

ACGME Program Requirements for Graduate Medical Education in Pain Medicine

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

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

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

Int.B. Definition and Scope of the Subspecialty

Pain medicine is the discipline of medicine that specializes in the management of patients suffering from acute or chronic pain, or pain in patients requiring palliative care. The management of acute and chronic pain syndromes is a complex matter involving many areas of interest and different medical disciplines. Clinical and investigative efforts are vital to the progress of the specialty. Physicians training in pain medicine may originate from different disciplines and approach the field with varying backgrounds and experience. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation, and coordination of a multiple modality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team. Therefore, the didactic and clinical curriculum of the pain program must address attainment of these competencies.

Int.C. Duration of the Fellowship

Subspecialty training in pain medicine shall consist of 12 months of full-time training, beginning after satisfactory completion of a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). If a program elects to extend the training beyond 12 months, a clear educational rationale must be developed for the additional experience offered.

I. Institutions

I.A. Sponsoring Institution

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

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

I.B. Participating Sites

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

The PLA should:

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

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

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

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

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

I.B.3. Only multidisciplinary programs will be accredited. A program in pain medicine will be accredited only if it is conducted in an institution that also sponsors residencies accredited by the ACGME in at least two of the following specialties: anesthesiology, neurology, physical medicine and rehabilitation, and psychiatry.

- I.B.4. There must be an institutional policy governing the educational resources committed to pain medicine that ensures cooperation of all the involved disciplines. There may be only one ACGME-accredited pain medicine program within a sponsoring institution, and a single multidisciplinary fellowship committee to regularly review the program's resources and its attainment of its stated goals and objectives.

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 a primary medical specialty board 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) subspecialty certification in Pain Medicine with both certificates recognized by the American Board of Medical Specialties, or must document qualifications acceptable to the sponsoring Review Committee.**
- II.A.4. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:**
- II.A.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 fellow 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 fellow 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 fellow updates to the ADS, and ensure that the information submitted is accurate and complete;**
- II.A.4.g) provide each fellow 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 fellows, 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 fellow 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 fellows and faculty;**
 - II.A.4.j).(2) monitor fellow 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 fellows, disciplinary action, and supervision of fellows;**
- 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 fellow complement;**
 - 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 fellow 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) together with the teaching staff, prepare and comply with written goals for the program. All educational components of the program should be related to the program goals. The program design must be approved by the Review Committee as part of the regular review process. A written statement of the educational objectives must be given to each fellow; and,**
- II.A.4.q) ensure that pain medicine conferences be held regularly. These**

should include morbidity and mortality conferences, journal reviews, and research seminars. Active participation in the planning and presentation of these conferences by the pain medicine fellow and faculty is essential.

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 fellows 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 fellows, and

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

II.B.2. The physician faculty must have current certification by a primary medical specialty board, or possess qualifications acceptable to the Review Committee.

II.B.2.a) Faculty must also possess subspecialty certification in Pain Medicine, with both certificates recognized by the American Board of Medical Specialties, and the faculty as a whole must possess expertise across the domains of acute and chronic pain, and pain in patients who require palliative care. At least three faculty members with expertise in pain medicine must be involved in pain medicine subspecialty training, and these must equal at least two full time equivalents. These numbers include the program director.

II.B.2.b) A ratio of at least one full-time-equivalent faculty (salaried or non salaried) to two fellows must be maintained. Qualified physicians with specialty expertise from three of the four cooperating disciplines involved in pain medicine must have a continuous and meaningful role in the fellowship.

II.B.2.c) Faculty from the four disciplines (anesthesiology, neurology, physiatry, and psychiatry) must be from training programs accredited by the ACGME. They must be members of the Pain Medicine Fellowship Program faculty, or have qualifications acceptable to the Review Committee.

II.B.2.d) For neurology faculty, image/study identification training shall be verified by a faculty member from an ACGME-accredited residency program in neurology, neurological surgery, or radiology, or by a faculty member with qualifications acceptable to the Review Committee.

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 fellows in scholarly activities.

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.D. Resources

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

II.D.1. Space and Equipment

A pain center offering subspecialty education must be located within a hospital/medical office complex, and must be designed specifically for the management of pain patients. Space for research and teaching conferences in pain medicine must be available. Appropriate monitoring and life support equipment must be immediately available wherever

invasive pain management procedures are performed. There must be appropriate on-call facilities for male and female fellows and faculty.

II.D.2. Support Services

The following functions and support must be available:

- II.D.2.a) appropriate radiologic imaging facilities;
- II.D.2.b) psychiatric/psychological services, including behavioral modification;
- II.D.2.c) physical and/or occupational therapy;
- II.D.2.d) social services; and,
- II.D.2.e) appropriate electrodiagnostic facilities.

II.D.3. Patient Population (Clinical Resources)

There should be, within the patient population, a wide variety of clinical pain problems. Such exposure is necessary for the development of broad clinical skills and knowledge required for a specialist in pain medicine. The program must be able to provide each fellow with the following clinical experiences:

- II.D.3.a) continuity of care (longitudinal outpatient experience), including the managing chronic and cancer pain;
- II.D.3.b) inpatient experience, including managing chronic and cancer pain;
- II.D.3.c) experience managing acute pain;
- II.D.3.d) exposure to interventional pain procedures; and,
- II.D.3.e) a palliative care experience (longitudinal involvement with patients with pain who require palliative care).

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Criteria

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

III.B. Number of Fellows

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

III.C. Fellow Transfers

III.C.1. Before accepting a fellow 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 fellow.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for fellows 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, fellows from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

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 fellows and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty annually, in either written or electronic form. These should be reviewed by the fellow at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows 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

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

IV.A.5.a).(1)

will enter the fellowship in pain medicine with a range of different experiences. The pain medicine program must demonstrate separate, identifiable clinical experiences that provide the elements from medical disciplines essential to the practice of pain medicine. The clinical experience within the four disciplines outlined below may take the form of discrete clinical rotations, or may occur concurrently with the core clinical curriculum. This fellowship will vary from institution to institution based on the interests and expertise of the faculty who work directly in the pain clinic. The training experience must be provided by the pain medicine program and acquired by the fellow over the course of the program. The program must provide each fellow distinct clinical experience in each of the disciplines listed, with the exception of the fellow's primary discipline. The principal multidisciplinary elements of pain medicine education from the disciplines relevant to pain medicine are as follows:

IV.A.5.a).(1).(a)

Anesthesiology

The fellow will demonstrate competency in:

IV.A.5.a).(1).(a).(i)

obtaining intravenous access in a minimum of 15 patients;

IV.A.5.a).(1).(a).(ii)

basic airway management, including a minimum of mask ventilation in 15 patients and endotracheal intubation in 15 patients;

IV.A.5.a).(1).(a).(iii)

provider course in basic life support and advanced cardiac life support;

IV.A.5.a).(1).(a).(iv)

management of sedation, including direct administration of sedation to a minimum of 15 patients; and,

IV.A.5.a).(1).(a).(v)

administration of neuraxial analgesia, including placement of a minimum of 15 thoracic or lumbar epidural injections using an interlaminar technique.

IV.A.5.a).(1).(b)

Neurology

The fellow shall be able to elicit a directed neurological history, perform a detailed neurological examination to include at least mental status,

cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in fifteen patients. Faculty shall verify this experience in a minimum of five observed patient examinations. The fellow shall also become familiar with basic neuro-imaging, and identify significant findings, to include at least MR and CT of the spine and brain on a minimum of 15 CT and/or MRI studies drawn from the examples within the following areas: brain, cervical, thoracic, and lumbar spine. The fellow shall have an understanding of the indicators and interpretation of electro-diagnostic studies;

IV.A.5.a).(1).(c)

Physical Medicine & Rehabilitation

The curriculum should be designed to emphasize the performance of a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain problems and developing rehabilitation programs for them. This should include assessments of static and dynamic flexibility, strength, coordination and agility for peripheral joint, spinal, and soft tissue pain conditions. Fellows should gain an understanding of the natural history of various musculoskeletal pain disorders and be able to appropriately integrate therapeutic modalities and surgical intervention in the treatment algorithm. The fellow shall have an understanding of the indicators and interpretation of electro-diagnostic studies. Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients, and demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of five patients; and,

IV.A.5.a).(1).(d)

Psychiatry

The fellow must carry out a complete psychiatric history with special attention to psychiatric and pain comorbidities, must conduct a complete mental status examination on a minimum of 15 patients, and must demonstrate this ability in five patients to a faculty observer. The program should provide educational experience in frequent psychiatric and pain co-morbidities, which include substance-related, mood, anxiety, somatoform, factitious, and personality disorders. The program should also provide educational experience in the effects of

pain medications on mental status. The fellow must understand the principles and techniques of the psychosocial therapies, with special attention to supportive and cognitive behavioral therapies, sufficient to explain to a patient and make a referral when indicated. Faculty must be psychiatrists or clinical psychologists who have documented experience in the evaluation and treatment of patients with chronic pain.

IV.A.5.a).(2)

must have education in specific areas of pain medicine practice, and many of these experiences will be undertaken in parallel. As an example, the continuity experience will often be carried out while trainees are also gaining experience with inpatients and acute pain patients. The minimum time requirements apply to areas of practice that do require a minimum length of time to gain perspective on pain care.

IV.A.5.a).(2).(a)

Outpatient (Continuity Clinic) Pain Experience

Continuity experience will provide the fellow with supervised experience in the ongoing management of a diverse population of patients with chronic pain, including cancer pain. The experience must allow interaction with other specialists in a multidisciplinary model of chronic pain management. To this end, the pain medicine fellow must attend a supervised outpatient clinic, approximately weekly, throughout the year of the program. Fellows may be absent from continuity clinic experience only if the rotation site is more than one hour from the core institution. The maximum allowable time away may be no more than four months. This will provide a minimum of eight months experience (full-time equivalent of at least 60 half-days). Primary responsibility for 50 different patients followed over at least two months each must be documented.

IV.A.5.a).(2).(b)

Inpatient Chronic Pain Experience

Inpatient chronic pain experience must be supervised on a pain team responsible for the assessment and management of inpatients with chronic pain including cancer pain. Patients may be seen through either a consultation team or while on a designated inpatient pain medicine service. To establish this experience, the fellow must document involvement with a minimum of 15 new patients assessed in this setting.

IV.A.5.a).(2).(c)

Acute Pain Inpatient Experience

Acute pain inpatient experience must be supervised in the assessment and management of inpatients with acute pain. To establish this experience, the fellow must document involvement with a minimum of 50 new patients.

IV.A.5.a).(2).(d)

Interventional Experience

Interventional experience must be supervised, and the objectives include understanding the selection criteria for a broad range of interventions, understanding the risks and potential advantages of these interventions, and obtaining exposure to the technical components involved in these interventions. It may be integrated with continuity experience or inpatient experience. To establish this experience, the fellow must document involvement with a minimum of 25 patients who undergo interventional procedures.

IV.A.5.a).(2).(e)

Cancer Pain

Cancer pain experience must be a supervised, longitudinal experience in an ambulatory or inpatient population who requires care for cancer pain, and may be integrated with continuity or inpatient experiences. The objectives should include:

IV.A.5.a).(2).(e).(i)

the understanding of a clinical approach to the treatments that comprise multidisciplinary cancer pain care, and

IV.A.5.a).(2).(e).(ii)

the understanding of strategies to integrate pain management into the treatment model. The fellow must document longitudinal involvement with a minimum of 20 patients.

IV.A.5.a).(2).(f)

Palliative Care Experience

Palliative care must be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care. The experience will include understanding a clinical approach to the multi-dimensional treatments that comprise palliative care, and an understanding of strategies to integrate pain management into this multi-dimensional treatment model. It may be integrated

with continuity experience or inpatient experience. To establish this experience, the fellow must document longitudinal involvement with a minimum of 10 patients who require palliative care.

IV.A.5.a).(2).(g)

Pediatric Experience

Experience with the assessment and treatment of pain in children is strongly encouraged.

IV.A.5.a).(2).(h)

Advanced Education in Interventional Pain Medicine

IV.A.5.a).(2).(h).(i)

Some programs will have faculty with extensive expertise in interventional pain medicine, and such programs are encouraged to provide an expanded didactic and clinical experience in interventional pain medicine. Those programs offering advanced education in interventional pain medicine shall be required to demonstrate that they provide substantial supervised clinical experience in addition to that required within the core curriculum.

IV.A.5.a).(2).(h).(ii)

The ACGME recognizes that interventional pain medicine is an evolving discipline. Programs shall not be required to offer all techniques to their trainees. However, the program director of an ACGME-accredited Pain Medicine Training Program that offers advanced education in Interventional Pain Medicine shall be required to demonstrate that fellows electing an advanced interventional track are exposed to a didactic curriculum that includes topics in Interventional Pain Treatment (*see Medical Knowledge* below), and that fellows receive direct, hands-on experience with a range of interventional pain treatment techniques. At the conclusion of the training period, the program director must prepare a final report for each fellow that clearly documents the specific interventional techniques with which fellows demonstrate competence. The following minimal experiences for interventional techniques are offered as guidelines:

IV.A.5.a).(2).(h).(ii).(a)	image-guided spinal injection techniques cervical spine (15 procedures);
IV.A.5.a).(2).(h).(ii).(b)	image-guided spinal injection techniques lumbar spine (25 procedures);
IV.A.5.a).(2).(h).(ii).(c)	injection of major joint or bursa procedures (10 procedures);
IV.A.5.a).(2).(h).(ii).(d)	trigger point injection (20 procedures);
IV.A.5.a).(2).(h).(ii).(e)	sympathetic blockade (10 procedures);
IV.A.5.a).(2).(h).(ii).(f)	neurolytic, techniques including chemical and radiofrequency treatment for pain (five procedures);
IV.A.5.a).(2).(h).(ii).(g)	intradiscal procedures, including discography (10 procedures);
IV.A.5.a).(2).(h).(ii).(h)	spinal cord stimulation (three procedures); and,
IV.A.5.a).(2).(h).(ii).(i)	placement of permanent spinal drug delivery system (three procedures).

IV.A.5.b)

Medical Knowledge

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

must be exposed to the following areas through a formal structured didactic program:

IV.A.5.b).(1)	Assessment of Pain
IV.A.5.b).(1).(a)	anatomy, physiology and pharmacology of pain transmission and modulation;
IV.A.5.b).(1).(b)	general principles of pain evaluation and management including neurological exam, musculoskeletal exam, psychological assessment;
IV.A.5.b).(1).(c)	diagnostic studies: X-Rays, MRI, CT and clinical nerve function studies;

IV.A.5.b).(1).(d)	pain measurement in humans: experimental and clinical;
IV.A.5.b).(1).(e)	psychosocial aspects of pain, including cultural and cross-cultural considerations;
IV.A.5.b).(1).(f)	taxonomy of pain syndromes;
IV.A.5.b).(1).(g)	pain of spinal origin including radicular pain, zygapophysial joint disease, discogenic pain;
IV.A.5.b).(1).(h)	myofascial pain;
IV.A.5.b).(1).(i)	neuropathic pain;
IV.A.5.b).(1).(j)	headache and orofacial pain;
IV.A.5.b).(1).(k)	rheumatological aspects of pain;
IV.A.5.b).(1).(l)	complex regional pain syndromes;
IV.A.5.b).(1).(m)	visceral pain;
IV.A.5.b).(1).(n)	urogenital pain;
IV.A.5.b).(1).(o)	cancer pain, including palliative and hospice care;
IV.A.5.b).(1).(p)	acute pain;
IV.A.5.b).(1).(q)	assessment of pain in special populations: patients with ongoing substance abuse, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired; and
IV.A.5.b).(1).(r)	functional and disability assessment.
IV.A.5.b).(2)	Treatment of Pain
IV.A.5.b).(2).(a)	Drug Treatment I: opioids;
IV.A.5.b).(2).(b)	Drug Treatment II: antipyretic analgesics;
IV.A.5.b).(2).(c)	Drug Treatment III: antidepressants, anticonvulsants and miscellaneous drugs;
IV.A.5.b).(2).(d)	psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy and treatment of psychiatric illness;
IV.A.5.b).(2).(e)	prescription drug detoxification concepts;

IV.A.5.b).(2).(f)	functional and vocational rehabilitation;
IV.A.5.b).(2).(g)	surgical approaches;
IV.A.5.b).(2).(h)	complementary and alternative treatments in pain management;
IV.A.5.b).(2).(i)	hospice and palliative care; and
IV.A.5.b).(2).(j)	treatment of pain in pediatric patients.
IV.A.5.b).(3)	General Topics, Research, and Ethics
IV.A.5.b).(3).(a)	epidemiology of pain;
IV.A.5.b).(3).(b)	gender issues in pain;
IV.A.5.b).(3).(c)	placebo response;
IV.A.5.b).(3).(d)	multidisciplinary pain medicine;
IV.A.5.b).(3).(e)	organization and management of a pain center;
IV.A.5.b).(3).(f)	Continuing Quality Improvement, Utilization Review and Program Evaluation;
IV.A.5.b).(3).(g)	patient and provider safety;
IV.A.5.b).(3).(h)	designing, reporting, and interpreting clinical trials of treatment for pain;
IV.A.5.b).(3).(i)	ethical standards in pain management and research; and,
IV.A.5.b).(3).(j)	animal models of pain, ethics of animal experimentation.
IV.A.5.b).(4)	Interventional Pain Treatment
IV.A.5.b).(4).(a)	airway management skills;
IV.A.5.b).(4).(b)	sedation/analgesia;
IV.A.5.b).(4).(c)	fluoroscopic imaging and radiation safety;
IV.A.5.b).(4).(d)	pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and steroid preparations. This must include treatment of local anesthetic systemic toxicity;

- IV.A.5.b).(4).(e) trigger point injections;
- IV.A.5.b).(4).(f) peripheral and cranial nerve blocks and ablation;
- IV.A.5.b).(4).(g) spinal injections including epidural injections: interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections;
- IV.A.5.b).(4).(h) discography and intradiscal/percutaneous disc treatments;
- IV.A.5.b).(4).(i) joint and bursal injections, including sacroiliac, hip, knee and shoulder joint injections;
- IV.A.5.b).(4).(j) sympathetic ganglion blocks;
- IV.A.5.b).(4).(k) epidural and intrathecal medication management;
- IV.A.5.b).(4).(l) spinal cord stimulation; and,
- IV.A.5.b).(4).(m) intrathecal drug administration systems.

IV.A.5.c)

Practice-based Learning and Improvement

Fellows 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. Fellows 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, fellows and other health professionals.

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

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

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

IV.A.5.e).(1) compassion, integrity, and respect for others;

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;

IV.A.5.e).(3) respect for patient privacy and autonomy;

IV.A.5.e).(4) accountability to patients, society and the profession; and,

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.f) Systems-based Practice

Fellows must demonstrate an awareness of and

responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resource in the system to provide optimal health care. Fellows are expected to:

- IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;
- 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.B. Fellows' Scholarly Activities

- IV.B.1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
- IV.B.2. Fellows should participate in scholarly activity.
- IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

- V.A.1.a) The faculty must evaluate fellow performance in a timely manner 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 fellow performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each fellow with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.

V.A.1.c).(1) These should include evaluations of attitude, interpersonal relationship skills, fund of knowledge, manual skills, decision-making skills, and critical analysis of clinical situations. Subspecialty trainees in pain medicine must obtain overall satisfactory evaluations at completion of 12 months of the fellowship to receive credit for the program.

V.A.1.d) Periodic evaluation of patient care (quality assurance) is mandatory. Subspecialty fellows in pain medicine should be involved in continuous quality improvement, utilization review, and risk management

V.A.2. Summative Evaluation

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

V.A.2.a) document the fellow's performance during the final period of education, and

V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

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

V.C. Program Evaluation and Improvement

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

V.C.1.a) fellow performance;

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) Fellows 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 fellows' 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.

VI. Fellow Duty Hours in the Learning and Working Environment

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

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

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

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

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

- VI.A.4.a)** be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
- VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.
- VI.A.5.** The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.5.a)** assurance of the safety and welfare of patients entrusted to their care;
- VI.A.5.b)** provision of patient- and family-centered care;
- VI.A.5.c)** assurance of their fitness for duty;
- VI.A.5.d)** management of their time before, during, and after clinical assignments;
- VI.A.5.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers;
- VI.A.5.f)** attention to lifelong learning;
- VI.A.5.g)** the monitoring of their patient care performance improvement indicators; and,
- VI.A.5.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6.** All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
- VI.B. Transitions of Care**
- VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care.
- VI.B.2.** Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- VI.B.3.** Programs must ensure that fellows are competent in communicating

with team members in the hand-over process.

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

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

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

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

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

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

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

VI.D. Supervision of Fellows

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

Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.

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

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

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

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty

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

VI.D.3. Levels of Supervision

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

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) Indirect Supervision:**
 - VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
 - VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**
 - VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
 - VI.D.4.c) 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 fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.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 fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

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

VI.F. Teamwork

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

VI.G. Fellow Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

The Review Committee for Anesthesiology, Neurology, Physical Medicine and Rehabilitation, or Psychiatry will not consider requests for exceptions to the 80-hour limit to the fellows' work

week.

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

VI.G.4.b).(3) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a) Under those circumstances, the fellow 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 fellow 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.

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.

Pain medicine fellows 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 fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

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 fellows for the duration of such a project.

Approved: February 14, 2006 Effective: July 1, 2007
Revised Common Program Requirements Effective: July 1, 2011`