

# ACGME Program Requirements for Graduate Medical Education in Physical Medicine and Rehabilitation

Common Program Requirements are in **BOLD**

Effective: July 1, 2007

## Introduction

**Int.A. 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 members 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 each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.**

**Int.B. Definition and Scope of Physical Medicine and Rehabilitation**

**Int.B.1. Physical medicine and rehabilitation (PM&R), also referred to as physiatry, is a medical specialty concerned with diagnosis, evaluation, and management of persons of all ages with physical and/or cognitive impairments and disability. This specialty involves diagnosis and treatment of patients with painful or functionally limiting conditions, the management of comorbidities and coimpairments, diagnostic and therapeutic injection procedures, electrodiagnostic medicine and emphasis on the prevention of complications of disability from secondary conditions.**

**Int.B.2. Physiatrists are trained in the diagnosis and management of impairments of the neurologic, musculoskeletal (including sports and occupational aspects) and other organ systems and the long-term management of patients with disabling conditions. Physiatrists provide leadership to multidisciplinary teams concerned with maximal restoration or development of physical, psychological, social, occupational and vocational functions in persons whose abilities have been limited by**

disease, trauma, congenital disorders or pain.

Int.C. Duration and Scope of Education

Int.C.1. Physicians seeking specialization in this field must complete four years of graduate medical education, three years of which must be physical medicine and rehabilitation training. Of these three years no more than six months can be elective. No more than one month of this elective time may be taken in a non-ACGME accredited program, unless prior approval is given by the Review Committee.

Int.C.2. One year of the four years' training will develop fundamental clinical skills. This year of training in fundamental clinical skills must consist of an accredited transitional year program or include at least six months in accredited training in family medicine, internal medicine, emergency medicine, obstetrics-gynecology, pediatrics, or surgery, or any combination of these patient care experiences. The remaining months of this year may include any combination of accredited specialties or subspecialties.

Int.C.3. Accredited training in any of the specialties or subspecialties selected must be for a period of at least four weeks. No more than eight weeks may be in non-direct patient care experiences, such as pathology, radiology and research. Training in fundamental clinical skills must be completed within the first two years of the four year training program.

Int.C.4. Training programs may provide either three or four years training.

Int.C.4.a) A training program of three years duration is responsible for the thirty-six months of physical medicine and rehabilitation training and for assuring that residents appointed at the PG-2 level have received satisfactory training in fundamental clinical skills.

Int.C.4.b) A training program of four years duration is responsible for the quality of the integrated educational experience for the entire training program, including twelve months of training in fundamental clinical skills which may not include more than four weeks of physical medicine and rehabilitation.

**I. Institutions**

**I.A. Sponsoring Institution**

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

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

- I.A.1. Physical medicine and rehabilitation must be organized as an identifiable specialty within the sponsoring institution.
- I.A.2. Programs that cosponsor combined training in PM&R and another specialty must so inform the Review Committee. Residents in such training must be informed of the necessary requirements of the specialty boards in question.

**I.B. Participating Sites**

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

**The PLA should:**

- I.B.1.a) **identify the faculty who will assume both educational and supervisory responsibilities for residents;**
- I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
- I.B.1.c) **specify the duration and content of the educational experience; and,**
- I.B.1.d) **state the policies and procedures that will govern resident education during the assignment.**

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

I.B.2.a) Change in participation by any site providing three months or more of training must be reported within 30 days to the Review Committee and be approved by the Review Committee.

I.B.3. Institutions sponsoring or sites participating in residency training in physical medicine and rehabilitation should be appropriately accredited by the Joint Commission on Accreditation of Healthcare Organizations or CARF. If the site is not so accredited, reasons why accreditation was not sought or was denied must be explained, and the inclusion of the site in resident education must be justified.

I.B.4. The sponsoring institution must notify the Review Committee promptly of any major changes in leadership, governance, affiliation or fiscal arrangements that affect the educational program. The Review Committee may schedule a site visit when notified of such changes.

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

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

- II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
- II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.3. Qualifications of the program director must include:**
- II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
  - II.A.3.b) current certification in the specialty by the American Board of Physical Medicine and Rehabilitation, or specialty qualifications that are acceptable to the Review Committee; and,**
  - II.A.3.c) current medical licensure and appropriate medical staff appointment.**
  - II.A.3.d) qualifications as a physiatrist;**
  - II.A.3.e) at least four years of recent, post-residency experience as a clinician, administrator, and educator in PM&R; and,**
  - II.A.3.f) appointment at a major participating site. A major participating site is one in which residents spend a minimum of six months.**
- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
- II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
  - II.A.4.b) approve a local director at each participating site who is accountable for resident education;**
  - II.A.4.c) approve the selection of program faculty as appropriate;**
  - II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
  - II.A.4.e) monitor resident supervision at all participating sites;**

- II.A.4.f)** prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;
- II.A.4.g)** provide each resident with documented semiannual evaluation of performance with feedback;
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
- II.A.4.i)** provide verification of residency education for all residents, including those who leave the program prior to completion;
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
  - II.A.4.j).(1)** distribute these policies and procedures to the residents and faculty;
  - II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
  - II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
  - II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or

**requests for the following:**

- II.A.4.n).(1)** **all applications for ACGME accreditation of new programs;**
- II.A.4.n).(2)** **changes in resident complement;**
- II.A.4.n).(2).(a) This includes a change of two or more resident positions per level from the approved resident complement approved at the last site visit.
- II.A.4.n).(3)** **major changes in program structure or length of training;**
- II.A.4.n).(4)** **progress reports requested by the Review Committee;**
- II.A.4.n).(5)** **responses to all proposed adverse actions;**
- II.A.4.n).(6)** **requests for increases or any change to resident duty hours;**
- II.A.4.n).(7)** **voluntary withdrawals of ACGME-accredited programs;**
- II.A.4.n).(8)** **requests for appeal of an adverse action;**
- II.A.4.n).(9)** **appeal presentations to a Board of Appeal or the ACGME; and,**
- II.A.4.n).(10)** **proposals to ACGME for approval of innovative educational approaches.**
- II.A.4.o)** **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
  - II.A.4.o).(1)** **program citations, and/or**
  - II.A.4.o).(2)** **request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) supply necessary information about residents and the program to the American Board of Physical Medicine and Rehabilitation, since this may impact resident admissibility for board certification;
- II.A.4.q) have the authority and time needed to participate with other institutional program directors in maintaining the quality of all training programs; and,
- II.A.4.r) maintain current understanding of residency training issues and

participate in continuing education activities related to GME, such as at national program director meetings.

II.A.4.r).(1) Upon receipt of notification of any program change, the Review Committee may schedule a site visit of the program.

**II.B. Faculty**

**II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

**The faculty must:**

**II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**

**II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

**II.B.2. The physician faculty must have current certification in the specialty by the American Board of Physical Medicine and Rehabilitation, or possess qualifications acceptable to the Review Committee.**

II.B.2.a) The physician faculty must include those qualified as physiatrists.

**II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**

**II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**

**II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**

**II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**

**II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:**

**II.B.5.b).(1) peer-reviewed funding;**

**II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**

**II.B.5.b).(3) publication or presentation of case reports or clinical**

**series at local, regional, or national professional and scientific society meetings; or,**

**II.B.5.b).(4)**

**participation in national committees or educational organizations.**

**II.B.5.c)**

**Faculty should encourage and support residents in scholarly activities.**

II.B.6.

The faculty must participate regularly and systematically in the training program, both clinical and didactic, must be readily available for consultations to the resident, and be available during clinical crises. Part-time faculty should have specific, regular teaching responsibilities.

**II.C.**

### **Other Program Personnel**

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

II.C.1.

Professional staff, appropriately credentialed, in the disciplines of occupational therapy, orthotics and prosthetics, physical therapy, psychology, rehabilitation nursing, social service, speech-language pathology, therapeutic recreation, and vocational counseling, should be integrated into both the didactic and clinical experience of the resident whenever relevant.

II.C.2.

The educational program must have mentors, role-model clinicians, and an environment that demonstrates the values of professionalism, such as placing the needs of the patient first, maintaining a commitment to scholarship, helping colleagues meet their responsibilities, maintaining a commitment to continued improvement, and being responsive to society's healthcare needs.

**II.D.**

### **Resources**

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

II.D.1.

Beds assigned to the physical medicine and rehabilitation service must be grouped in one or more geographic area(s). Averaged over time, there should be a minimum census of eight physical medicine and rehabilitation inpatients available for each full-time equivalent resident assigned to an acute or subacute inpatient rehabilitation service. Other concurrent experiences such as outpatient clinics or inpatient consults would proportionally reduce this full-time equivalency and require additional time on inpatient services.

II.D.2.

Adequate office space should be available for the faculty and residents so that they may participate in clinical examination of ambulatory patients.

There must be facilities for team conferences and specialty care clinics and adequate space for resident self-study.

- II.D.3. There must be adequate equipment and space available to carry out a comprehensive training program in physical medicine and rehabilitation. Equipment must be available for all age groups, and must include modified equipment for the pediatric and geriatric patient. This must include exercise equipment, ambulatory aids, wheelchairs, and special devices for the disabled driver, electrodiagnostic equipment, urodynamic laboratory instruments, and simple splinting apparatuses. The occupational therapy area must be adequately equipped to give the residents experience in activities of daily living, and the evaluation of and training in devices to improve skills in activities of daily living. Psychometric, vocational and social evaluation and test instruments must be adequate to expose the resident to the broad spectrum of their prescription and their use and interpretation in the common practice of rehabilitation medicine.
- II.D.4. Basic teaching aids such as computers, projection equipment, and videotape facilities are essential. Reasonable access to these items on nights and weekends for residents and staff must be available. Adequate space must be available for seminars, lectures, and other teaching experiences.
- II.D.5. Facilities must be accessible to persons with disabilities.

## **II.E. Medical Information Access**

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

## **III. Resident Appointments**

### **III.A. Eligibility Criteria**

**The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.**

- III.A.1. Residents in such training must be informed of the necessary requirements of the specialty boards in question.

### **III.B. Number of Residents**

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

- III.B.1. To ensure the stimulating educational atmosphere that a peer group provides, the training program should have residents enrolled at all times.

All training programs should have at least two residents per year in each year of training, with an approximately equal distribution of these residents. In addition, each training program should provide educational experiences which bring together all of the residents of the training program at frequent and regular intervals.

- III.B.2. The program must demonstrate its ability to retain qualified residents by consistently graduating at least 80% of residents accepted into the program.
- III.B.3. The program director will establish the maximum number of resident positions that can be supported by the educational resources for the program, subject to the approval of the Review Committee. The program director must promptly report any change in the number of resident positions offered through ADS.

### **III.C. Resident Transfers**

- III.C.1. **Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.**
- III.C.2. **A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.**

### **III.D. Appointment of Fellows and Other Learners**

**The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.**

- III.D.1. Physical medicine and rehabilitation residents must have interaction with residents and faculty from other specialties and/or medical students in order to provide opportunities for peer interaction and teaching.

## **IV. Educational Program**

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

- IV.A.1. **Overall educational goals for the program, which the program must distribute to residents and faculty annually;**
- IV.A.2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form.**

**These should be reviewed by the resident at the start of each rotation;**

**IV.A.3. Regularly scheduled didactic sessions;**

**IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**

**IV.A.5. ACGME Competencies**

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

**IV.A.5.a) Patient Care**

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

IV.A.5.a).(1) must have a sufficient variety, depth, and number of clinical experiences. However, clinical activities must not compromise the educational requirements of the training program;

IV.A.5.a).(2) must have at least 12 months' direct and complete responsibility for inpatient management on the physical medicine and rehabilitation service;

IV.A.5.a).(3) must spend at least 12 months of their training in the care of outpatients. This outpatient experience must include significant experience in the care of patients with musculoskeletal disorders, and it excludes time spent in EMG training;

IV.A.5.a).(4) must, with each year of training, have increasing responsibility in patient care, leadership, teaching and administration. Clinical experiences should allow for progressive responsibility with lesser degrees of supervision as the resident advances and demonstrates additional competencies. The program director must establish written guidelines for supervision of more junior residents by more senior residents when this occurs and of all residents by attending physicians with attention to the acuity, complexity and severity of patient illness. Supervision must include faculty review of a clearly written patient history and physical examination and a meaningful continuous record of the patient's illness, background, management strategies, as well as lucid presentations of the case summary;

- IV.A.5.a).(5) must develop the attitudes and psychomotor skills required to:
- IV.A.5.a).(5).(a) modify history-taking technique to include data critical to the recognition of functional abilities, and physical and psychosocial impairments which may cause functional disabilities;
- IV.A.5.a).(5).(b) perform the general and specific physiatric examinations, including electromyography, nerve conduction studies, and other procedures common to the practice of physical medicine and rehabilitation;
- IV.A.5.a).(5).(c) make sound clinical judgments;
- IV.A.5.a).(5).(d) design and monitor rehabilitation treatment programs to minimize and prevent impairment and maximize functional abilities; and,
- IV.A.5.a).(5).(e) prevent injury, illness and disability .
- IV.A.5.a).(6) must attain competence in the following areas:
- IV.A.5.a).(6).(a) history and physical examination pertinent to physical medicine and rehabilitation;
- IV.A.5.a).(6).(b) assessment of neurological, musculoskeletal and cardiovascular-pulmonary systems;
- IV.A.5.a).(6).(c) assessment of disability and impairment and familiarity with the ratings of disability and impairment;
- IV.A.5.a).(6).(d) data gathering and interpreting of psychosocial and vocational factors;
- IV.A.5.a).(6).(e) performance of electrodiagnostic studies. In general, involvement in approximately 200 electrodiagnostic consultations per resident, under appropriate supervision, represents an adequate number;
- IV.A.5.a).(6).(f) therapeutic and diagnostic injection techniques;
- IV.A.5.a).(6).(g) prescriptions for orthotics, prosthetics, wheelchairs and ambulatory devices, special beds and other assistive devices;
- IV.A.5.a).(6).(h) written prescriptions with specific details appropriate to the patient for therapeutic modalities, therapeutic exercises and testing performed by physical

- therapists, occupational therapists, speech/language pathologists. It is necessary to provide for an understanding and coordination of psychologic and vocational interventions and tests;
- IV.A.5.a).(6).(i) familiarity with the safety, maintenance, as well as the actual use, of medical equipment common to the various therapy areas and laboratories;
- IV.A.5.a).(6).(j) pediatric rehabilitation; and,
- IV.A.5.a).(6).(k) geriatric rehabilitation.
- IV.A.5.a).(7) must have progressive responsibility in diagnosing, assessing, and managing the conditions commonly encountered by the physiatrist in the rehabilitative management of patients of all ages in the following areas:
- IV.A.5.a).(7).(a) acute and chronic musculoskeletal syndromes, including sports and occupational injuries;
- IV.A.5.a).(7).(b) acute and chronic pain management;
- IV.A.5.a).(7).(c) congenital or acquired myopathies, peripheral neuropathies, motor neuron and motor system diseases and other neuromuscular diseases;
- IV.A.5.a).(7).(d) hereditary, developmental and acquired central nervous system disorders, including cerebral palsy, stroke, myelomeningocele, and multiple sclerosis;
- IV.A.5.a).(7).(e) rehabilitative care of traumatic brain injury;
- IV.A.5.a).(7).(f) rehabilitative care of spinal cord trauma and diseases, including management of bladder and bowel dysfunction and pressure ulcer prevention and treatment;
- IV.A.5.a).(7).(g) rehabilitative care of amputations for both congenital and acquired conditions;
- IV.A.5.a).(7).(h) sexual dysfunction common to the physically impaired;
- IV.A.5.a).(7).(i) postfracture care and rehabilitation of postoperative joint arthroplasty;
- IV.A.5.a).(7).(j) experience in evaluation and application of cardiac and pulmonary rehabilitation as related to physiatric responsibilities;

- IV.A.5.a).(7).(k) pulmonary, cardiac, oncologic, infectious, immunosuppressive and other common medical conditions seen in patients with physical disabilities;
- IV.A.5.a).(7).(l) diseases, impairments and functional limitations seen in the geriatric population;
- IV.A.5.a).(7).(m) rheumatologic disorders treated by the physiatrist;
- IV.A.5.a).(7).(n) medical conditioning, reconditioning and fitness; and,
- IV.A.5.a).(7).(o) tissue disorders such as burns, ulcers and wound care.

**IV.A.5.b) Medical Knowledge**

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

- IV.A.5.b).(1) must have didactic instruction that is well organized, thoughtfully integrated, based on sound educational principles, and carried out and attended on a regularly scheduled basis. It must expose residents to topics appropriate to their level of training. Systematically organized didactic instruction includes a series of lectures by faculty, seminars, assigned reading, journal clubs, and clinical case conferences. Active participation by the faculty in the didactic program is required;
- IV.A.5.b).(2) must have teaching rounds with faculty at least five times per week. These rounds must include patient contact with those hospitalized in inpatient rehabilitation facilities (IRFs);
- IV.A.5.b).(3) must gain knowledge about the diagnosis, pathogenesis, treatment, prevention, and rehabilitation of those neuromusculoskeletal, neurobehavioral, cardiovascular, pulmonary, and other system disorders common to this specialty in patients of both sexes and all ages.
- IV.A.5.b).(4) must have education in the principles of bioethics as applied to medical care, and the residents must participate in decision-making involving ethical issues that arise in the diagnosis and management of their patients;
- IV.A.5.b).(5) must have adequate and systematic instruction in basic sciences relevant to physical medicine and rehabilitation such as anatomy, physiology, pathology and

pathophysiology of the neuromusculoskeletal, cardiovascular and pulmonary systems, kinesiology and biomechanics, functional anatomy, electrodiagnostic medicine, fundamental research design and methodologies, and instrumentation related to the field. This instrumentation should pertain to physiologic responses to the various physical modalities and therapeutic exercises, and the procedures commonly employed by physiatry. This instruction should be correlated with clinical training but should, when appropriate, include basic science faculty. There must be an accessible anatomy laboratory for dissection or an equivalently structured program in anatomy;

- IV.A.5.b).(6) must review pertinent laboratory and imaging materials for the patient. Opportunity to observe directly and participate in the various therapies in the treatment areas must occur regularly throughout the residency program, including the proper use and function of equipment and tests;
- IV.A.5.b).(7) must observe and gain fundamental understanding of orthotics and prosthetics, including fitting and manufacturing, through instruction and arrangements made with appropriate orthotic-prosthetic facilities; and,
- IV.A.5.b).(8) must learn the principles of pharmacology as they relate to the indications for and complications of drugs utilized in physical medicine and rehabilitation.

#### **IV.A.5.c)**

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

**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:**

- IV.A.5.c).(1) **identify strengths, deficiencies, and limits in one's knowledge and expertise;**
- IV.A.5.c).(2) **set learning and improvement goals;**
- IV.A.5.c).(3) **identify and perform appropriate learning activities;**
- IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;**

**IV.A.5.c).(6)** locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

**IV.A.5.c).(7)** use information technology to optimize learning; and,

**IV.A.5.c).(8)** participate in the education of patients, families, students, residents and other health professionals.

**IV.A.5.c).(8).(a)** The training program must stress the importance of self-evaluation, continuing medical education, and continued professional development after graduation.

**IV.A.5.d) Interpersonal and Communication Skills**

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

**IV.A.5.d).(1)** communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

**IV.A.5.d).(2)** communicate effectively with physicians, other health professionals, and health related agencies;

**IV.A.5.d).(3)** work effectively as a member or leader of a health care team or other professional group;

**IV.A.5.d).(4)** act in a consultative role to other physicians and health professionals; and,

**IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical records, if applicable.

**IV.A.5.d).(6)** develop the necessary written and verbal communication skills essential to the efficient practice of physiatry;

**IV.A.5.d).(7)** have training in counseling of patients and family members, including end of life care; and,

**IV.A.5.d).(8)** have instruction in medical administration and teaching methodology.

**IV.A.5.e) Professionalism**

**Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical**



- IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**
- IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;**
- IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.**
- IV.A.5.f).(7) receive formal instruction regarding the principles, objectives and process of performance improvement and program evaluation, risk management and cost effectiveness in medicine;
- IV.A.5.f).(8) coordinate effectively and efficiently an interdisciplinary team of allied rehabilitation professionals for the maximum benefit of the patient through:
- IV.A.5.f).(8).(a) an understanding of each allied health professional's role;
- IV.A.5.f).(8).(b) the ability to write adequately detailed prescriptions based on functional goals for psychiatric management; and,
- IV.A.5.f).(8).(c) the development of management and leadership skills.
- IV.A.5.f).(9) observe and gain fundamental understanding of the types of patients served, referral patterns and services available in the continuum of rehabilitation care in community rehabilitation facilities. These might include subacute units and skilled nursing facilities, sheltered workshops and other vocational facilities, schools for persons with multiple handicaps, including deafness and blindness, independent living facilities for individuals with severe physical impairments, day hospitals, and home health care services, and community based rehabilitation. Introduction to these options for care may be made by on-site visits to some of these facilities as well as didactic lectures. Residents should be encouraged to interact with health care consumer groups and organizations in supervised working environments; and,
- IV.A.5.f).(10) have experience in the continuing care of patients with long-term disabilities through appropriate follow-up care.

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

**IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**

**IV.B.2. Residents should participate in scholarly activity.**

IV.B.2.a) The curiosity and creativity of all residents must be stimulated. They must be involved in the critical appraisal of current literature.

IV.B.2.b) Residents should have the opportunity to participate in structured, supervised research training. Residents should be encouraged to produce a peer reviewed publication or engage in an in-depth scholarly activity during the residency program. A program director may elect to offer a special research or academic track for selected residents. This may take the form of an elective or research rotation, not to exceed six months, within the 36 months of physical medicine and rehabilitation residency training.

**IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

## **V. Evaluation**

### **V.A. Resident Evaluation**

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

**V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**

**V.A.1.b) The program must:**

**V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

**V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**

**V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,**

**V.A.1.b).(4) provide each resident with documented semiannual**

**evaluation of performance with feedback.**

- V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**
- V.A.1.d) There must be a formal system for evaluation of the clinical competence of residents, together with annual in-service examinations, post-rotation evaluations, or external examinations, such as those provided by the American Academy of Physical Medicine and Rehabilitation.
- V.A.1.e) In the evaluation process, the resident's rights must be protected by due process procedures. The resident must be provided with the written institutional policy concerning his/her rights and the institution's obligations and rights.
- V.A.1.f) Adequate permanent records of the evaluation and educational counseling process within the training program for each resident must be maintained. Such records must be available in the resident file and must be accessible to the resident and other authorized personnel.

**V.A.2. Summative Evaluation**

**The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:**

- V.A.2.a) document the resident's performance during the final period of education, and**
- V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**
- V.A.2.c) be discussed with the resident, and
- V.A.2.d) the program must accept responsibility for completion of the resident's training and fulfillment of educational goals and objectives leading to admissibility for board certification.

**V.B. Faculty Evaluation**

- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.**
- V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

**V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.**

V.B.4. Where indicated, substantive efforts should be made to correct faculty weaknesses.

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

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

**V.C.1.a) resident performance;**

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

**V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,**

**V.C.1.d) program quality. Specifically:**

**V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**

**V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**

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

V.C.3. A program will be judged deficient by the Review Committee if during the most recent five-year period less than 75% of its graduates taking the examination pass either part of the Board examination on the first try. At least 75% of graduates should take the examination.

**VI. Resident Duty Hours in the Learning and Working Environment**

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

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

**VI.A.2. The program must be committed to and responsible for promoting**

**patient safety and resident well-being in a supportive educational environment.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**VI.B. Transitions of Care**

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

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

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

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

**VI.C. Alertness Management/Fatigue Mitigation**

**VI.C.1. The program must:**

**VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**

**VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**

**VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**

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

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

**VI.D. Supervision of Residents**

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

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

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

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

**Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other 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 may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.**

**VI.D.3. Levels of Supervision**

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

**VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.**

**VI.D.3.b) Indirect Supervision:**

**VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**

**VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**

**VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**

**VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**

**VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**

**VI.D.4.b) Faculty members functioning as supervising physicians**

should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

**VI.D.4.c)** Senior residents or fellows should 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.

**VI.D.5.** Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

**VI.D.5.a)** Each 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.

**VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

**VI.D.6.** Faculty supervision assignments should be 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.

**VI.E. Clinical Responsibilities**

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

**VI.F. Teamwork**

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

**VI.G. Resident Duty Hours**

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

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

**VI.G.1.a) Duty Hour Exceptions**

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

**sound educational rationale.**

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

- VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
- VI.G.1.a).(2)** Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.
- VI.G.2. Moonlighting**
- VI.G.2.a)** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- VI.G.2.b)** Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
- VI.G.2.c)** PGY-1 residents are not permitted to moonlight.
- VI.G.3. 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.
- VI.G.4. Maximum Duty Period Length**
- VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- VI.G.4.b)** Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
- VI.G.4.b).(1)** It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

**VI.G.4.b).(2)** Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

**VI.G.4.b).(3)** 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.

**VI.G.4.b).(3).(a)** Under those circumstances, the resident must:

**VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

**VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

**VI.G.4.b).(3).(b)** The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

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

**VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

**VI.G.5.b)** Intermediate-level 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.

PGY-2 and PGY-3 residents are considered to be at the intermediate level.

**VI.G.5.c)** Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

PGY-4 residents are considered to be in the final years of education.

**VI.G.5.c).(1)** This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-

**off-in-seven standards. While it is desirable that 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.**

**VI.G.5.c).(1).(a)**

**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 monitored by the program director.**

**VI.G.5.c).(1).(b)**

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

**VI.G.6.**

**Maximum Frequency of In-House Night Float**

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

**VI.G.6.a)**

Night float cannot exceed more than 18 nights total per year.

**VI.G.7.**

**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).**

**VI.G.8.**

**At-Home Call**

**VI.G.8.a)**

**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.**

**VI.G.8.a).(1)**

**At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.**

**VI.G.8.b)**

**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”.**

## **VII. Innovative Projects**

**Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

\*\*\*

ACGME Approved: September 2005 Effective: July 2006  
Revised Common Program Requirements Effective: July 1, 2007  
Revised Common Program Requirements Effective: July 1, 2011