ACGME Program Requirements for Graduate Medical Education
in Physical Medicine and Rehabilitation
Summary and Impact of Major Requirement Revisions

Requirement #: **Introduction**

Requirement Revision (significant change only):

Definition of Specialty

~~*Physical medicine and rehabilitation is the medical specialty that focuses on the diagnoses, evaluation, and management of persons of all ages with physical and/or cognitive impairments, disabilities, and functional limitations.*~~

Physiatrists are physicians who specialize in physical medicine and rehabilitation (PM&R) and provide comprehensive patient-centered preventative, acute, and chronic care for persons across the entire life spectrum who have disability or pain caused by disease, disorder, or injury. PM&R focuses on optimizing function, independence, and quality of life.

Physiatrists provide care that optimizes functional independence in their patients by advancing movement, endurance and cognition which may include assistive and adaptive methods. Therefore, PM&R requires expertise in the diagnosis, treatment, and long-term management of neurologic and musculoskeletal impairments, as well as strong knowledge of the cardiopulmonary and vascular systems. Physiatrists often treat complex medical patients and must manage their comorbidities so that they can participate in their rehabilitation program. Physiatrists commonly treat patients across the life spectrum with acquired and congenital brain injuries, acute and chronic pain, burns and wounds, cancer related impairments, limb loss, musculoskeletal and neuromuscular disorders, spinal cord injuries, and sports injuries.

In addition to traditional methods, physiatrists utilize functional assessment, electrodiagnosis and ultrasound to assess impairments. They manage disabling conditions and pain using a variety of tools. These tools may include medications; manual, thermal, and electrical modalities; minimally invasive procedures to manage pain and spasticity including ultrasound, fluoroscopic, and electrodiagnostically guided injections; and prescription of exercise, orthoses, prostheses, and adaptive equipment, and rehabilitation therapies.

Physiatrists lead teams to provide integrated, interdisciplinary care aimed at recovery of the individual's physical, emotional, medical, vocational, and social needs. They focus on the whole individual rather than the disease or injury. Their goal is to minimize activity limitations and maximize participation in society.

A competent physiatrist has broad-based clinical knowledge, strong critical thinking skills, and the flexibility to practice in many settings and circumstances. Excellent communication skills are essential for interactions with patients, families, and care teams. This includes helping patients and families understand prognosis and long-term management of their conditions.

Physiatrists serve as strong advocates for people with disabilities. They ensure their patients receive the appropriate health care and benefits. At the same time, physiatrists are good stewards of health care resources. They understand and collaboratively navigate the changing economic aspects of healthcare. Physiatrists utilize data and evidence-based practice to inform and advance patient care, resulting in high-value patient-centered care, continuous quality improvement, and equitable and ethical service delivery. As self-directed lifelong learners, physiatrists stay current with and critically evaluate advanced and emerging technologies.

1. Describe the Review Committee's rationale for this revision:

   Every 10 years, ACGME Review Committees are required to evaluate the applicable specialty-specific Program Requirements for revision. In 2017, the ACGME re-envisioned the process by which this is done. The new process, which includes scenario-based strategic planning, called for rigorous and creative consideration about what the specialty will look like in the future prior to proposing any revisions, recognizing the future is marked with significant uncertainty.

   Several themes emerged from the scenario planning efforts for this revision that provide insight into the physiatrists of the future and their practice:
   Acquiring Enduring Professional Skills
   Designing the Clinical Education Process
   Reimagining the Clinical Education Curriculum
   Caring for a Diverse Patient Population
   Advocating for Patients and the Specialty
   Thriving in Interprofessional Teams
   Exploring Intelligent Technologies
   Working Within Complex Care Systems

   It is recognized that the physiatrist of the future will not achieve mastery of all the competencies identified during residency alone. Residency must serve as the foundation for career-long professional development and adaptation to a changing health care system and community need. Many physiatrists go on to attain further education and training in subspecialty areas.

   The definition of a physiatrist reflects the core functions and values of physical medicine and rehabilitation that are foundational, and that faculty members and graduates of physical medicine and rehabilitation residency programs should possess and/or practice.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Although this is a vision statement and functions as an introduction to the Program Requirements, the Review Committee expects that the views expressed will encourage and promote program improvements and innovation in resident education, patient safety, and patient care quality.

3. How will the proposed requirement or revision impact continuity of patient care?
   The new definition stresses the role of the specialty across the continuum of care settings, thus improving continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Additional resources are not anticipated.

5. How will the proposed revision impact other accredited programs?
   This will not affect other accredited programs.

Requirement #: **3.3.a.1.;4.11.c.1.a. - 4.11.c.2.b.4.;**

Requirement Revision (significant change only):

3.3.a.1. Prior to commencing the 36 months of physical medicine and rehabilitation education, a resident ~~must~~ should have successfully completed 12 months of education in fundamental clinical skills in a transitional year, preliminary medicine, preliminary surgery, or pediatrics residency program that satisfies the requirements in 3.3 and must include primary responsibility in inpatient care, exposure to the intensive care unit, and no more than three months of physical medicine and rehabilitation. (Core)

4.11.c.1.a. The clinical skills training year must include primary responsibility in inpatient care, exposure to the intensive care unit, and not more than three months of physical medicine and rehabilitation. (Core)

~~4.11.c.2. These 12 months of education in fundamental clinical skills must be completed in either:~~

~~4.11.c.2.a a transitional year program that satisfies the requirements in 3.3., or; (Core)~~
~~4.11.c.2.b. a residency program that satisfies the requirements in 3.3. (Core)~~

~~4.11.c.2.b.1. At least six months must include emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, surgery, or any combination of these patient care experiences. (Core)~~

~~4.11.c.2.b.2. The remaining months of these 12 months of education may include any combination of accredited specialty or subspecialty education. (Detail)~~

~~4.11.c.2.b.3. Rotations in any of the specialties or subspecialties selected must be for a period of at least four weeks. (Detail)~~

~~4.11.c.2.b.4. No more than eight weeks may be in non-direct patient care experiences, such as pathology, radiology and research and no more than four weeks may be in physical medicine and rehabilitation. (Detail)~~

1. Describe the Review Committee's rationale for this revision:
   This modification simplifies the requirements and allows for flexibility. An intensive care unit (ICU) rotation requirement was added as feedback from program directors indicated that some incoming PGY-2 residents were ill-equipped to manage the complexity of patients often seen in inpatient rehabilitation settings. Internships in emergency medicine, obstetrics and gynecology, and family medicine were not felt

to educate and train physical medicine and rehabilitation residents adequately for the patient populations they typically see.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Residents will be better equipped to manage complex patients.

3. How will the proposed requirement or revision impact continuity of patient care?
   Not applicable.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Minimally, as some programs may not currently include ICU rotations in the PGY-1.

5. How will the proposed revision impact other accredited programs?
   There should be minimal impact on transitional year, preliminary medicine, and preliminary surgery programs.

Requirement #: **4.5.a.; 4.5.c.; 4.11.y.; 4.11.y.1.**

Requirement Revision (significant change only):

~~**4.5.a Residents must be involved in a minimum of 200 electrodiagnostic evaluations, of which residents must demonstrate competence in the performance, documentation, and interpretation of a minimum of 150 complete electrodiagnostic studies from separate patient encounters.** (Core)~~

4.5.c. Residents must demonstrate competence in appropriate patient selection and performance of core physiatric procedures/techniques. (Core)

4.11.y. Each graduating resident must perform the minimum number of cases as established by the Review Committee. (Outcome)

Specialty-Specific Background and Intent: Core physiatric procedures/techniques include chemodenervation procedures for spasticity (i.e., botulinum toxin, phenol); electrodiagnosis (EMG/NCS); and intra-articular/bursal injections. Core electrodiagnostic procedures would include the assessment of peripheral nerve injuries, neuropathies, and radiculopathies.

Program directors may make reasonable accommodation or assessment for residents with disabilities regarding the performance of procedures as long as the resident is able to demonstrate the requisite knowledge of the procedure.

4.11.y.1. Performance of the minimum number of cases by a graduating resident must not be interpreted as equivalent to the achievement of competence. (Core)

Specialty-Specific Background and Intent: The minimum number of procedures each resident is expected to perform is listed below.

Procedure:	Total	Minimum Performed	Simulated/Observed
Chemodenervation procedures for spasticity (i.e., botulinum toxin, phenol) (per limb)	50	40	Up to 10 may be simulated
EMG/NCS (per limb)	150	125	Up to 25 may be simulated or observed
Intra-articular/bursa injections (per structure)	50	40	Up to 10 may be simulated
Axial facet-based and sacroiliac joint procedures	5	0	All may be observed or simulated
Diagnostic musculoskeletal ultrasound	10	0	All may be simulated
Epidural injections	5	0	All may be observed or simulated
Intrathecal pump programming/refills	5	0	All may be simulated
Periarticular injections (e.g., tendon sheath, deep gluteal, peripheral nerve)	10	0	All may be observed or simulated
Ultrasound guidance for procedures	40	10	Up to 30 may be simulated

Recognizing the evolving technology of virtual reality, simulations, access to cadavers, and variable training resources available to programs, some of the cases may be performed by simulation if the program can demonstrate achievement of equivalent educational value.

Additional information regarding the required numbers of procedures by defined categories is provided on the Documents and Resources tab of the ACGME PM&R specialty page.

1. Describe the Review Committee's rationale for this revision:
   Electrodiagnostic studies were removed from the requirements and placed instead in Specialty-Specific Background and Intent, along with other procedures. The Review Committee also defined which electrodiagnostic procedures are core to the specialty (procedures with which all graduates should be familiar, as opposed to more advanced skills, which may require further education, training, or a fellowship). This puts this area on more equal footing with other procedures. Furthermore, regarding all procedures, the Review Committee allows reasonable accommodation for residents with disabilities and the use of simulation of some procedures, reflecting improved technology to do such simulations. The numbers reflected here are based on surveys of both residents and program directors. By including this in the Specialty-Specific Background and Intent, the Review Committee will have the ability to nimbly adjust the numbers to reflect future practice patterns.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   The changes in procedure numbers reflect current practice and provide a more balanced exposure to the range of physiatric procedures.

3. How will the proposed requirement or revision impact continuity of patient care?
   Not applicable.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   This change reduces the number of electrodiagnostic studies, which should reduce burden. The increase in the numbers for diagnostic and guided injection ultrasound procedures may require some additional resources. However, based on the survey of program directors, this is not expected to be too onerous. Also, the allowance for simulation for many of the required procedures which should accommodate programs that do not have adequate patient volumes.

5. How will the proposed revision impact other accredited programs?
   This should not have an impact on other specialties.

Requirement #: 4.11.e.-4.11.e.6.

Requirement Revision (significant change only):

4.11.e. There should be a minimum of 12 months of inpatient rehabilitation care. (Core)

4.11.e.1. Of those 12 months, at least 10 months should be in an appropriately licensed comprehensive inpatient rehabilitation facility. (Core)

Specialty-Specific Background and Intent: Programs may use up to two months of the 12 months for rotations in other levels of inpatient care, such as skilled nursing facilities or long-term care facilities.

4.11.e.2. The PGY-4 year should include at least one month of inpatient experience. (Detail)

4.11.e.3. During comprehensive inpatient rehabilitation facility rotations, residents should cover an average minimum daily census of 6 inpatients. Residents should oversee the primary management of no more than 14 inpatients per day, except during call coverage, weekends, and holidays. (Core)

Specialty-Specific Background and Intent: The management of patients includes admissions and discharges. For example, in one day, a resident with a patient census of 12 could do two discharges and two admissions and not exceed the management of 14 patients.

4.11.e.4. Inpatient rehabilitation facility daily rounds with faculty should occur a minimum of five times per week. (Detail)

4.11.e.5. For skilled nursing facilities or long-term acute care facilities the patient care average daily census should not exceed 20 patients. (Detail)

4.11.e.6. Daily rounds in skilled nursing facilities or long-term acute care facilities must be in the presence of a supervising attending physician. (Core)

1. Describe the Review Committee's rationale for this revision:
   The Review Committee considers it important to expose residents to practice in skilled care and/or long-term care facilities. The allotment of up to two of the 12 inpatient rotation months allows programs some flexibility to accommodate this. According to the survey data from residents, too much of the inpatient experience was "front loaded" in the PGY-2, so the requirement for PGY-4 residents to have at least a month of inpatient and PGY-2 residents to have at least a month of outpatient experience was added. This also allows for more teaching of junior residents by senior residents. Program Requirement 4.11.e.3. clarified a previous requirement. Program Requirement 4.11.e.5. reflects that the census at a skilled nursing facility is generally higher than in acute inpatient rehabilitation facilities as the patients are less complex.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   More guidance was provided to ensure appropriate resident supervision and patient care responsibilities in skilled care or long-term care facilities. It also allows a greater continuum of exposure to different patient populations throughout the course of the educational program.

3. How will the proposed requirement or revision impact continuity of patient care?
   More physicians will be prepared to manage patients in skilled nursing and long-term acute care settings.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   This should not necessitate additional resources.

5. How will the proposed revision impact other accredited programs?
   This should not have an impact on other specialties.

Requirement #: **4.11.f. – 4.11.f.5.**

Requirement Revision (significant change only):

4.11.f. There should be a minimum of 12 months of outpatient experience. (Core)

4.11.f.1. The outpatient experience should include longitudinal care of patients with chronic pain or disability. (Core)

Specialty-Specific Background and Intent: Longitudinal care may include experiences such as a continuity care clinic or a specialty-specific care clinic such as spinal cord injury care.

4.11.f.2. The outpatient experience should include acute and chronic musculoskeletal care. (Core)

4.11.f.3. The outpatient experience should include limb loss care, prosthetics, and orthotics. (Core)

4.11.f.4. The outpatient experience should include neurorehabilitation sequelae management including spasticity. (Core)

4.11.f.5. The PGY-2 year should include at least one month of outpatient experience. (Detail)

1. Describe the Review Committee's rationale for this revision:
   This revision is proposed to ensure adequate depth and breadth of core diagnosis spanning the duration of the educational program.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   This change will allow earlier exposure to an outpatient population and enhance long-term management of patients.

3. How will the proposed requirement or revision impact continuity of patient care?
   This change will provide improved opportunities for long-term patient care management.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   This should not necessitate additional resources.

5. How will the proposed revision impact other accredited programs?
   This should not have an impact on other specialties.

Requirement #: **4.11.h.**

Requirement Revision (significant change only):

There should be a minimum of three and a maximum of six months of individualized educational experiences. (Core)

Specialty-Specific Background and Intent: The requirements acknowledge that in addition to providing residents with broad foundational educational experiences in ambulatory and inpatient-based physical medicine and rehabilitation, programs must ensure residents have educational experiences that take into account their future plans and the different paces and trajectories at and on which residents will learn and demonstrate competence in the foundational areas. Individualized educational experiences will be determined by the program director and take into account demonstrated competence in the foundational areas noted above, resources, program aims, and the residents' future practice plans.

Although a maximum of six months can be devoted to individualized experiences, some residents may require more time to achieve competence in the foundational educational areas, which may result in less time for individualized educational experiences. Some

residents may need to devote the entirety of residency to achieve competence in the foundational areas and may not have the time to devote to individualized experiences.

Programs may have the flexibility to individualize educational opportunities for residents who have achieved or are on target to achieve competence in the foundational areas. These opportunities may include more ambulatory/outpatient experiences for residents interested in practicing in an outpatient setting after residency, more inpatient experiences for those interested in inpatient rehabilitation careers, or more experiences in a subspecialty for those interested in subspecializing. Individualized educational experiences may be integrated throughout the 36 months of the educational program and do not need to be consecutive.

1. Describe the Review Committee's rationale for this revision:
   This proposed requirement will allow residents to gain more knowledge and experience in areas of their choosing, and to work toward their personal and professional goals. These individualized experiences of three to six months in duration may be granted by the program if a resident is on track to achieve competence in the core rehabilitation competencies.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   By allowing greater growth in areas important to each resident following the principles of competency-based medical education, resident education will be enhanced.

3. How will the proposed requirement or revision impact continuity of patient care?
   Not applicable.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   This should not necessitate additional resources.

5. How will the proposed revision impact other accredited programs?
   This should not have an impact on other specialties.