

# ACGME Program Requirements for Graduate Medical Education in Sports Medicine

*Common Program Requirements are in BOLD*

*Effective: July 1, 2000*

## I. Scope and Duration of Training

- I.A. An educational program in sports medicine must be organized to provide a well-supervised experience at a level sufficient for the resident to acquire the competence of a physician with added qualifications in this field. It shall be 12 months in duration.
- I.B. The practice of sports medicine is the application of the physician's knowledge, skills, and attitudes to those engaged in sports and exercise. Thus, the program must provide training in the development of the clinical competencies needed to diagnose and manage medical illnesses and injuries related to sports and exercise, for example, first-degree sprains, strains, and contusions, including appropriate referrals of, for example, fractures, dislocations, and third-degree sprains. Clinical experience must include injury prevention, preparticipation evaluation, management of acute and chronic illness or injury, and rehabilitation, as applied to a broad spectrum of undifferentiated patients. There must be experience functioning as a team physician and in the promotion of physical fitness and wellness.
- I.C. The program should emphasize physiology and biomechanics; principles of nutrition; pathology and pathophysiology of illness and injury; pharmacology; effects of therapeutic, performance-enhancing, and mood-altering drugs; psychological aspects of exercise, performance, and competition; ethical principles; and medical-legal aspects of exercise and sports.

## II. Institutions

### II.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 institutions.**

### II.B. Participating Institutions

- II.B.1. **Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**
- II.B.2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of**

agreement should:

- II.B.2.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
- II.B.2.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
- II.B.2.c) specify the duration and content of the educational experience; and
- II.B.2.d) state the policies and procedures that will govern resident education during the assignment.

### III. Program Personnel and Resources

#### III.A. Program Director

- III.A.1. There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).
- III.A.2. The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.
- III.A.3. Qualifications of the program director are as follows:
  - III.A.3.a) The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.
  - III.A.3.b) The Program Director must be certified in the specialty by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or Physical Medicine and Rehabilitation, or possess qualifications judged to be acceptable by the RRC.
    - III.A.3.b).(1) Directors must possess a CAQ in Sports Medicine. The RRC will determine the adequacy of alternate qualifications.
  - III.A.3.c) The program director must be appointed in good standing

and based at the primary teaching site.

**III.A.4. Responsibilities of the program director are as follows:**

**III.A.4.a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**

**III.A.4.b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**

**III.A.4.c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**

**III.A.4.d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:**

**III.A.4.d).(1) the addition or deletion of a participating institution;**

**III.A.4.d).(2) a change in the format of the educational program;**

**III.A.4.d).(3) a change in the approved resident complement for those specialties that approve resident complement.**

**III.A.4.d).(4) On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**

**III.B. Faculty**

**III.B.1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.**

**III.B.2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.**

- III.B.3. Qualifications of the physician faculty are as follows:**
- III.B.3.a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
- III.B.3.b) The physician faculty must be certified in the specialty by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or Physical Medicine and Rehabilitation, or possess qualifications judged to be acceptable by the RRC.**
- III.B.3.c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
- III.B.4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:**
- III.B.4.a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**
- III.B.4.b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**
- III.B.4.c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**
- Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.**
- III.B.5. Qualifications of the nonphysician faculty are as follows:**
- III.B.5.a) Nonphysician faculty must be appropriately qualified in their field.**
- III.B.5.b) Nonphysician faculty must possess appropriate institutional appointments.**
- III.B.6. Teaching Staff**

III.B.6.a) In addition to the program director, each program must have at least one other faculty member with similar qualifications who devotes a substantial portion of professional time to the training program.

III.B.6.b) The teaching staff must include orthopedic surgeons who are engaged in the operative management of sports injuries and other conditions and who are readily available to teach and provide consultation to the residents. Teaching staff from the disciplines of nutrition, pharmacology, pathology, exercise physiology, physical therapy, behavioral science, and clinical imaging also should be available to assist in the educational program. Coaches and athletic trainers also should be included.

### **III.C. Other Program Personnel**

**Additional necessary professional, technical, and clerical personnel must be provided to support the program.**

### **III.D. Resources**

**The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**

The program must include the following:

#### **III.D.1. Patient Population**

A patient population that is unlimited by age or gender and is adequate in number and variety to meet the needs of the training program must be available. The program director must ensure that residents are accorded meaningful patient responsibility with the supervision of a faculty member at all facilities and sites.

#### **III.D.2. Sports Medicine Clinic**

III.D.2.a) There must be an identifiable clinic that offers continuing care to patients who seek consultation regarding sports- or exercise-related health problems. The nonsurgical trainees must be supervised by a physician who has qualifications in sports medicine and is certified by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics or Physical Medicine and rehabilitation who possesses suitable equivalent qualifications.

III.D.2.b) Adequate, up-to-date diagnostic imaging and rehabilitation services must be readily available and accessible to clinic patients. Consultation in medical and surgical subspecialties, physical therapy, nursing, nutrition, and pharmacy must be available. The opportunity to render continuing care and to

organize recommendations from other specialties and disciplines is mandatory and will require that medical records include information pertinent to the assessment and management of patients with health problems related to sports and exercise.

III.D.3. Sporting Events/Team Sports/Mass-Participation Events

The program must have access to sporting events, team sports, and mass-participation events during which the resident can have meaningful patient responsibility.

III.D.4. Acute-Care Facility

There must be an acute-care hospital with a full range of services associated with and in proximity to the sponsoring residency. This facility must be readily accessible to patients served by the program.

**IV. Resident Appointments**

**IV.A. Eligibility Criteria**

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

IV.A.1. Residents appointed to the sports medicine programs should have completed an ACGME-accredited residency in emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation.

**IV.B. Number of Residents**

**The RRC may approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.**

**IV.C. Resident Transfers**

**To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.**

**IV.D. Appointment of Fellows and Other Students**

**The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to**

regularly appointed residents.

**V. Program Curriculum**

**V.A. Program Design**

**V.A.1. Format**

**The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.**

**V.A.2. Goals and Objectives**

**The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.**

**V.B. Specialty Curriculum**

**The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.**

V.B.1. The curriculum must provide the educational experiences necessary for the residents to achieve the cognitive knowledge, psychomotor skills, interpersonal skills, professional attitudes, and practical experience required of physicians in the care of patients with health problems related to sports and exercise.

V.B.2. Didactic as well as clinical learning opportunities must be provided as part of the required curriculum for all residents. Conferences or seminars/workshops in sports medicine should be specifically designed for the residents to augment the clinical experiences. All educational activities must be adequately supervised, while allowing the resident to assume progressive responsibility for patient care. The clinical activities in sports medicine should represent a minimum of 50% of the time in the program. The remainder of the time should be spent in didactic, teaching, and/or research activities and in the primary care, emergency medicine, physical medicine and rehabilitation, or ambulatory facility.

V.B.3. Residents must spend 1/2 day per week maintaining their skills in their primary specialty.

V.B.4. Participation in the following must be required of all residents:

V.B.4.a) Preparticipation Evaluation of the Athlete

The program must ensure that all sports medicine residents are

involved in the development and conduct of preparticipation examination programs.

V.B.4.b)

Acute Care

The resident must have appropriate authority and responsibility to participate meaningfully in the medical care that is provided to acute-care patients (see Scope and Duration of Training, above). In addition, the program should arrange for residents to observe - representative in patient and outpatient operative orthopedic procedures.

V.B.4.c)

Sports Medicine Clinic Experience

V.B.4.c).(1)

The resident must attend patients in a continuing, comprehensive manner, providing consultation for health problems related to sports and exercise. The resident shall spend at least 1 day per week for 10 months of the training period in this activity.

V.B.4.c).(2)

If patients are hospitalized, the resident should follow them during their inpatient stay and resume outpatient care following the hospitalization. Consultation with other physicians and professionals in other disciplines should be encouraged.

V.B.4.d)

On-Site Sports Care

The resident should participate in planning and implementation of all aspects of medical care at various sporting events. The program must ensure that supervised sports medicine residents provide on-site care and management to participants in these events. In addition, the resident must participate in the provision of comprehensive and continuing care to a sports team. Preferably, the experience should include several teams that engage in seasonal sports.

V.B.4.e)

Mass-Participation Sports Events

The resident should participate in the planning and implementation of the provision of medical coverage for at least one mass-participation event. The program must ensure that its residents have experience that includes providing medical consultation, direct patient care, event planning, protection of participants, coordination with local EMS systems, and other medical aspects of those events.

VI. Specific Knowledge and Skills

VI.A. Clinical

The program must provide educational experiences that enable residents to develop clinical competence in the overall field of sports medicine.

The curriculum must include but not be limited to the following content and skill areas:

- VI.A.1. Anatomy, physiology, and biomechanics of exercise
- VI.A.2. Basic nutritional principles and their application to exercise
- VI.A.3. Psychological aspects of exercise, performance, and competition
- VI.A.4. Guidelines for evaluation prior to participation in exercise and sport
- VI.A.5. Physical conditioning requirements for various activities
- VI.A.6. Special considerations related to age, gender, and disability
- VI.A.7. Pathology and pathophysiology of illness and injury as they relate to exercise
- VI.A.8. Effects of disease, e.g., diabetes, cardiac conditions, arthritis, on exercise and the use of exercise in the care of medical problems
- VI.A.9. Prevention, evaluation, management, and rehabilitation of injuries
- VI.A.10. Understanding pharmacology and effects of therapeutic, performance-enhancing, and mood-altering drugs
- VI.A.11. Promotion of physical fitness and healthy lifestyles
- VI.A.12. Functioning as a team physician
- VI.A.13. Ethical principles as applied to exercise and sports
- VI.A.14. Medical-legal aspects of exercise and sports
- VI.A.15. Environmental effects on exercise
- VI.A.16. Growth and development related to exercise
- VI.B. Patient Education/Teaching

The program must provide the experiences necessary for the residents to develop and demonstrate competence in patient education regarding sports and exercise. They must have experience teaching others, e.g., nurses, allied health personnel, medical students, residents, coaches, athletes, other professionals, and members of patients' families. There must also be relevant experience working in a community sports medicine network involving parents, coaches, certified athletic trainers, allied medical personnel, residents, and physicians.

**VI.C. Residents Scholarly Activities**

**VI.D. Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.**

**VI.E. ACGME Competencies**

**VI.F. The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:**

**VI.F.1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;**

**VI.F.2. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;**

**VI.F.3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;**

**VI.F.4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;**

**VI.F.5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;**

**VI.F.6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.**

**VII. Resident Duty Hours and the Working Environment**

**Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

**VII.A. Supervision of Residents**

**VII.A.1.** All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

**VII.A.2.** Faculty schedules must be structured to provide residents with continuous supervision and consultation.

**VII.A.3.** Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

**VII.B. Duty Hours**

**VII.B.1.** Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

**VII.B.2.** Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

**VII.B.3.** Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

**VII.B.4.** Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

**VII.C. On-call Activities**

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

**VII.C.1.** In-house call must occur no more frequently than every third night, averaged over a 4-week period.

**VII.C.2.** Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

**VII.C.3. No new patients may be accepted after 24 hours of continuous duty.**

**VII.C.4. *At-home call (or pager call)* is defined as a call taken from outside the assigned institution.**

**VII.C.4.a) The frequency of at-home call is not subject to the every-third- night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.**

**VII.C.4.b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

**VII.C.4.c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.**

**VII.D. Moonlighting**

**VII.D.1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

**VII.D.2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**

**VII.D.3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.**

**VII.E. Oversight**

**VII.E.1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.**

**VII.E.2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.**

## **VII.F. Duty Hours Exceptions**

**An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.**

## **VIII. Evaluation**

### **VIII.A. Resident**

#### **VIII.A.1. Formative Evaluation**

**The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.**

**VIII.A.1.a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**

**VIII.A.1.b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.**

**VIII.A.1.c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.**

#### **VIII.A.2. Final Evaluation**

**The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.**

### **VIII.B. Faculty**

**The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and**

**scholarly activities. This evaluation must include annual written confidential evaluations by residents.**

**VIII.C. Program**

**The educational effectiveness of a program must be evaluated at least annually in a systematic manner.**

**VIII.C.1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**

**VIII.C.2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.**

**IX. Experimentation and Innovation**

**Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

**X. Certification**

**Residents who plan to seek certification by the American Board of Emergency Medicine, the Family Practice, the Internal Medicine, the Pediatrics, or the Physical Medicine and Rehabilitation should communicate with the office of the board regarding the full requirements for certification.**

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