Frequently Asked Questions: Physical Medicine and Rehabilitation
Review Committee for Physical Medicine and Rehabilitation
ACGME

Questions	Answers
Program Personnel and Resources	
Does the Review Committee grant waivers for current American Board of Physical Medicine and Rehabilitation (ABPMR) certification for the program director? *[Program Requirement: II.A.3.b)]*	No. The Review Committee uses ABPMR certification as one of its major outcome measures and an ABPMR-certified program director demonstrates to the residents the value and importance of board certification.
What kind of meetings fulfill the requirement that the program director participate in continuing education activities related to graduate medical education (GME)? *[Program Requirement: II.A.4.p)]*	The goal of this requirement is to promote the sharing of ideas and continuous program improvement. Examples of activities include local or regional GME conferences, the annual Residency/Fellowship Directors' Workshop at the Association of Academic Physiatrists, as well as the ACGME Annual Educational Conference.
What qualifications are acceptable to the Review Committee for physician faculty members without current ABPMR certification in physical medicine and rehabilitation? *[Program Requirement: II.B.2.]*	Years of practice are not an equivalent of board certification. The onus of documenting evidence for consideration of alternate qualifications is on the program director, however the determination of whether qualifications are an acceptable alternative to certification by the ABPMR is a judgment call on the part of the Review Committee. The Review Committee will take into consideration a significant record of publication in peer-reviewed journals as evidence of adequate specialty qualifications.
What is an appropriate range of involvement of the faculty in scholarly activities? *[Program Requirement: II.B.5.b)]*	The Review Committee expects at least 50 percent of the core faculty to participate in the scholarship of discovery (as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal), dissemination (as evidenced by review articles or chapters in textbooks), or application (as evidenced by the publication or presentation of, for example, case reports, clinical series, or lectures and workshops at local, regional, or national professional and scientific society meetings; or participation in national committees or leadership roles in professional or academic societies).

Questions	Answers
What is an appropriate inpatient census? *[Program Requirements: II.D.1.; IV.A.7.c).(1); IV.A.7.c).(4)]*	It is the program director's responsibility to ensure that the number of inpatients available for each resident is adequate. Insufficient experience will not meet educational needs and an excessive patient load implies an inappropriate reliance on residents for service. A minimum of 12 months of inpatient experience is required. Because patient acuity may vary significantly by hospital, the expectation for an average daily census of eight patients (range six-14) may be averaged over the experiences for the whole 12 months. In settings with a census greater than 14, programs should provide additional medical support to the resident to ensure safe patient care.
Resident Appointments	
Are individuals who completed a traditional rotating osteopathic internship in an American Osteopathic Association (AOA)-approved program eligible to apply to ACGME-accredited physical medicine and rehabilitation programs? *[Program Requirement: III.A.1]*	The Review Committee understands that during the transition period to a single GME accreditation system, programs may wish to consider applicants from AOA-approved programs that are not yet pre-accredited or accredited by the ACGME. Core programs will not jeopardize their accreditation status if they accept such applicants. Applicants should check with the ABPMR and/or the American Osteopathic Board of Physical Medicine and Rehabilitation (AOBPMR) regarding certification eligibility.
Can a program accept a resident transferring from an AOA-approved program? *[Common Program Requirements: III.A.1.a) and III.A.2]*	The Review Committee understands that during the transition to a single GME accreditation system, ACGME-accredited programs may wish to accept residents seeking to transfer from an AOA-approved program. Programs will not jeopardize their accreditation status if they accept such transfer residents if they remain within their approved resident complement or obtain Review Committee approval of an increase if needed. In these circumstances, the program director of the accepting program will determine what credit may be given for prior training, as well as how much further training is necessary to complete the ACGME-accredited program. It is the responsibility of the program director to ensure that each resident is made aware of the requirements for eligibility for certification by the applicable American Board of Medical Specialties member board and/or AOA certifying board.
Can the program director increase the program complement without ACGME approval? *[Program Requirement: III.B.1.]*	All requests for changes in resident complement must be submitted to the ACGME via the Accreditation Data System (ADS) and be prior-approved by the Review Committee. Guidelines for requesting an increase in complement can be found on the Documents and Resources page of the Physical Medicine and Rehabilitation section of the ACGME website.

Questions	Answers
Are residents who matched to the program at the PGY-2 level considered transfer residents? *[Program Requirement: III.C.1.]*	Yes. The program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of an entering PGY-2 resident.
Educational Program	
What are acceptable ways for residents to review didactic instruction if they are unable to attend a presentation? *[Program Requirement: IV.A.3.a)]*	Required clinical activities may not be scheduled during didactic time, although residents may receive pages related to their patients or for consultation requests. The program director should monitor the burden of pages received and make alternative coverage arrangements if residents are disturbed too frequently during didactics. The Review Committee accepts a variety of solutions as long as residents have the opportunity to experience missed educational instruction. The solutions can include teleconference, webcasting, taped didactics, slides available on a website, and repeating conferences.
Can the residents conduct didactic instruction? *[Program Requirement: IV.A.3.c)]*	While residents are expected to learn to teach and may provide some of the didactics or seminars, the primary responsibility for teaching lies with the faculty. Residents should present at journal club. Supervision of resident teaching in didactics, seminars, or journal clubs by one or more faculty members is required.
What qualifies as an equivalently structured program in anatomy? *[Program Requirement: II.D.3. and IV.A.3.d).(1)]*	Residents must have instruction in neuromusculoskeletal anatomy. This should include supervised teaching of residents in an anatomy laboratory for dissection or study of prosected cadavers. If a cadaver laboratory experience is not included in the anatomy curriculum, didactic instruction in anatomy must be supplemented with visual aids such as slide pictures, simulation models, or online virtual anatomy websites.
What experiences are expected for residents to attain competence in pediatric rehabilitation? *[Program Requirement: IV.A.5.a).(1).(a).(v)]*	In addition to didactics addressing pediatric rehabilitation, the Review Committee expects residents to have two months of clinical experiences that *may include* inpatient pediatric rehabilitation and pediatric rehabilitation consults, but *must include* outpatient management of the common disabling disorders of childhood, including cerebral palsy and muscular dystrophy. Outpatient experiences may be under the supervision of attending physicians in pediatric rehabilitation and related specialties, such as pediatric neurology, pediatric neurological surgery, neuro-developmental pediatrics, or pediatric orthopaedics.

Questions	Answers
What are the expectations for involvement in approximately 200 electrodiagnostic consultations per resident? *[Program Requirement: IV.A.5.a).(2).(a).(i)]*	Each resident is expected to be involved in 200 electrodiagnostic consultations. Ideally, each resident should perform all 200 consultations. The combination of observed and performed electrodiagnostic studies should not exceed 25 percent for observation and should be at least 75 percent performed and interpreted by the resident under appropriate supervision. Each patient encounter may only be counted as one consultation, even if multiple EMGs or Nerve Conduction Studies are performed during an examination, and may only be counted as "performed" by one resident. Only one resident may count an "observed" study on a patient. Somatosensory evoked potentials may be counted toward the electrodiagnostic consultation requirement, but are not required.
What therapeutic and diagnostic injections should residents learn? *[Program Requirement: IV.A.5.a).(2).(a).(ii)]*	Therapeutic and diagnostic injections include those for spasticity management, as well as joint, soft tissue, and axial injections.
How can residents demonstrate that they identify strengths, deficiencies, and limits in their knowledge and expertise; set learning and improvement goals; and identify and perform appropriate learning activities? *[Program Requirements: IV.A.5.c).(1)-(3)]*	Throughout their education, residents should engage in reflection on their knowledge and expertise and write a learning plan to address deficiencies and limits. The semiannual formative evaluation process should include an assessment of these plans and the performance of learning activities by the resident. A learning portfolio is one means by which a resident can review his or her strengths and opportunities to improve over the span of the program.
What qualifies as significant experience in the care of patients with musculoskeletal disorders? *[Program Requirement: IV.A.7.b)]*	A significant experience in musculoskeletal disorders is at least four months of outpatient clinics, which can include management of patients with acute and chronic pain disorders, sports injuries, occupational injuries, rheumatologic conditions, and training in use of musculoskeletal ultrasound. When a patient with a musculoskeletal disorder needs an electrodiagnostic evaluation, the resident may perform the study without the program having to fractionally account for that time in calculating the outpatient experience.
Is a resident continuity clinic required? *[Program Requirement: IV.A.7.b)]*	No. If there is no resident continuity clinic, residents must participate in faculty clinics that provide follow-up care for patients with long-term disabilities.

Questions	Answers
Under what circumstances can a subacute rehabilitation service count toward the inpatient requirement? *[Program Requirement: IV.A.7.c)]*	A subacute rotation may only be counted toward the inpatient requirement if the resident has the same direct and primary responsibility for an assigned group of patients as on an acute inpatient rehabilitation service. An attending physician must round daily (a minimum of five times/week) to supervise and teach the resident on a subacute rotation.
Will the cap of 14 inpatients apply to weekend and holiday coverage and when an inpatient service resident goes on vacation, and can residents covering for another resident temporarily exceed the cap? *[Program Requirements: IV.A.7.c).(2)-(3)]*	The cap of 14 applies to the typical work day and does not apply to weekends, holidays, or on-call coverage. The cap would apply when an inpatient service resident is on vacation. If a situation arises and the cap is temporarily exceeded, patient safety must be ensured by providing additional medical support.
What are the expectations for teaching rounds five times per week? *[Program Requirement: IV.A.7.c).(5)]*	On inpatient rotations, it is expected that faculty members will round daily (Monday-Friday) with residents and provide clinical teaching in the context of patient care.
How should residents participate in scholarly activity? *[Program Requirement: IV.B.2.]*	Residents should investigate one topic in depth. Outcomes of this research/investigation could include: a chapter or review article; a local, regional, or national presentation; a case report/series presented as a poster or platform presentation at a national meeting; preparation or submission of a manuscript for publication; or a research project.
Evaluation	
How should the program use the results of the self-assessment examination provided by the American Academy of Physical Medicine and Rehabilitation (AAPMR)? *[Program Requirement: V.A.1.b).(1)]*	The self-assessment examination from the AAPMR may be used to guide program improvement and resident self-directed learning. However, it is not sufficiently reliable or valid to be used for advancement to an increased level of responsibility, or for promotion or graduation decisions.

Questions	Answers
Can the final evaluation submitted to the ABPMR be used to meet the requirements of documentation of a resident's performance during the final period of education and to verify that the resident has demonstrated sufficient competence to enter practice without direct supervision? *[Program Requirements: V.A.2.a)-b)]*	Yes, the final evaluation submitted to the ABPMR can serve as verification of a resident's competence to enter practice independently, and will satisfy this portion of the summative evaluation requirement. Programs that are considered non-compliant with this requirement might receive the following citation: *"At the time of the site visit, it was reported that summative evaluations had not been completed for all residents who have completed the program."* The major reason for this citation is that the cited program did not specifically verify through documentation in the summative evaluation, "…that the resident has demonstrated sufficient competency to enter practice without direct supervision" (PR V.A.2.b).(3)). Having the completed, signed copy of the ABPMR application form on-hand for review at the time of a site visit *will satisfy the requirement*.
The Learning and Working Environment	
Are there any non-physician licensed independent practitioners who may supervise residents? *[Program Requirement: VI.A.2.a).(1)]*	Advanced nurse practitioners and psychologists may supervise residents, as appropriate.

Questions	Answers
Under what circumstances can a PGY-1 resident be supervised indirectly with direct supervision immediately available? *[Program Requirement: VI.A.2.e).(1).(a)]*	PGY-1 residents participate in a variety of rotations, including in emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, and surgery, or in subspecialties of internal medicine and surgery, as well as up to one month in physical medicine and rehabilitation. Each of these programs must assess the independence of each PGY-1 resident based upon the six core competencies in order to progress to indirect supervision with direct supervision immediately available. These different rotations necessitate different sets of skills. That is, if a PGY-1 resident is deemed to have progressed to indirect supervision with direct supervision immediately available while on the internal medicine service, this may not be the case in a subsequent rotation such as emergency medicine or surgery. When PGY-1 residents are assigned to physical medicine and rehabilitation rotations, second- or third-year (or higher) residents or other appropriate supervisory physicians (e.g., subspecialty residents or attending physicians) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on-site to supervise.
What is an appropriate patient load for residents? *[Program Requirement: VI.E.1.]*	PGY-1 residents work on primarily non-physical medicine and rehabilitation rotations. Their workload must comply with the respective specialty-specific clinical responsibility requirements. For PGY-2-4 residents on inpatient services, the program director must make an assessment of the learning environment with input from faculty members and residents. The optimal caseload will allow each resident to see a variety of patients without being overwhelmed by patient care responsibilities, and without compromising his or her educational experience or patient safety. Inpatient loads should generally be a minimum of eight patients averaged over the inpatient rotations, and should not generally exceed 14. There may be situations when lower loads are appropriate due to severity of illness or when higher loads are appropriate due to lower acuity of illness or team support, such as with hospitalists or mid-level providers.
Who should be included in the interprofessional teams? *[Program Requirement: VI.E.2.]*	Appropriately credentialed professional staff members in the disciplines of occupational therapy, orthotics and prosthetics, physical therapy, psychology, rehabilitation nursing, social service, speech-language pathology, therapeutic recreation, and vocational counseling should be integrated into residents' didactic and clinical experience whenever relevant.