Basic Standards for
Residency Training in
Physical Medicine and Rehabilitation

American Osteopathic Association
and
American Osteopathic College of Physical Medicine and Rehabilitation

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Table of Contents

ARTICLE I – INTRODUCTION.................................................................2
ARTICLE II – MISSION........................................................................2
ARTICLE III – EDUCATIONAL PROGRAM GOALS............................2
ARTICLE IV – INSTITUTIONAL REQUIREMENTS.................................3
ARTICLE V – PROGRAM REQUIREMENTS AND CONTENT...............4
ARTICLE VI – PROGRAM DIRECTOR / FACULTY...............................7
ARTICLE VII – RESIDENT REQUIREMENTS........................................7
ARTICLE VIII – EVALUATION.............................................................8
ARTICLE I – INTRODUCTION
A. Contained herein are the basic standards for residency training in Physical Medicine and Rehabilitation as approved by the American Osteopathic Association (AOA) and the American Osteopathic College of Physical Medicine and Rehabilitation (AOCPMR). These standards are in addition to the general residency requirements of the AOA and are designed to provide the osteopathic resident with training in the fundamental skills of Physical Medicine and Rehabilitation to allow successful practice of the specialty and preparation for certification by the American Osteopathic Board of Physical Medicine and Rehabilitation.

ARTICLE II – MISSION
A. The mission of the osteopathic physical medicine and rehabilitation training program is to provide residents with comprehensive, structured, cognitive and clinical education that will enable them to become competent, proficient and professional osteopathic physical medicine and rehabilitation physicians. Each resident completing this training should demonstrate competency in the assessment and management of individuals with congenital and acquired impairments from a biopsychosocial and environmental perspective. Residents in PM&R should be able to create and implement a treatment goal that allows each individual to achieve optimum function within the disease state allowable. Efficient, evidenced based, team oriented medical and rehabilitative care to the impaired acute and chronically ill patient will be the emphasis of these residency training programs.

ARTICLE III – EDUCATIONAL PROGRAM GOALS
A. An approved osteopathic residency in Physical Medicine and Rehabilitation must provide an educational program that will ensure its graduates those competencies necessary for entry-level independent practice of the specialty. This educational program must provide:

1. Knowledge about the diagnosis, etiology, treatment, prevention and rehabilitation of those neuromusculoskeletal, cardiovascular, pulmonary and other system disorders common to this specialty in patients of both sexes and all ages.
2. The trainee with the opportunity to develop the attitudes and psychomotor skills required to:
   a. Perform the general and specific physiatric examination including electromyography, nerve conduction studies and other procedures common to the practice of physiatry.
   b. Modify history taking to include data critical to the recognition of physical and psychosocial impairment that may create functional disability.
   c. Design rehabilitation programs to minimize and prevent impairment and maximize functional skills.
   d. Make sound clinical judgments.
   e. Perform an appropriate palpatory examination and identify somatic dysfunction and be able to apply appropriate osteopathic manipulative techniques.
3. The opportunity for residents to learn the management and leadership skills necessary to effectively and efficiently coordinate an interdisciplinary team of rehabilitation professionals for the maximum benefit of the patient.
4. The opportunity for residents to understand the role of each allied health professional in the treatment of the patient.
5. Education in the writing of detailed prescriptions and programs based on functional goals as
part of Physiatric management.

6. Opportunity for research.

B. Additionally, the program must highlight for the trainee the importance of self-evaluation, continuing medical education and ongoing professional development.

C. The resident must be provided with the opportunity to develop the written and verbal communication skills necessary for the effective practice of Physiatry.

D. The organization of the program must stimulate the initiative and originality of the resident, in order to promote independence of mind as well as their critical appraisal of the literature.

E. The training program must be organized to allow progressive responsibility in patient care and ensure knowledge and skills common to all branches of medicine.

F. Instruction in osteopathic principles and osteopathic manipulative techniques as they relate to the practice of Physiatry must be an integral part of the program.

G. An opportunity to demonstrate basic, entry-level competency in each of the following fundamental areas:

1. Patient Care: clinical judgment, application of general and physiatry specific skills.
2. Medical Knowledge: maintaining broad general and physiatry specific information base.
3. Practice-Based Learning for Self-Improvement: self-analysis; application of business principles as well as research and statistical methods to medicine; use of information technology and evidence-based medicine; participation in the education of students and other professionals.
4. Interpersonal Communication Skills: ability to work with others; listening skills; clear and effective communications with patients, families, and other health professionals; preparation of timely, complete and legible medical records.
5. Professionalism: including attitudes and humanistic qualities.
6. Systems-Based Practice: knowledge of practice and delivery systems; evaluation of risks, benefits, limitations, and costs of available resources.
7. Osteopathic Principles and Practice: understanding the broad context of holistic patient evaluation; use of appropriate manipulative treatment and other manual skills.

ARTICLE IV – INSTITUTIONAL REQUIREMENTS

A. Physical Medicine and Rehabilitation must to provide service to other departments in medicine and surgery. It is necessary to have beds assigned in one geographic area to facilitate patient care and teaching. The institution must provide patient volume to properly train a minimum of two residents per year in physical medicine and rehabilitation. All programs must have residents in each year of training with an equal distribution of residents. Educational experiences must bring all residents together once weekly. A minimum of eight inpatients must be available for each resident while assigned to a full time inpatient service.

B. The sponsoring institution must provide an professional library containing textbooks and journals in general medicine and surgery pertinent to the practice of Physical Medicine and Rehabilitation as well as journals within the specialty.

C. Basic teaching aids and multi-media audiovisual projection units and a broad selection of videotapes and computer digital storage disks must be provided. Access to these facilities must be
available for residents and staff, specifically including nights and weekends.

D. The institution shall provide equipment, instruments and space for a comprehensive program in Physical Medicine and Rehabilitation. Specific equipment for physical medicine interventions must be available. Residents must have actual experience with this equipment. Equipment must be suitable for all age groups. Adequate office space must be available for faculty and residents to participate in the clinical examination of patients and in self-study. All facilities must be accessible to the disabled.

E. Minimal Equipment Requirements:

1. Electrodiagnostic medicine – EMG machine.
2. X-ray, fluoroscopy, MRI, CAT scan, musculoskeletal US devices
3. Epidural catheters, needles, neurostimulation units for nerve blocks
4. Typical office equipment including but not limited to the following:
   a. Neuro hammers
   b. Stethoscopes
   c. Blood pressure equipment
   d. AED units
   e. Etc.

**ARTICLE V – PROGRAM REQUIREMENTS AND CONTENT**

A. A minimum of three (3) years of residency training to train a physician specializing in Physical Medicine and Rehabilitation. During the three (3) years of training in Physical Medicine and Rehabilitation, no more than six (6) months can be elective.

B. General Requirements

1. Integration of osteopathic philosophy and principles of practice in patient care must be an ongoing feature with continuing training in osteopathic palpation, diagnosis and manipulation treatment.
2. Clinical training provided must include supervised management of inpatients and outpatients.
3. A structured and organized didactic series must be provided.
4. Residents must be provided with the opportunity to participate in structured, supervised research training.

C. Clinical Components of the Educational Program

1. The clinical curriculum must include a variety, depth and number of clinical experiences. The volume of clinical responsibilities must not, however, compromise the educational atmosphere of the program.
2. The training program must include a amount of time spent in providing primary care of patients hospitalized on the Physical Medicine and Rehabilitation service. Residents must
devote at least 12 months of their residency experience to the primary care of inpatients hospitalized on the Physical Medicine and Rehabilitation service.

3. A minimum of 12 months must be devoted to the care of outpatients.

4. Residents must be provided with the opportunity to review pertinent laboratory, biopsy and imaging studies of their patients.

5. Residents must have a regular opportunity to observe and directly participate in therapies that occurs in various treatment areas throughout their training. This would include proper use and function of equipment.

6. Residents must have the opportunity to observe and gain fundamental understanding of orthotics and prosthetics including fitting and manufacturing through exposure to appropriately certified orthotists and prosthetists.

7. Residents must observe and gain a basic understanding of the types of patients served, referral patients and services available in the continuum of rehabilitation care. This includes subacute and skilled facilities, sheltered workshops, vocational facilities, school for the multiple handicapped, deaf and blind, independent living facilities for the physically impaired, day hospitals, nursing homes, home health care services and community re-entry services. This can be accomplished through didactic lectures and on site visits to facilities.

8. Residents must interact with health care consumer groups.

D. Clinical curriculum must follow specific learning objective and allow for the comprehension development of measurable competencies for each resident in the following areas:

1. History and physical examination pertinent to Physical Medicine and Rehabilitation.

2. Assessment of neurologic, musculoskeletal and cardiovascular system.

3. Determining impairment and disability.

4. Data gathering and interpreting of psychosocial and vocational factors.

5. Performance of electromyography, nerve conduction and somatosensory evoked potential studies. Each resident must perform 200 electrodiagnostic consultations under appropriate supervision.

6. Physiatric injection techniques.

7. Prescriptions for orthotics, prosthetics, wheelchairs and ambulatory devices, special beds and other assistive devices.

8. Written prescriptions for and appropriate supervision of therapeutic modalities.

9. Testing and treatment provided by physical therapists, occupational therapists, speech-language pathologists and the understanding and coordination of psychological and vocational interventions and tests.

10. The use, safety, calibration and maintenance of medical equipment common to various therapies.

11. A formal experience in the evaluation and rehabilitation of cardiovascular and pulmonary systems as related to physiatric practice.

12. Analysis of growth and development, relating to the rehabilitation of children.

13. Collaboration with other medical professionals and members of the allied health team.
including management techniques consistent with resident’s leadership role.

E. Clinical curriculum must provide the resident with opportunities for progressive responsibility in diagnosing, assessing and managing the conditions commonly encountered by the physiatrist including:

1. Acute musculoskeletal pain syndrome, including sports and occupational injuries.
2. Chronic pain management.
3. Congenital or acquired myopathies, peripheral neuropathies and motor system diseases.
5. Hereditary, developmental and acquired central nervous systems disorders including cerebral palsy, stroke, myelomeningocele and multiple sclerosis.
7. Amputations of both congenital and acquired conditions in patients of all ages.
8. Sexual dysfunction common to the physically impaired.
10. Pulmonary, cardiac, oncologic and other common medical conditions seen in patients with physical disabilities.
11. Diseases, impairments with functional limitations seen in the geriatric population, especially the frail elderly.
12. Rheumatologic disorders
13. Medical conditioning, reconditioning and fitness.
14. Palpatory diagnosis of somatic dysfunction and appropriate use of OMT.
15. Daily rounds on inpatients must be made by residents with faculty at least five (5) times per week.

F. The curriculum must include adequate and systematic training in basic sciences relevant to rehabilitation such as:

1. Anatomy
2. Physiology
3. Pathology and pathophysiology of the neuromuscular, cardiovascular and pulmonary systems
4. Kinesiology
5. Functional Anatomy
6. Physics
7. Electronics
8. Statistics
9. Computer literacy and instrumentation related to the field
10. Physiologic responses to the various physical modalities
11. Therapeutic Exercise

12. Procedures commonly employed by physiatrists must be correlated with clinical training but must include basic science faculty when appropriate. An accessible anatomy laboratory for discussion is highly desirable.

13. Residents must also receive training in administration, unit management, cost containment, quality improvement, ethics and teaching.

G. Educational Policies

1. Residents must participate in structured supervised research training.

ARTICLE VI – PROGRAM DIRECTOR / FACULTY

A. Program Director

1. The program director must be certified in Physical Medicine and Rehabilitation by the AOA, through the American Osteopathic Board of Physical Medicine & Rehabilitation.

3. The program director shall be required to submit quarterly program reports to the director of medical education. Annual reports shall be submitted to the AOCPMR.

B. Faculty and Staff

1. There must be one (1) full time equivalent physiatric faculty member for every two (2) residents.

2. Faculty must be board eligible or certified by the American Osteopathic Board of Physical Medicine & Rehabilitation. Non-Physiatric medical faculty must be appropriately.

3. Teachers must participate regularly and systematically in the training program, both clinical and didactic, and must be available for consultations to the resident and immediately available during crisis in clinical care. Part time faculty must have specific regular teaching responsibilities.

4. Faculty will set examples for residents and must make scholarly contributions, provide quality clinical care, participate in research and contribute to the professional literature. Teachers must be afforded the opportunity to advance educational methodology skills.

5. Professional staff in nursing, occupational therapy, physical therapy, psychology, rehabilitation nursing, orthotics and prosthetics, social services, speech-language pathology, recreational services and vocational counseling, who are appropriately credentialed must be integrated into the educational experience, didactic and clinical, of the resident.

ARTICLE VII – RESIDENT REQUIREMENTS

A. Applicants for residency training in Physical Medicine and Rehabilitation must:

1. Have successfully completed an AOA-approved Physical Medicine and Rehabilitation preliminary year (OGME-1P) as follows:
   a. Emergency Medicine – one (1) month
   b. Family Medicine or Internal Medicine – one (1) month ((may be met with ½ day per week in FM or IM continuity clinic for no less than 46 weeks.)
   c. General Surgery – one (1) month
   d. General Internal Medicine – two (2) months
   e. Pediatrics – one (1) month
f. OB/GYN or Ambulatory Gynecology – one (1) month

g. Electives – three (3) months

h. Discretion of Program – two (2) months

B. During the training program it the resident must:

1. Submit an annual report to the AOCPMR.

2. Produce one (1) scientific paper suitable for publication and approved by the program director, with recommendation to submit copy to the AOCPMR.

3. Attend the educational portion of all regular staff and departmental meetings and conferences of the institution and other organized meetings and conferences as assigned by the program director.

4. Maintain a record of training activities. Patients under the resident's care shall not be identified other than by diagnosis and associated disability or functional impairment. Educational experience relative to consultations, basic science studies, research, teaching experience and advanced educational courses taken shall also be noted.

5. Attend the annual or mid-year meetings of the AOCPMR, and that the training program budget to cover the nominal cost of any required registration fees.

ARTICLE VIII – EVALUATION

A. The program shall document a formal evaluation process related to the resident’s performance within the program. These documents shall be maintained by the institution and available to evaluators or the AOCPMR on request. Evaluations shall document the resident’s performance as related to the core competencies.

B. The curriculum shall be evaluated annually by faculty and residents as a method for revision and updating of the documents.

C. The program director, with faculty input, shall complete written quarterly evaluations of resident performance. This shall include evaluations from all affiliated training sites and supplemented rotation sites.

D. Evaluations shall be learner-centered, developmental, foster continuous improvement and be based upon educational objectives for each assignment and program activity.

E. Completed evaluations shall be shared with the resident in consultation for improvement. They shall be signed by the program director and resident to document that evaluation and counseling have occurred quarterly as required. Copies of evaluations shall be made available to the resident.

F. The program director shall document that residents requiring remediation, redirection or counseling as a result of the evaluation process must be given feedback and a corrective action plan in a timely manner. There shall be documentation of follow-up evaluations of these residents. The program director shall review these with the core faculty.

G. The resident shall anonymously evaluate faculty on an annual basis.