td>Metastatic neoplasm brain/cord</td>
</tr>
<tr>
<td>Pain: facial/headache</td>
<td></td>
</tr>
<tr>
<td>346</td>
<td>Migraine</td>
</tr>
<tr>
<td>350.2</td>
<td>Atypical facial pain</td>
</tr>
<tr>
<td>784.0</td>
<td>Posttraumatic headache</td>
</tr>
<tr>
<td>473.9</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>307.81</td>
<td>Tension headache</td>
</tr>
<tr>
<td>350.1</td>
<td>Trigeminal neuralgia</td>
</tr>
<tr>
<td>Pain: limb/back</td>
<td></td>
</tr>
<tr>
<td>724.5</td>
<td>Back pain</td>
</tr>
<tr>
<td>355.9</td>
<td>Causalgia</td>
</tr>
<tr>
<td>729.5</td>
<td>Limb pain</td>
</tr>
<tr>
<td>780.9</td>
<td>Multifocal pain</td>
</tr>
<tr>
<td>721</td>
<td>Cervical spondylosis</td>
</tr>
<tr>
<td>724.02</td>
<td>Lumbar spinal stenosis</td>
</tr>
<tr>
<td>053.19</td>
<td>Post-herpetic neuralgia</td>
</tr>
<tr>
<td>345</td>
<td>Seizures</td>
</tr>
<tr>
<td>780.3</td>
<td>Convulsions</td>
</tr>
<tr>
<td>780.0</td>
<td>Altered consciousness</td>
</tr>
<tr>
<td>Sleep disorders</td>
<td></td>
</tr>
<tr>
<td>347</td>
<td>Cataplexy/narcolepsy</td>
</tr>
<tr>
<td>780.5</td>
<td>Sleep disturbance, apnea</td>
</tr>
<tr>
<td>333.90</td>
<td>Periodic movements of sleep</td>
</tr>
<tr>
<td>333.99</td>
<td>Restless leg syndrome</td>
</tr>
<tr>
<td>359</td>
<td>Muscle diseases</td>
</tr>
<tr>
<td>729.1</td>
<td>Myalgias</td>
</tr>
<tr>
<td>710.4</td>
<td>Polymyositis</td>
</tr>
<tr>
<td>358</td>
<td>Neuromuscular junction diseases</td>
</tr>
<tr>
<td>353.357</td>
<td>Peripheral nerve disorders</td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
</tr>
<tr>
<td>300.00</td>
<td>Anxiety disorder</td>
</tr>
<tr>
<td>296.7</td>
<td>Bipolar</td>
</tr>
<tr>
<td>300.11</td>
<td>Conversion disorder</td>
</tr>
<tr>
<td>311</td>
<td>Depression</td>
</tr>
<tr>
<td>306.1</td>
<td>Hyperventilation</td>
</tr>
<tr>
<td>384.8</td>
<td>Organic brain syndrome</td>
</tr>
<tr>
<td>300.01</td>
<td>Panic disorder</td>
</tr>
<tr>
<td>395.9</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
</tr>
<tr>
<td>432.1</td>
<td>Subdural hematoma</td>
</tr>
<tr>
<td>853.0</td>
<td>Brain traumatic hemorrhage</td>
</tr>
<tr>
<td>803.0</td>
<td>Skull fracture</td>
</tr>
<tr>
<td>767.4</td>
<td>Spine fracture</td>
</tr>
</tbody>
</table>
ATTACHMENT 9: Medical Cost Awareness for New Housestaff

In an academic health center, residents are responsible for the majority of patient care decisions involving clinical resources such as radiology, laboratory, and length of time patients spend in the hospital. To adequately prepare themselves for future practice in any setting, housestaff must be aware they will be entering a competitive marketplace in which physician performance is measured and reported routinely.

The two most common measures of performance in healthcare are cost and quality. It is the relationship between the patient’s outcome and the cost of supporting that outcome which defines the value a healthcare provider can claim to provide. Increasingly, medical care payment is managed by payers responding to cost and satisfaction data which may compel them to choose one institution as more effective and efficient over another. Patient care costs are followed closely within the Shands system. Use of billable items such as x-rays, diagnostic laboratory tests, intensive care days, and O.R. time are tracked. Patient satisfaction is surveyed and comparison reports are shared among dozens of academic health centers similar to Shands.

The Clinical Resource Management office (395-0374) and the Clinical Resource Management Council, comprised of representative clinical attending faculty, support evaluation and ongoing improvement in patient care outcomes, costs, and value. Shands’ Coordinated Care program, administered through the Department of Nursing and Patient Services, works with CRM to assist physicians in identifying clinical practice patterns which are efficient, effective, and satisfying for the patient as well as care provider.

During two years of concentrated effort, over 10% of Shands’ internal costs have been trimmed by residents and attendings making more judicious and appropriate decisions to utilize tests, exams, sites of care, and days of hospitalization. There remain, however, many opportunities to reduce clinical cost without negatively affecting care. It is the housestaff member’s particular daily challenge to identify these opportunities and act on them.

Costs to Patients and Their Payers

Examples of the 1996 price-to-the-patient for typical, high-volume diagnostic orders within Radiology and the Clinical Laboratory are found in the tables below. Shands must often discount these charges heavily to ensure continuing payment within the increasingly competitive marketplace. Even when discounted, payment by insurers and for those without insurance rarely meets total billings. Because we cannot rely on consistent levels of reimbursement, it is imperative that our internal costs be as lean as possible to afford providing the broadest array of clinical services and resident training. Further information about managed care is available through the CRM office. Specific charges to patients for other exams can be obtained by calling Radiology Administration at 395-0101, or the Clinical Laboratory at 395-0172.

High-Volume Radiology Exams (Annual Shands at UF Patients: Approx. 25,000)

<table>
<thead>
<tr>
<th>Exam</th>
<th>Patient Charge per Exam</th>
<th>Annual Quantity Ordered</th>
<th>Annual Inpatient Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest x-ray, 1 view</td>
<td>$100</td>
<td>65,884</td>
<td>$6,588,400</td>
</tr>
<tr>
<td>Chest x-ray, pa/lat (2 views)</td>
<td>$115</td>
<td>6,692</td>
<td>$769,580</td>
</tr>
<tr>
<td>Portable Svc. Charge</td>
<td>$0</td>
<td>72,000</td>
<td>$0</td>
</tr>
<tr>
<td>Abdomen, 1 view</td>
<td>$105</td>
<td>2,830</td>
<td>$297,150</td>
</tr>
<tr>
<td>Abdominal Ultrasound</td>
<td>$310</td>
<td>1,841</td>
<td>$570,630</td>
</tr>
<tr>
<td>CT-Abdomen w/ contrast</td>
<td>$1,537</td>
<td>4,804</td>
<td>$7,382,460</td>
</tr>
<tr>
<td>MRI Brain</td>
<td>$1,697</td>
<td>1,890</td>
<td>$3,208,090</td>
</tr>
</tbody>
</table>

Note: Housestaff are more likely to independently make decisions about use of less complex radiology exams such as abdominal and chest views than more expensive MRI and CT scans. Yet it can quickly be seen from the table that due to annual volume, resident decisions determine the greater overall financial impact of these top-volume radiology resources. Hypothetically, if all 600 residents participated equally in deciding to utilize chest and abdominal exams alone, each resident would have accounted for over $15,000 in cost-to-patient during the year for just these 2 resources.
### High-Volume Laboratory Tests

<table>
<thead>
<tr>
<th>Exam</th>
<th>Patient Charge per Exam</th>
<th>Annual Quantity Ordered</th>
<th>Annual Inpatient Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolyte Battery</td>
<td>$66</td>
<td>118</td>
<td>$ 7,762</td>
</tr>
<tr>
<td>Renal Disease Batt.</td>
<td>$133</td>
<td>114</td>
<td>$15,198</td>
</tr>
<tr>
<td>Liver Battery</td>
<td>$135</td>
<td>22,705</td>
<td>$3,075,952</td>
</tr>
<tr>
<td>UA</td>
<td>$ 44</td>
<td>16,975</td>
<td>$ 743,206</td>
</tr>
<tr>
<td>CBC w/Diff</td>
<td>$114</td>
<td>57,109</td>
<td>$6,488,219</td>
</tr>
<tr>
<td>CBC</td>
<td>$ 40</td>
<td>110,031</td>
<td>$4,386,428</td>
</tr>
<tr>
<td>PT/INR</td>
<td>$ 48</td>
<td>55,524</td>
<td>$2,652,684</td>
</tr>
<tr>
<td>Blood Culture</td>
<td>$111</td>
<td>29,748</td>
<td>$3,302,028</td>
</tr>
<tr>
<td>Urine Culture</td>
<td>$ 56</td>
<td>13,969</td>
<td>$ 788,918</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>$ 44</td>
<td>11,942</td>
<td>$ 522,088</td>
</tr>
</tbody>
</table>

Again, it can be easily seen that during a single day (and night) on-service, a busy resident ordering multiple, serial lab batteries or common, single tests can impact his or her patient’s billings by thousands of dollars. In the intensive care areas, that figure can jump to thousands of dollars per day per patient.

### Sensitivity and Specificity Criteria

The judicious use of diagnostic technology is a skill requirement for successful 21st century medical practice. This skill depends upon the clinician’s knowledge of a test’s sensitivity (the ability of the test to detect the disease), and its specificity (the ability of the test to exclude patients without the disease), and the prevalence of the disease in the population under consideration. The predictive value of an abnormal test result (how often the abnormal results will be due to the presence of the disease as opposed to a false positive) can be calculated from the sensitivity and specificity of the test and the prevalence of the disease. For example:

Clean catch urine cultures in women may illustrate the predictive value of a test. A single clean catch specimen, using a count of $\geq 10^5$ organisms/mm, indicates a diagnosis of urinary tract infection with a sensitivity of 95% and a specificity of 84% (1). When women with complaint of both polyuria and dysuria are cultured, 60% will have true urinary tract infections (2). A positive urine culture will thus have a predictive value of 90% when compared to direct bladder puncture. When women complaining of dysuria alone are cultured, only 33% will have infection, as they have vaginitis (3). A positive culture in this situation will be of less use, with a predictive value of about 75%. If women with no symptoms are studied, only 5% will have asymptomatic bacteriuria. In this situation, the predictive value of a positive culture indicating true infections is only 24%, much less than flipping a coin. Thus a laboratory test is most helpful in the context of strong clinical suspicion.

### When to Order a Test?

For many patient groups, planned coordination of care will include specific pre-printed order sets to launch a patient into the clinical setting. Order sets will most often be used in conjunction with a clinical pathway, a time-and-event grid of the necessary care to ensure specific patient outcomes during hospitalization. The clinical pathway, developed by a multi-disciplinary team including attending faculty members, is used as a guide to optimizing the patient’s ongoing care and may include suggested intervals for standard diagnostic and monitoring tests. Although structured across a time grid, the pathway is intended to be adjusted to each individual patient’s particular situation.

An adjunct to a pathway may be an algorithm, or mapped-out sequence of key decision points which assist the housestaff member in weighing treatment and diagnostic options. When applied to the care of a specific patient, algorithms and pathways both will involve the ongoing tracking of selected variances from intended outcomes. It is through the analysis of variance patterns that structured data emerges. The data are used to enhance revision of these tools, better supporting the clinician’s decision-making process.

Beyond the structured test-ordering patterns suggested in pathways and algorithms, housestaff should consult with their attendings and may order exams and tests to:

- confirm a clinical diagnosis based on reasonable expected prevalence
- rule out treatable, life-threatening or serious disease
- stage a disease for therapeutic or prognostic purposes
- screen for asymptomatic disease only if evidence exists that finding the condition in an asymptomatic state can alter the long-term outcome of the patient
* monitor drug therapy (pharmacy will provide guidelines 395-0418)
* generate clinical research data among patients participating, with informed consent. (Cost of tests are absorbed by the institution and not applied to a patient=s bill)

The predictive value of laboratory tests and diagnostic procedures must be measured against the norm of the diagnostic power of a medical history and exam. Historically, the ability to solve clinical problems at the beside without the laboratory information approached 90% (4). Today and in the future, the housestaff member’s skill in judging when and to what extent further diagnostic information clearly contributes to clinical decision-making and avoiding complications of care will be a critical factor in the success of that physician=s professional career.

References

ATTACHMENT 10: Impaired Physician

INTENT: The sponsoring institution and each program is responsible for monitoring residents for signs of psychological and substance abuse problems and for initiating appropriate interventions.

POLICY STATEMENT: The University of Florida College of Medicine will fully participate in the provisions of the Florida Medical Practice Act (F.S.458), the rules of the Board of Medicine, and Department of Professional Regulation. The College of Medicine supports the Florida Impaired Practitioners Program.

DESCRIPTION:

1. Faculty, staff, peers, family or other individuals who suspect that a member of the housestaff is suffering from a psychological or substance abuse problem are obligated to report such problems. Individuals suspecting such impairment can either report directly to the Florida Professional’s Resource Network (PRN) or can discuss their concerns with the Program Director, Chairman, or Associate Dean of Graduate Medical Education.
   a) It is the intent of the sponsoring institution that all appropriate rules that govern the practice of medicine be strictly enforced.
   b) All referrals to the PRN are confidential and are evaluated by the professionals of the PRN. Decisions about intervention, treatment and after care are determined by the PRN.
   c) As long as the practitioner satisfactorily participates in the PRN program no regulatory action would normally be anticipated by the Board of Medicine.
   d) Resumption of clinical activity and residency program will be contingent upon the continued successful participation in the PRN and continuation of the resident in the program will be determined in consultation between the program director and the professionals at the PRN.
   e) Information on the Florida Professional Resource Network (PRN) and its program can be obtained by calling 1-800-888-8PRN or by writing to the PRN at P.O. Box 1020, Fernandina Beach, Florida 32035. (see attached)

2. Each program will provide an educational program to their residents regarding substance abuse.

3. Compliance with the above will be monitored in the internal review process.

Last Reviewed and Approved: Graduate Medical Education Committee
December 13, 2012
ATTACHMENT 11: Institutional Policy on Sexual Harassment

SUBJECT: Sexual Harassment

INTENT: The Accreditation Council for Graduate Medical Education Institutional Requirements requires the Sponsoring Institution to have written policies covering sexual and other forms of harassment.

POLICY STATEMENT: It is the policy of The University of Florida to provide an educational and working environment for its students, faculty and staff that is free from sex discrimination and sexual harassment. In accordance with federal and state law, the University prohibits discrimination on the basis of sex, including sexual harassment. Sex discrimination and sexual harassment will not be tolerated, and individuals who engage in such conduct will be subject to disciplinary action. The University encourages residents / fellows, students, faculty, staff and visitors to promptly report sex discrimination and sexual harassment.

DEFINITION: Sexual Harassment is a form of sex discrimination that can occur when:
• The submission to unwelcome physical conduct of a sexual nature, or to unwelcome requests for sexual favors or other verbal conduct of a sexual nature, is made an implicit or explicit term or condition of employment or education; or
• The submission or rejection to unwelcome physical conduct of a sexual nature, or to unwelcome requests for sexual favors or other verbal conduct of a sexual nature, is used as a basis for academic or employment decisions or evaluations; or
• Unwelcome physical acts of a sexual nature, or unwelcome requests for sexual favors or other verbal conduct of a sexual nature, have the effect of creating an objectively hostile environment that interferes with employment or education on account of sex.

REPORTING: Confidential Discussion – No Reporting

Resident Reporting
If a resident / fellow would like to confidentially discuss this type of issue prior to reporting they may contact Shae Kosch, Ph.D., kosch@ufl.edu, Darrell-594-0507, Maricel-594-0571, Linda Holt-594-0570.

This designated counselor does not have an obligation to report any incident that is brought to his/her attention.

Mandatory Action Required
A person who believes that he or she has been subjected to sex discrimination or sexual harassment may report the incident to any University official, administrator or supervisor. However, the Office of Human Resource Services, Larry Ellis, investigates all complaints. Incidents should be reported as soon as possible after the time of their occurrence. Additional policy information should be reviewed and can be obtained at http://hr.ufl.edu/eeo

Any complaint or report of sexual harassment to any UF official MANDATES that individual to report it the Office of Human Resource Services.

Self Reporting—A resident / fellow can contact this person directly:
All Sexual Harassment complaints are investigated by the Office of Human Resource Services. The Complaint form is available is at http://www.hr.ufl.edu. All incidents should be reported as soon as possible to:

Larry T. Ellis, Director of Administration and Equal Employment Opportunity
Human Resource Services
P.O. Box 115010
Gainesville, FL 32611-5010
352-392-1075

Last Reviewed and Approved: Graduate Medical Education Committee
December 13, 2012
ATTACHMENT 12: Extra Duty Policy

INTENT: The Accreditation Council for Graduate Medical Education Institutional Requirements require that the Sponsoring Institution have policies regarding professional activities outside the educational program.

POLICY STATEMENT: Housestaff must adhere to State University System Guidelines regarding outside activities/outside employment, conflict of interest, and additional compensation. Such outside activity includes private practice, private consultation, teaching, research, or other employment outside State government which is not part of assigned University duties and for which the University provides no compensation. Individual housestaff programs are accredited by their Residency Review Committee (RRC) and must adhere to RRC requirements regarding outside employment. Although RRC’s vary, the general theme is that any professional activities which are outside the established educational program must not interfere with the resident’s established educational process or the quality care of patients. Residents shall not be required to engage in professional activities outside the educational program.

DESCRIPTION

1. Each program must have a policy regarding additional duty employment which meets RRC requirements and University of Florida College of Medicine policy. There are two categories of extra duty activity defined in University of Florida policy:
   a. Programmatic: These activities are initiated by departmental training programs to provide additional clinical experiences within the program specialty. These activities usually occur at campus health care sites. Supplemental salary income is provided by the University to housestaff who participate in programmatic activities.
   b. Non-programmatic: These activities are initiated by the resident and do not involve any agreement between the College of Medicine and an outside employer. Residents must be licensed for unsupervised medical practice in the state where such activity occurs and attest to adequate professional liability coverage. In no circumstance is the resident to hold himself or herself out as an employee of the University while engaged in such activities.

2. Each program’s rules regarding outside and extracurricular employment must be reviewed during the periodic internal program reviews and subsequently approved by the GMEC. The program director is ultimately responsible for assuring that outside activities do not interfere with the educational program and should monitor all outside activities of the residents in their program on an ongoing basis. Program Directors are required to prospectively approve any programmatic and non-programmatic activities, to be aware of the number of hours per week such activities shall consume.

Programmatic & Non-Programmatic includes time spent in patient care, and consideration of patient and resident safety demand that these hours must be counted toward the residents’ 80 hour per week maximum, counted toward residents’ maximum continuous duty period (24 hours) and counted toward requirements for time free from patient care responsibilities. All Programmatic & Non-Programmatic must be completed at least 10 hours prior to the next scheduled residency duty period.

3. A summary annual report of programmatic and non-programmatic professional employment of housestaff will be provided by the program director to the GMEC indicating that the program director is aware of the activities and approves.

4. All housestaff participating in non-programmatic outside professional employment must first complete a Non-Programmatic Professional Activity Form for approval and signature by their chairperson or program director and the Associate Dean, GME before undertaking such activity—Each episode of anticipated service must be included. Requests may be made for activities spanning up to one month, but in no circumstance will blanket approval for periods longer than one month be permitted. (See: http://gme.med.ufl.edu/files/2011/12/Extra-Duty-Policy-Form.pdf)

5. Programs, departments and services will be responsible for enforcement of this policy. Violation by the resident may lead to immediate dismissal.
6. Housestaff employed under a J-1 or H1-b visa may participate in PROGRAMMATIC extra duty activities only. Non-Programmatic extra duty activities are strictly prohibited by law. However, prior to beginning any extra duty activities, each individual with a J-1 or H1-b visa must be certain that their individual visa permits this additional work activity and receive clearance from the program director, the Office of Graduate Medical Education, and the College of Medicine Dean’s office.

7. PGY-1 Housestaff may not moonlight

(CPR VI.G.2.C) Last Reviewed and Approved: Graduate Medical Education Committee December 13, 2012
ATTACHMENT 13: Official holidays as defined by the Housestaff office for Academic year 2014-2015:

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Day</th>
<th>Date</th>
<th>Shands</th>
<th>VAMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence Day</td>
<td>Friday</td>
<td>7/4/2014</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Monday</td>
<td>9/1/2014</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Columbus Day</td>
<td>Monday</td>
<td>10/13/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran's Day (observed)</td>
<td>Tuesday</td>
<td>11/11/2014</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>Thursday</td>
<td>11/27/2014</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day after Thanksgiving</td>
<td>Friday</td>
<td>11/28/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christmas Day</td>
<td>Thursday</td>
<td>12/25/2014</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New Year's Day</td>
<td>Thursday</td>
<td>1/1/2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Martin Luther King Day</td>
<td>Monday</td>
<td>1/19/2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>President's Day</td>
<td>Monday</td>
<td>2/16/2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memorial Day</td>
<td>Monday</td>
<td>5/25/2015</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
ATTACHMENT 13:  
University of Florida  
College of Medicine  
Policy on Industry Conflicts of Interest/Industry Academic Relations  
Introduction  
The University of Florida has long had a document providing guidelines, policies and procedures on conflict of interest and outside activities for faculty, staff and students. All COM faculty, residents, staff and students must be familiar with this policy and its reporting requirements. The policy can be accessed at:  
http://www.research.ufl.edu/research/outside_activities.html  
The faculty, staff and students of the College of Medicine (COM) must be especially sensitive to even the appearance of conflict of interest when it comes to relationships with the pharmaceutical and medical device industry. The basic principle of healthcare is that the patient’s well being takes priority over that of the care giver’s. Recently, several high profile instances have come to light where it appears physicians and researchers have violated this trust. The public has responded with outrage and legislation at both the state and federal levels has been proposed that would establish government regulation of the vendor-healthcare provider relationship.  
The pharmaceutical and medical device industry spends more on advertising to healthcare providers and the public than it spends on research and development. There is ample evidence that such advertising efforts are effective in influencing prescribing practice, especially when advertising is accompanied by gifts. Data reflect that even small gifts create a sense of obligation in the recipient that translates as sales for the company. Besides calling into question the issue of the provider’s unwavering devotion to the patient’s well being, such practice also may lead to higher cost by increasing the volume of prescriptions and the tendency to prescribe name-brand rather than generic drugs.  
Because there are legitimate and necessary interactions between COM faculty, residents, staff and students and the pharmaceutical and medical device industry, the COM has established a policy that defines the boundaries regarding acceptable relationships with the pharmaceutical and medical device industry, as well as establishing mechanisms to monitor these relationships.  
Applicability of Policy  
This policy applies to all COM faculty, residents, staff and students. This policy does not supersede the University of Florida’s policy regarding the disclosure of outside activities, financial interests and conflict of interest, which is applicable to all University of Florida employees.  
Statement of Policy  
The goal of this policy is to ensure that all clinical, educational and research decision-making is free of influence created by relationships with any outside interest and that all individuals are aware of their individual and institutional responsibilities with regard to industry relations. It is the policy of the COM that complete transparency shall occur in all interactions and encounters between COM faculty, residents, staff and students and the pharmaceutical and medical device industry. A care giver’s primary responsibility is to his/her patients. Researchers must be free of any potential for bias. When appropriate interactions occur between industry and COM faculty, residents, staff and students, the boundaries for such interaction must be consistent with this policy.  
All COM faculty, residents, staff and students shall receive specific instruction tailored to their role in appropriate academic-industry interactions. Ultimately, the COM and its faculty, residents, staff and students are accountable for their respective actions. The following guidelines identify specific activities that address interactions with industry representatives and vendors. COM faculty, residents, staff and students also should consult with their respective department chairs or immediate supervisors to obtain further guidance.  
Specific Activities
COM faculty, residents, staff and students may not accept gifts from industry representatives or vendors regardless of the monetary value of the gift.

B. Pharmaceutical Samples, Devices and Other Materials

Pharmaceutical Samples
Pharmaceutical samples shall be distributed through a voucher system administered by Shands HealthCare pharmacy service. In the event a faculty member feels doing so would jeopardize a vulnerable population of patients, the physician may request a waiver from this rule from the UFP Clinical Safety Committee. Physicians requesting a waiver must show clear benefit and provide safeguards for the appropriate distribution and control of samples. Samples shall not be accepted for personal use by faculty, staff, residents or students.

Teaching Aids/Books/Devices
COM faculty, residents, staff and students are not permitted to accept books, instruments and other teaching aids from industry representatives or vendors. Industry representatives or vendors requesting to support the educational mission of the COM may provide an unrestricted grant, which will be placed in a central fund and monitored/distributed by the COM Industry Academic Relations committee.

Patient materials
Educational materials for COM faculty, residents, staff and students or for patients supplied by industry representatives or vendors is permitted provided such materials are preapproved by the COM Industry Academic Relations committee and are not “branded” by the supplier of the materials. Such materials may not be distributed directly to COM faculty, residents, staff and students or to patients by industry representatives or vendors.

C. On-Site Access by Industry Representatives and Vendors
On-site access by industry representatives or vendors is restricted to non-patient care and public areas only. Industry representatives and vendors are permitted access to patient care areas and non-public areas only when their presence is necessary for educational purposes and then only by appointment and, when appropriate, with the prior consent of the patient. Such on-site access by industry representatives and vendors must be under the constant supervision of a COM faculty member. These activities also are subject to the policies of Shands HealthCare regarding such access.

On-site access by industry representatives and vendors at “vendor fairs” is permitted with the preapproval of the COM Industry Academic Relations committee. Participation by industry representatives and vendors in such events is subject to the provisions referenced in the “Gifts” section of this policy.

D. Continuing Medical Education (CME)

On-Site Courses
COM faculty, residents, staff and students are permitted to engage in educational activities in on-site venues. All such courses must conform to ACCME standards and must be processed through and approved by the COM’s Continuing Medical Education office.

Off-Site Courses
COM faculty, residents, staff and students are permitted to participate in off-site CME courses if these courses conform to the requirements of the ACCME. Specifically there must be full disclosure of the sources of financial support, the program must be free of bias and the planners and speakers must declare any source of possible conflict of interest. Payment for attendance is prohibited. Individuals may receive an honorarium for speaking from the sponsors of the CME event.

Required On-Site Training
Industry representatives or vendors may provide on-site training to COM faculty, residents, staff and students with preapproval from the COM’s Continuing Medical Education office. Such training shall be conducted in accordance with ACCME standards. Training to be conducted in patient care areas must conform to Shands HealthCare policy.

E. Speaker Bureaus
is discouraged. However, where such activity has an educational value and is preapproved by the employee’s department chair or immediate supervisor, COM faculty, residents, staff and students engaging in such activity must comply with the University of Florida’s regulation regarding the disclosure of outside activities, financial interests and conflict of interest. Approval for such activity will be denied if the content of the talk is in any way provided by industry or subject to industry approval or if the attendees of the event are selected by industry or provided a gift or stipend to attend. Such activities also require the COM faculty, resident or staff to report appropriate leave usage while in engaged in such activities.

**F. Food/Entertainment**

**On Site Food**

COM faculty, residents, staff and students may not accept food or meals sponsored by or provided by industry representatives or vendors. Industry representatives or vendors requesting to support the educational mission of the COM may provide an unrestricted grant, which will be placed in a central fund and monitored/distributed by the COM Industry Academic Relations committee. Food and meals supplied by industry representatives or vendors in conjunction with a CME event sponsored by the COM must comply with the guidelines established by the COM’s Continuing Medical Education office.

**Off Site Food/Entertainment**

COM faculty, residents, staff and students may not accept food or meals sponsored by or provided by industry representatives or vendors at off-site locations. This includes events with an educational component (e.g. journal club) unless this event has been approved by the CME office. Industry funding may not be accepted for departmental meetings, retreats or social events. Dinners or entertainment sponsored by and paid for by industry representatives or vendors for a small group of select individuals at national meetings/conferences is not permitted.

COM faculty, residents, staff and students may attend educational events during national meetings/conferences where food is provided by or sponsored by industry representatives or vendors provided such events adhere to ACCME standards.

**G. Travel to Meetings/Honoraria for Attendance**

COM faculty, residents, staff and students are not permitted to accept travel funds or payment from industry representatives or vendors to attend a meeting or conference. Industry representatives or vendors requesting to support the educational mission of the COM may provide an unrestricted grant, which will be placed in a central fund and monitored/distributed by the COM Industry Academic Relations committee.

**H. Ghostwriting**

COM faculty, residents, staff and students are not permitted to allow their professional presentations, books, articles, reports or other materials, oral or written, to be by written by another party or by an industry representative.

**I. Scholarships/Fellowships**

COM faculty, residents, staff and students may not accept scholarships or fellowships to support training initiatives from industry representatives or vendors. Industry representatives or vendors requesting to support the educational mission of the COM may provide an unrestricted grant, which will be placed in a central fund and monitored/distributed by the COM Industry Academic Relations committee. There shall be no quid pro quo associated with such funding.

**J. Outside Employment/Consulting**

COM faculty, residents and staff may engage in outside employment, consulting, and other similar activities in addition to their COM employment provided such activities do not conflict with the employee’s duties and responsibilities to the COM and to the University of Florida. Such activities also must be permitted under state law and University of Florida policies. For such activity to be approved, the COM faculty, resident and staff must provide evidence that such activities further the educational mission of the COM in exchange for any remuneration.
Outside employment and consulting activities of COM faculty, residents and staff are of concern to the University of Florida and may be disallowed if they result in conflicts with the employee's duties, responsibilities, and obligations to the COM.

K. Purchasing

COM faculty, residents, staff and students engaged in the purchase of equipment, supplies, etc. are subject to the provisions of the University of Florida’s regulation regarding the disclosure of outside activities, financial interests and conflict of interest.

COM department chairs and immediate supervisors are responsible for informing employees that the University of Florida requires that an approved Disclosure of Outside Activities and Financial Interests form be attached to each applicable Requisition to Purchase from an enterprise in which an employee has material financial or managerial interest. If there is a requisition prepared to purchase from an enterprise in which an employee has a material interest, the employee with the interest cannot approve the requisition. If the purchase is allowed under state law, the approval of the employee's supervisor will be required when an outside interest exists regardless of whether the proposed purchases fall under the sole source, emergency, or special purchasing categories.

L. Monitoring

The COM will establish an “Industry Academic Relations” committee to provide oversight and enforcement of the provisions of the COM’s Policy on Industry Conflicts of Interest/Industry Academic Relations.

M. Disclosure and Notification

COM faculty, residents and staff wishing to engage in activities outside the COM have an obligation to disclose and receive approval prior to engaging in these activities and to assure that such activities do not infringe upon an employee’s responsibilities and obligations to the COM and to the University of Florida. Each employee is responsible for complying with the rules and laws concerning outside activities and financial interests.

COM faculty, residents and staff engaging in outside activities must take reasonable precautions to ensure that the outside employer or other recipient of services understands that he or she is engaging in the activities as an individual and not on behalf of the COM or the University of Florida. An employee may not use the University’s resources, including its name or addresses, without express written approval from a COM administrator designated by the University of Florida President to approve such use.

The disclosure of outside activities and financial interests are to be reported on the University of Florida’s form titled Disclosure of Outside Activities and Financial Interests, which is to be reviewed by the department chair or immediate supervisor and forwarded to the dean or director as necessary for authorization. This form should be completed and filed prior to such time as the outside activity or financial interest begins and at the beginning of each contractual year of employment. If a material change in the information presented occurs during the contractual year, a new form must be submitted. All paperwork associated with continuing outside employment/activity must be renewed on a fiscal-year basis.

College of Medicine faculty who present formal lectures to students or residents of the University of Florida must disclose any and all possible conflicts, financial interests or personal relationships with industry at each presentation.

Annual Reporting

Prior to the end of each academic year, COM faculty and staff reporting the disclosure of outside activities and financial interests during the year shall report the total financial compensation received for such activities. Financial compensation shall be reported using three categories of compensation: $0 to $5,000, $5,001 to $10,000, and $10,001 and greater.

COM faculty, residents and staff who have no outside activities or financial interests to report are required to provide an annual attestation to that effect.

N. Penalties and Enforcement

All COM faculty, residents and staff are subject to the constitution and laws of the state of Florida and to the rules, regulations and policies of the University of Florida.
University of Florida Board of Trustees.
COM faculty, residents, staff and students who fail to abide by the provisions of the COM’s Policy on Industry Conflicts of Interest/Industry Academic Relations are subject to appropriate administrative or disciplinary action.

O. Education
COM directors, department chairs and immediate supervisors are responsible for informing and educating employees in their respective work units about the COM and the University of Florida's policy on disclosure of outside activities and financial interests, and for ascertaining that an employee's COM and University of Florida responsibilities are not being abrogated by the activity after it has been disclosed.

COM directors, department chairs and immediate supervisors are responsible for providing new employees with the information regarding outside activities and conflict of interest. COM directors, department chairs and immediate supervisors also are responsible for reviewing the disclosure and notifying the employee whether or not the activity may be conducted. If not, the reasons for not allowing the activity must be provided. If the activity is allowed with conditions, the administrator shall state the conditions under which the activity may be pursued.

Authorization also may be required by Research and Graduate Education if the activity involves waiving any rights to intellectual property.

P. Effective Date and Approval
This policy was approved by the College of Medicine Executive Committee and is effective June 18, 2009.
Approved:
Michael L. Good, M.D.
Interim Dean, College of Medicine
Folke H. Peterson Dean’s Distinguished Professor
PRIMARY CARE / NEUROLOGY PROVIDER AGREEMENT
6/20/11

Purpose: To develop a seamless consultation process in the NF/SG Veterans Health System to ensure appropriate referrals, delivery of safe, effective and timely care to veteran patients, and to improve clinic efficiency.

The objectives of this agreement are:

- Implement a set of principles that define referring-consulting provider relationships and responsibilities of referring-consulting providers.
- Maintain meaningful and timely referrals for the benefit of patients and referring-consulting providers.
- Providers function collaboratively as part of an interdisciplinary team to achieve positive patient outcomes.

Guiding Principles of Referring-Consulting provider Relationships:

- Referring-Consulting providers have an obligation to use health resources appropriately and prudently.
- Referring providers should obtain consultation when they feel a need for assistance in caring for a patient. If a patient requests a referral when the provider does not believe it is indicated, the provider should discuss his/her clinical reasoning with the patient, seek out underlying concerns and anxieties, and create a mutually agreed upon plan of action consistent with the patient’s desires and professional judgment.

Procedures:

- Service contracts will establish consult protocols that delineate appropriate diagnoses, conditions, ongoing management problems and objectives that are indications for specialty referrals. These protocols will also include criteria that would identify inappropriate conditions and diagnosis for referral and criteria for return to primary care.
- A system be developed for non-visit (email and telephone) contact with specialty services outlining when and how as well as “do’s and don’ts” involved.

Joint Responsibilities of Referring and Consulting Providers:

- Establish mutually agreed upon critical pathways and practice guidelines to achieve a health care delivery system that is responsive to reasonable cycle times.
- Explore system failures and institute improvements using root cause analysis.

Evaluating Quality of Care and Referral Decisions:

- Audit 10% of consults from primary care to the specialty care providers and specialty service consult responses. Determine trends, projections, and cause and effect assessment (monthly X 3 and then quarterly).
- Resource conservation and waste reduction analysis should include:
- Number of consults made.
- Timelines- Specialty Clinic Consult requested, appointment and completion of consult.
- Appropriateness of consult.
- Completion of diagnostic workup required for consult.
- Patient and provider (both Primary care and Specialist) satisfaction with consultative process.

- Analysis and problem solving to evaluate outcomes and improve consultative process that will drive future goal setting for performance improvement.