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American Academy of
Physical Medicine and Rehabilitation

Association of Academic Physiatrists
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October 18, 2018

Pain Medicine Review Committee
Accreditation Council for Graduate Medical Education
401 North Michigan Avenue, Suite 2000
Chicago, IL 60611

Sent via email: an@acgme.org

Dear Pain Medicine Review Committee:

On behalf of the American Academy for Physical Medicine and Rehabilitation (AAPM&R), the American Board of Physical Medicine and Rehabilitation (ABPMR), and the Association of Academic Physiatrists (AAP), we thank you for the opportunity to review and comment on the current Accreditation Council for Graduate Medical Education's (ACGME) Program Requirements for Pain Medicine.

Physiatrists have the distinctive ability to bring together and lead an interdisciplinary care team focused on managing patients' pain and optimizing function. Team care is a fundamental element of physiatric training. Our comprehensive approach is about patient-centered care; it promotes physical, functional, emotional, and psychosocial well-being to enhance function and minimize the use of medications. Representing practicing physiatrists, many of whom are residency and fellowship program directors, faculty members, and resident physicians, we appreciate being the voice for our members and providing input regarding the requirements. After reviewing the document "ACGME Program Requirements for Graduate Medical Education in Pain Medicine (Anesthesiology, Neurology, or Physical Medicine and Rehabilitation)," we have the following comments to share with the ACGME:

- **I.B.1.a) (Moved from I.B.3)** As a reiteration from the letter that was submitted in March of 2017, there are negative implications with only allowing a program in pain medicine to be conducted in an institution and/or its participating sites that sponsor(s) ACGME-accredited residencies in at least two of the following specialties: anesthesiology, physical medicine and rehabilitation, and child neurology/or neurology. This requirement has had a significant negative impact on PM&R-based programs that are not associated with or a part of a multi-residency institution. This requirement is especially egregious given the fact that many other multispecialty fellowships only require a single ACGME accredited residency. If a program meets all the other requirements of a multispecialty pain fellowship, this requirement only serves to unnecessarily restrict the number of fellowships and fellowship slots at a time of recognized shortage of such specialists.

- **I.B.1.b) (Moved from I.B.4)** Again, this is a reiteration from the letter that was submitted in March of 2017, but it must be known there are two major concerns with the requirement that there must be only one ACGME-accredited pain medicine program within a sponsoring institution. By prescribing the specific number of programs that a sponsoring institution can have, the ACGME is both limiting the number of fellows that can be trained in Pain Medicine and creating unintentional bias with regard to who is accepted to these programs.

Limiting the number of pain fellowship programs decreases the number of proficient pain physicians available, thereby restricting patient access to quality care. There is concern that current knowledge about pain management is not being well integrated into medical practice, ultimately creating workforce issues, resulting in a shortage of competent pain care providers.

There has been ongoing discussion about how the one-institution legacy policy negatively impacts many freestanding rehabilitation hospitals/centers that can sponsor pain fellowships and still provide multidisciplinary education. Even though this inequity was mentioned in the March 2017 response, it is being highlighted again because of its the long-term impact. The immediate consequences are already evident, given the need for expansion in pain management because of the opioid epidemic and the proposed Opioid Workforce Act (would expand GME positions by 1,000, which will be reserved for pain and addiction medicine). Physiatrists provide excellent holistic pain care and PM&R should be a part of the national solution to this public health crisis.

Overall, we believe these two core requirements should be unrestrictive and allow for equal unbiased access to host training from both Anesthesiology program sponsorship and PM&R program sponsorship. Anesthesiology programs are often linked to traditional multi-residency institutions whereby PM&R programs are often located in freestanding hospitals without multi-residency co-training but with multidisciplinary faculty and equal, if not enhanced, ability to provide multidisciplinary and holistic pain education. In addition, and in line with ACGME precedent for other multidisciplinary fellowships such as Palliative Care and Sports Medicine, if a multi-residency institution has the resources to offer dual sponsorship and host more than one pain program, the ACGME should not limit this. If an institution chooses to have one program under Physical Medicine and Rehabilitation, and another one under Anesthesiology, then the institution should make that decision.

By imposing restrictions on the provision of excellent education, especially at this critical time in our nation's history when there is a need for a greater numbers of holistically trained pain physicians, access is being limited for many patients in need of care for pain. Implementing changes that remove the restriction on the one-program per institution limitation and that permit PM&R-sponsorship outside of multi-residency institutions will certainly lead to improved patient access, patient care, and increased educational prospects in many institutions by having an equable distribution of these fellowship slots.

- **II.A.3.b and II.B.3.b).(1))** By changing the wording of these requirements, which currently states that the program director and core faculty must be board certified by an ABMS-recognized board, the ACGME is encouraging Pain Medicine programs to be housed exclusively in Anesthesiology departments and run by Anesthesiology departments. There is no evidence these proposed rule changes would improve fellowship training or patient outcomes, and it grants an unfair advantage to one of the participating sponsoring specialties. We strongly recommend the wording remain as it currently is written, to require the program director and core faculty to be board-certified in Pain Medicine and by any primary ABMS board.

In addition to commenting on some of the proposed changes, we recommend addressing two key issues:

- There needs to be more transparency within the pain programs to ensure there is oversight on application and admission processes for each program. We believe an audit should be conducted to show there is an equal opportunity for residents to apply to a pain program, regardless of the specialty sponsoring the fellowship. The audit should also ensure pain programs are utilizing a multidisciplinary faculty, which addresses both fair processes in admission and a comprehensive coverage of the curriculum. The current requirements leave room for potential bias regarding the recruitment of fellows into a program. If residents are being excluded from programs that are outside of their specialty this should be reviewed as it's a restraint of trade that inhibits and discriminates a select group of residents. It is our recommendation:
    - Pain fellowship program core faculty should include pain board certified physicians from at least two of the core specialties of Anesthesiology, Physical Medicine and Rehabilitation and Child Neurology/Neurology.
    - Pain fellowship program recruitment committees should include faculty from the four core educational areas of Anesthesiology, Physical Medicine and Rehabilitation, Child Neurology/Neurology and Psychiatry/Psychology to ensure that fellow candidates are evaluated on their abilities across the entire domain of pain medicine fellowship education and their fit into that multidisciplinary structure.

  It is believed that this approach will improve theses pain programs and the diversity of the graduating fellows.

- We believe there should be a multidisciplinary Review Committee (RC) to review all pain programs on an ongoing basis. This would ensure adherence to requirements for a multidisciplinary core faculty and comprehensive coverage of all components of the curriculum. We believe the review of the programs for meeting requirements in all areas and in multidisciplinary management requires a multidisciplinary RC to ensure equality.

While we applaud the ACGME's efforts in attempting to revise the Program Requirements for Graduate Medical Education in Pain Medicine, we feel there are requirements within the revisions that will continue to negatively impact the field of PM&R as written. Specifically, requirements I.B.1.a), I.B.1.b), II.A.3.b, and II.B.3.b).(1) have led to a larger polarization of specialties and may create perceived bias regarding those who are accepted into the pain programs. Since the overall goal has always been to ensure competence in pain medicine, this is only achievable if there is an opportunity to engage as many eligible physicians as possible in a fair process aligned with other multispecialty-sponsored ACGME fellowships.

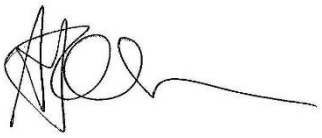
There are limited spaces available to Pain Medicine fellowships, and with how core requirements I.B.1.a) and I.B.1.b) are written, there is potential bias against PM&R specialist accessing these fellowships. We note the performance of PM&R physicians in Pain Medicine certification to be the highest of the participating specialties. We believe this relates to the patient-centered, team-based approach that is foundational to PM&R residency training. Given the potential for bias, the ACGME should carefully reconsider requirements I.B.1.a) and I.B.1.b), since the single program restriction poses a limitation on training, which should not be acceptable, especially given the rising epidemic of pain the United States. As indicated above, excluding qualified residents from any program based on their specialty negatively impacts patient care at a time when more specialists in Pain Medicine are needed. Additionally, the

exclusion of qualified residents is akin to violating antitrust law, which is something we're taking seriously, and we are hopeful no residents are excluded from a program they are qualified to train in.

Again, thank you for the opportunity to comment. We look forward to continuing to work with you and others to enhance the Program Requirements for Graduate Medical Education in Pain Medicine.

Sincerely,

Darryl L. Kaelin, MD, FAAPMR
AAPM&R President



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