

ACGME Sports, ACGME Pain, or Non-ACGME Sports and Spine: Which Is the Ideal Fellowship Training for PM&R Physicians Interested in Musculoskeletal Medicine?

CASE SCENARIO

R.J. is a third-year physical medicine and rehabilitation resident. She has a strong interest in general musculoskeletal medicine, including spine care and interventional procedures. She envisions a practice that is a mixture of acute and chronic musculoskeletal and spine injuries, with the ability to see all age groups, from young patients with acute traumatic injuries to patients with age-related degenerative changes. She plans on doing electromyograms for her own patients as well as interventional procedures in the lumbar spine and peripheral joints by using fluoroscopy and ultrasound. She wants to be a clinician educator at an academic physical medicine and rehabilitation program due to her love of teaching. She plans on going to a fellowship for additional training and possibly certification.

Her coresidents have told her that she will only be able to perform fluoroscopic spine procedures after her fellowship if she completes an Accreditation Council for Graduate Medical Education (ACGME) pain medicine fellowship. She is concerned that there are ACGME requirements for a pain fellowship that she has no interest in, for example, cancer pain. She also does not think that she wants to be a “pain physician.” She likes the idea of an ACGME sports medicine fellowship, but her goals are general musculoskeletal and spine care and not necessarily sideline coverage. She also has been told that sports medicine board certification is essential for an academic job in a physical medicine and rehabilitation department. Several non-ACGME fellowships, some even at academic institutions, do fulfill her educational goals, but she is worried that she may not be able to get a job or even get credentialed to perform interventional procedures after engaging in such a fellowship.

E. Kano Mayer, MD, will argue that a non-ACGME fellowship may better suit her educational desires. Joe Ihm, MD, and Joel Press, MD, will argue that she should do an ACGME sports medicine fellowship. David Sibell, MD, will argue she should consider an ACGME pain fellowship.

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E. Kano Mayer, MD, Responds

[People] will find it very hard to look up to the leaders who are only keeping their ears to the ground.

Sir Winston Churchill

Leadership is lifting a person's vision to high sights, the raising of a person's performance to a higher standard, the building of a personality beyond its normal limitations.

Peter Drucker

Our institution sees 25-30 residents from physical medicine and rehabilitation (PM&R), rheumatology, neurology, and

anesthesia every year with similar questions to R.J.'s. Sadly, through no fault of her own, R.J. will have to make an imperfect choice. This current situation, unfortunately, represents a failure of leadership (as defined in the quotes above) within the specialty societies to match training to market reality. These societies thus have ensured that R.J. will not have a well-trodden path that will meet her goal to be a well-rounded musculoskeletal (MSK) specialist.

To summarize the case, R.J. is trying to acquire a set of specialized skills with a 30+ year history of patient and/or

market demand in virtually all communities across the United States. Moreover, well-respected physiatrists such as Stan Herring, Joel Press, Scott Nadler, Jim Rainville, Jeff Saal, Joel Saal, and others have evolved the same hybrid practice requested by R.J. in this hypothetical case. The combination of MSK-spine specialized care, spinal injections, electromyography, and sports-injury-specific care is a skill set still demanded by the market but unavailable within the Accreditation Council for Graduate Medical Education (ACGME) structure due to the political machinations that have arisen from multiple specialty societies not agreeing on the best interests for the future of their trainees.

A discerning reader will note that both the ACGME sports and ACGME pain fellowships fail to describe a pathway with which R.J. will acquire all of her desired skills for a hybrid MSK and spine practice that includes the following: clinical knowledge, procedural skills, electrodiagnostic acumen, practical teaching skills, and professional mentee relationships. The need for health institutional low-cost labor and professional societies' need to generate operating revenue have combined with fruitless political discourse to create a insidious compromise that serves no long-term interest (and, more specifically, fails to meet R.J.'s training goals and needs). By process of elimination, R.J. may feel the need to either accept a non-ACGME fellowship or matriculate to multiple ACGME fellowships in electromyography, sports medicine, and pain to meet her subspecialized training needs.

The crux of the problem lies in the mythology that R.J.'s coresidents are perpetuating as stated in the second paragraph of the hypothetical case. Given proper training, case collection, and demonstration of competence, R.J. should be able to perform spinal procedures, electrodiagnostic evaluations, sports injury assessment and treatment, and high-quality clinical care at any institution after graduating from a non-ACGME-hybrid fellowship. Sadly, it is true that some smaller institutions engage in inappropriate, cartel-like behavior. These institutions threaten to withhold privileging for spinal procedures without ACGME-accredited pain fellowships. In the face of good mentorship and appropriate case collection, this behavior can be construed as institutional "restraint of trade" to prevent competition. This illegal activity has been litigated in multiple cases and repeatedly has been shown to violate state and federal trade laws. However, this is a hassle that R.J. may not be prepared to endure.

Fellows who undergo training at our institution and other academically based non-ACGME fellowships typically get a more than adequate number of interventional spinal procedures (400-700/y), which allows them to safely practice independently upon graduation. Furthermore, fellows have an opportunity to preform many supervised electrodiagnostic examinations and ultrasound-guided procedures. In addition, fellows have the option of working sidelines at sports games as well as seeing outpatient sports injuries in the acute,

subacute, and chronic phases. The requirements of the ACGME fellowships make obtaining this well-rounded, appropriate, and thorough MSK and spine training almost impossible. The ACGME pain fellowships require months of cancer pain instruction in procedures such as intubations as well as inpatient pain medicine responsibilities. Due to these and other requirements, these fellowships typically do not facilitate strong training in general MKS medicine with or without ultrasound, and seldom or never allow sports medicine sideline coverage. The ACGME sports fellowships typically have difficulty providing fellows with the appropriate numbers and mix of fluoroscopically guided spinal procedures because these procedures essentially fall outside of the scope of the fellowship, which leads some ACGME sports fellows to seek additional training at either a non-ACGME spine fellowship or as a pain fellowship.

The individuals employed by our institution remain strong advocates for the hybrid training sought by R.J. This hybrid "sports and spine" specialization is what has consistently proven a pathway to success in the marketplace and to national society leadership. Past presidents of The American Academy of Physical Medicine and Rehabilitation, International Spinal Injection Society, North American Spine Society, American Academy of Pain Medicine, Association of Academic Physiatrists, and American Society of Interventional Pain Physicians each rose to academic and political prominence through the hybrid-training model that teaches fellows to be comprehensive spine and sports specialists whose goal is always to improve function rather than merely medicate pain. Moreover, in the 10 years since eligibility to take the pain boards was closed to all except graduates of an ACGME fellowship, metrics of quality from the Office of the Inspector General and the Institute of Medicine have shown continued decline. Simultaneous increases in costs, medical utilization, and disability belie the contention that a closure of eligibility for subspecialty boards has led to higher quality. This failure of specialty training to improve quality metrics is demonstrated by a 10-fold increase in the number of opioids prescribed, with increasing harms and/or deaths rising by >10-fold during the same time. There may not be a causal relationship between the restricting of the pain boards and these changes, but it may be time to rethink whether these negative data reflect our highest aspirations as physicians, patient advocates, and healers. It is likely time to increase eligibility for pain boards.

It remains in the best interest of our field to allow the highest level of training for our residents. The current ACGME-imposed structure of artificially dividing the world into pain and sports merely serves to set arbitrary barriers that foster neither excellence nor efficiency. The failure of ACGME to serve the most common technical and skills-based training practiced by most board-certified physiatrists, is slowly destroying an effective and efficient

hybrid model that reflects the training demanded by the marketplace.

My parting advice to R.J. is to use 3 criteria to judge a fellowship: skill acquisition, the ability to practice in your chosen community, and the track record of a fellowship to support its graduates. R.J. should ask former fellows about resources supplied by the fellowship that are value added in the long term for her career. The future of the spine care and MSK medicine field from the perspective of physiatry, anesthesiology, neurology, rheumatology, or family medicine should be aligned. Training residents to deliver low-cost, efficient, value-based care that reduces

disability and maximizes function (not profit) is our ethical duty as stewards to a great professional tradition in medicine.

My parting request for R.J. is that, whatever fellowship she chooses, I hope that she remembers the difficult choice we, her older colleagues, have forced her to make. I hope she will become active in a national society and advocate for change. Hopefully, under her leadership, professional societies will represent the true interests of our residents and younger colleagues. The best thing that can come from this challenging decision is a little fire in R.J.'s belly to advocate for change rather serving an unsavory status quo.

Joe M. Ihm, MD, and Joel M. Press, MD, Response

When trying to choose the ideal fellowship, the key thing to consider is what you want to do the rest of your life professionally. Each type of fellowship has unique qualities that may suit particular needs and can help graduates pursue their ideal career. Pain fellowships prepare trainees primarily by having them treat patients with all types of pain symptoms. Many pain fellowships, if not most, are heavily injection and medication prescription oriented. In these fellowships, the degree of training in other areas (ie, detailed MSK physical examination, exercise prescription, kinesiology, and biomechanics) is variable. ACGME accredited sports fellowships may or may not offer spinal injection training as part of the program, but, compared with a pain fellowship, they may offer more peripheral joint, peritendinous, and bursa injections. In these programs, the emphasis is on treating all aspects of diseases and injuries in athletes and active individuals. Even among ACGME sports medicine fellowships, there is variability in the relative strength of specific areas of training (ie, sports coverage and general medical issues in the athlete versus MSK injury evaluation and treatment with the use of injections). Although non-ACGME-accredited fellowships may be just as rigorous, they are not required to be. Thus, the quality and skills learned in these fellowships are even more variable because formal oversight is less or absent, and there are no universal requirements that all of these fellowships must meet.

The major concerns for graduating residents interested in completing an MSK fellowship in PM&R seems to come down to a few main issues: (1) whether or not to complete an ACGME-accredited fellowship, (2) a desire or the importance of obtaining subspecialty board certification in pain or sports medicine, (3) what skills the resident wants to learn during the fellowship, and (4) whether or not the job after fellowship requires subspecialty board certification or that the fellow completes an ACGME-accredited fellowship. With these issues come more specific questions. Will I be trained to do injections (spine, soft tissue, peripheral joints) with and/or without image guidance? Can I see sports patients after

completing a physiatric MSK fellowship, ACGME or non-ACGME accredited, without being subspecialty boarded in sports medicine? Will I be allowed to do spinal injections without subspecialty board certification in pain? Will I be able to practice at an academic institution if I did not complete an ACGME-accredited fellowship? In the following paragraphs, we will try to provide answers to these questions as they pertain to completing an ACGME-accredited sports medicine fellowship.

The advantages of attending an ACGME-accredited fellowship, pain or sports medicine, are numerous. ACGME accreditation significantly raises the bar about what is required to be taught and what skills need to be obtained. ACGME fellowships are routinely reviewed by the ACGME to maintain accreditation. In the near future, even more routine documentation will have to be communicated to the ACGME by demonstrating achievement of milestones and completion of a quality-improvement project to maintain accreditation. This does not mean that all fellowships meet these requirements equally or that a non-ACGME-accredited fellowship does not aspire to and actually meet or exceed those standards. It does mean that there are mandatory requirements for accreditation with associated penalties if these are not met. The changes that have occurred in our fellowship program in transitioning from a long-standing non-ACGME-accredited MSK PM&R fellowship to an ACGME-accredited sports medicine fellowship have definitely enhanced the fellowship.

Besides the advantage of a high bar of required teaching and instruction provided to the fellow, ACGME accreditation does lend some advantage to fellows interested in careers in academic centers. By definition, ACGME-accredited fellowships are required to have at least 2 sports medicine-boarded physicians actively involved in teaching. Multiple active faculty members facilitate fellow networking for jobs and/or to provide the fellow with connections to get involved in our specialty on a national level.

The significant efforts required to obtain and maintain ACGME accreditation in sports medicine have clear and major benefits to the fellow. The fellow's required curriculum is extensive and covers many aspects of caring for the athlete and the active individual. All sports medicine fellows are required to complete a scholarly activity, which may further enhance the fellow's knowledge base on a specific topic. The fellow must also provide medical coverage for both a mass participation sporting event (eg, a marathon) and for team coverage, and understand the respective role of the medical director and the team physician. Although the fellow's exposure to spinal injections may be variable, the fellow should, and most likely will, get extensive exposure to peripheral joint and soft tissue injections. To maintain accreditation, 75% of fellows who graduate from an ACGME-accredited fellowship must take and pass the subspecialty sports medicine board examination on the first attempt. This is significant considering the pass rates for first-time examinees for the sports medicine board examination in 2012 were 73% for the summer and 58% for the winter periods [1]. Through informal communication among the sports medicine fellowship directors most, if not all, of fellows who have graduated from an ACGME-accredited sports fellowship have taken and passed the subspecialty board examination on the first attempt. Much of the reason for the low pass rate may be related to individuals who have taken the examination without completing an accredited sports medicine fellowship. After 2013, only those completing an accredited fellowship will be able to take the subspecialty board examination.

The sports medicine subspecialty board certification may be required to obtain certain jobs. However, many jobs in MSK physiatry, including those that involve evaluation and treatment of individuals who have athletic injuries, may require the physician to be fellowship trained but may not necessarily require a Sports Medicine Board certification. The subspecialty board certification is required to become a sports fellowship program director of an ACGME-accredited sports medicine fellowship. Other than this specific job, it is unclear at this time what a sports medicine subspecialty board certification means in relation to any given job. The ACGME Web site contains the ACGME Program Requirements for Graduate Medical Education in Sports Medicine and in Pain Medicine [2,3]. These documents outline, in detail, what the fellow should experience during the fellowship. If you are familiar with the requirements, then you can ask pointed questions of both the accredited and nonaccredited fellowships to see if the experience you expect is what is being delivered.

Although there are clear advantages to completing an ACGME-accredited fellowship, there are disadvantages as well. Although it is notable that there are rigorous standards for a fellowship to achieve and maintain accreditation, the educational experiences of the fellow require a number of mandatory objectives. In the case of sports medicine fellow-

ships, a certain population of patients needs to be seen, and 60% of patients who are seen need to have a diagnosis that is related to a sports injury. Although some of the current PM&R sports fellowships offer spinal injections, not all do, and the fellow should not expect to achieve competency in spinal injections unless the program clearly states that this will occur. When applying to accredited sports medicine fellowships or nonaccredited MSK fellowships, a resident who is interested in gaining spinal injection competency should clarify exactly what skills will be attained during the fellowship. Also, the applicant should consider where he or she would like to work after the fellowship, which may help guide what is needed to obtain a job there and perform these injections. Fellows from our program and some other programs are performing fluoroscopically guided spinal injections at academic institutions, and they did not have any major difficulties with obtaining a job that would allow them to do so. Some institutions, however, may require completion of an accredited pain fellowship to perform injections after the fellowship. Although it has not been completely determined how many spinal injections allow someone to be competent in these procedures, a fellow would likely perform more spinal injections in an ACGME-accredited pain fellowship compared with an accredited sports medicine fellowship. The requirements for the advanced procedural track in an ACGME-accredited pain medicine fellowship states that the fellows must perform 15 cervical and 25 lumbar image-guided spinal injections [2]. This can easily be achieved in any fellowship, but some have argued (rightly so) that these numbers are too low to achieve competence [4]. With regard to obtaining reimbursement from insurance companies after performing a spinal injection, there is no evidence to date that a physician who does not have a pain board certification or has not completed an ACGME-accredited pain fellowship will have difficulty in obtaining payment from an insurance provider. Another disadvantage of completing an accredited fellowship is that the fellow generally has the status of a postgraduate year 5 resident, which means that the fellow cannot evaluate patients in the clinic without supervision. The ACGME requires that the fellow be given gradually more responsibility during the fellowship year, but this is not the same as managing patients independently in one's own clinic.

In the end, fellowship choice is a personal decision. Each type of fellowship will teach certain skills and has its advantages and disadvantages. If you want detailed experience with sports and MSK injuries in an active population and/or would like to be subspecialty boarded in sports medicine, then an ACGME-accredited sports medicine fellowship is for you. If you are looking for a fellowship heavily focused on management of multiple types of pain with extensive interventional experience and/or would like to be subspecialty boarded in pain, then an ACGME-accredited pain fellowship is for you. If you know a non-ACGME-accredited fellowship that gives you the skills and experience you want, and you are not

planning to pursue subspecialty board certification, then this type of fellowship is for you. Whatever you choose, make an attempt to understand why each fellowship type is or is not appropriate for you.

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David M. Sibell, MD, Responses

R.J. has many choices to make as she progresses through her postgraduate training, including what type of postresidency education she wishes to pursue. However, before she answers those questions, she has to ask herself, “What sort of physician do I want to be?” The fact is that, in pain medicine, pretty much any purveyor of medical or quasi-medical services may hang a shingle and tell the world he or she is a specialist. In academic pain medicine, we have long faced this challenge: if we make the rigors of training too onerous, or a poor fit to the market, would-be specialists will skip the training we value and enter the community anyway. Neurosurgeons and oncologists do not face this sort of competition. Not too many people would agree to have brain surgery or a bone marrow transplantation from someone who did not complete an ACGME-accredited training program, but plenty of people receive treatment from persons of varying credentials who sell pain management services.

So, what type of physician does R.J. want to be? Someone fully qualified as a consultant in pain medicine? Or perhaps, someone who focuses only on the procedures that she likes to do, regardless of the effect on the patient’s outcome. Or maybe, anywhere in between. In the modern pain medicine landscape, there are practitioners all over that map. The economics of the situation drive these decisions more than anything else. Why would a physician knowingly subject him- or herself to dealing with difficult patients’ needs when he or she can make more money doing 30 epidural steroid injections a day and send the patients “somewhere else” for their noninterventional needs? One reason is that the latter provider may be serving his or her own needs but not those of the patients he or she treats.

Therefore, if the answer to the first question, what type of physician R.J. wants to be, is, “I want to serve my future patients’ needs as best I can,” that is going to take some training. If it is, “I want to do as many procedures as possible and not have to deal with the messy side of patient care,” a few weekend courses will suffice. The focus on appropriate training for procedures is only part of the equation and somewhat misleading; knowing how to use the procedures in the context of patient-centered medical care is at least as important as knowing where to put the needle.

This conversation has been rehearsed in countless settings, including the journal *Pain Medicine*, most recently in 2010 [1]. Within the academic pain medicine community, there are wide ranges of practices, from very interventional to noninterventional. However, to meet ACGME accreditation criteria, pain medicine fellowships must include training in comprehensive patient assessment and management. This must include training in the relevant aspects of anesthesiology, neurology, PM&R, and psychiatry. Because treating patients with complex pain symptoms requires depth and breadth of knowledge, there is a required syllabus and a qualifying examination. This training includes interventional pain medicine [2], and it prepares medical practitioners to provide for the care of patients who require interventional pain medicine and to practice in an ethical manner.

Unfortunately, if R.J. elects to be trained in an informal setting, out of context, and by focusing on the high revenue procedural side of medicine, she may appear to be ideally suited to the executives who manage privileges at the surgicenter or hospital where she chooses to work. The financials look very good when the practice is primarily high-volume interventional, at least at first. These executives may not understand the medical education process or may not prioritize the quality of education. Furthermore, there are now many routes through which practitioners may come to be referred to as something that sounds like “board certified.” The American Academy of Pain Management’s Web site states that of its credentialing, “Although the credential gives you additional status in the pain management field, it cannot be used as board certification” [3]. The American Board of Pain Medicine requires that its “Applicants must have satisfactorily completed an ACGME-accredited residency training program that included identifiable training in the specialty of pain medicine” [4]. That could be a complete, prolonged immersion experience or a very topical one, depending on the residency. It is also possible to get some fairly impressive-looking certificates after weekend courses sponsored by medical equipment manufacturers. I am not equating these different types of credentialing, which vary considerably in rigor and requirements, but it is important to recognize 3 concepts on the topic of what accreditation means:

1. There are a variety of ways to obtain different types of certification. Some of these require extensive training and experience; others do not.
2. Executives, and even other physicians, may not know or care about the differences between them.
3. Only one certification is recognized by the American Board of Medical Specialties: that which is accredited by the ACGME.

So, say that R.J. completes training in an ACGME-accredited program, which includes managing patients who have cancer. She does not intend to focus on that population after she finishes, but she cannot know who is going to come through her door once she is in practice. Given her experience, if one of her patients who comes for an epidural steroid injection for sciatica also happens to have metastatic breast cancer or has had a bone marrow transplantation, then she will be more capable of caring for her patient's special needs. She will be aware of how steroids will interact with the immunocompromised state of her patient who had a transplantation and be more aware of what that new pain symptom might represent for her patient with metastatic breast cancer. If she lacks that training, then she may treat these patients as just another epidural steroid injection and miss the opportunity to be a comprehensive and caring physician to her patients. It happens every day with providers who focus too much on the specific treatments with which they are interested, and it results in poor patient care. An inclusive training program prepares specialists to be better physicians, not just better interventionalists.

Granted, there are also disadvantages to entering an ACGME-accredited fellowship. The process of change, of adapting to alterations in the marketplace, is slow. ACGME-accredited programs may not embrace every new procedure that comes on the market as soon as it is available, although some do pioneering research in new procedures. On this count, it should be possible for applicants to select a program that fits their needs. ACGME-accredited programs are only offered in academic medical centers, which may not fit with the geographic needs of some applicants. Furthermore, there are a limited number of positions, and those positions come with prerequisite training requirements and qualifications. That does limit access to training, deliberately.

However, part of being a consultant in pain medicine involves mastery of relevant procedures. Spine interventions have been a critical part of the field of pain medicine since before there was an organized field called pain medicine.

Being an interventionalist and being a pain medicine consultant are mutually inclusive. As a consultant, a physician is able to put an interventional procedure in the appropriate context of the evaluation and management of the patient and provide a continuity of care that patients require. This is expected of surgeons who treat patients with spinal symptoms; if we expect less from ourselves, then we will be a less valuable resource to our patients. As the medical compensation model in the United States moves from primarily fee for service to a more value-based model, physicians who have bet too heavily on cherry picking the high compensation, less entanglement-prone aspects of care may be poorly positioned to deal with the future [5].

When R.J. meets a patient, she is going to have to ask herself another important question. If the question is, "What procedure are you here to have" as opposed to "What care do you need," then she succumbs to the conflict between her financial interests and those that pertain primarily to the patient's welfare. Suddenly, everybody is a candidate for a procedure, whether they need it or not. Although training in an ACGME-accredited fellowship is no guarantee against this, the broad-based education and experience required to complete such training does provide the trainee with many more tools to deal with complex medical scenarios than the training involved in a purely procedural curriculum.

Therefore, if the answer to R.J.'s first question is, "I want to be a physician who has a broad knowledge of pain medicine, including when and how to use interventional care," then I would suggest she matriculate into an ACGME-accredited pain medicine fellowship. I would also encourage her that this is the way to start a career as a safe and effective spine interventionalist.

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E. Kano Mayer, MD, Rebuts

Fundamentally, I agree with my co-contributors Drs Sibel, Ihm, and Press. The goal of subspecialty training and certification is to create physicians who have the intellectual, emotional, and moral strength, and courage to act

ethically, wisely, and professionally in the face of external pressures. Where I disagree with my coauthors is the false dichotomy both essays set forth that state R.J. "has to make choices." Readers will recognize the philosophical contra-

diction in “choosing” between incomplete training in one area or another rather than complete training. If the “choices” were so stark, then we would see better metrics in the literature or with the market accepting what is nothing more than a “political choice” by leadership. One cannot escape metrics from the Centers for Medicare and Medicaid Services, North Carolina, and DEA that show that, during the “academic balkanization” of the MSK-spine and sports field, disability claims increased, cost increased, utilization increased, and deaths owing to prescription misuse and/or overuse increased [1-4].

Whether we apply more rigorous fellowship standards across the board in PM&R, open the pain and sports boards to all, or create a new ACGME subspecialty, one immutable fact remains, what we are doing is not working. For the sake of all the future R.J.s, it is time for our

specialty to recognize our current state in Ben Franklin’s aphorism: “We must hang together, or surely we shall hang separately.”

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Joe M. Ihm, MD, and Joel M. Press, MD, Rebut

We disagree with the notion that R.J. will have to make an imperfect choice as Dr Mayer suggests. Many PM&R-based ACGME sports medicine fellowships are in fact hybrid fellowships that provide much of the training that Dr Mayer describes. In addition to evaluating patients with sports-related injuries in an office setting, the other clinical requirements include the following: participation in preparticipation physical examinations, providing care to a single sports team across a season, planning and implementing a mass-participation event, and having experience working with the community sports medicine network. The only other ACGME mandated clinical time during a sports medicine fellowship is a half day per week spent in the primary specialty area. For PM&R physicians, this half day per week could be spent doing electrodiagnostics or even spinal procedures. Although the ACGME-accredited fellowships have requirements that need to be met, there are clearly opportunities for elective time. This

time, depending on the program, facilitates the ability to gain additional experience in multiple areas, including electromyograms or fluoroscopic- or ultrasound-guided injections. Also, many of the sports fellowships have extensive teaching and academic responsibilities, which will provide the graduate with practical skills for an academic job. We, therefore, still believe that it is possible to obtain all of the desired skills for a “hybrid MSK practice” in an ACGME sports medicine fellowship. As proof, many graduates from our fellowship have taken academic jobs where sports patients are seen, fluoroscopic- and ultrasound-guided injections of the spine and peripheral joints are performed, in addition to electromyograms. Because many fellows obtain the skills they desire to practice in a hybrid MSK practice from the ACGME sports medicine fellowship, it is uncommon for an individual to pursue a second fellowship after a sports medicine fellowship as Dr Mayer suggests.

David M. Sibell, MD, Rebut

Both of my colleagues make excellent points in favor of their positions. The nonaccredited path is as flexible as the learner wants it to be; the ACGME-accredited sports medicine fellowship includes important aspects of clinical care not included in the pain medicine fellowship. Certainly, there currently are practicing physicians who have completed nonaccredited training and who are excellent physicians. Without a doubt, sports medicine is an important and growing field, with many excellent practitioners. Also, it is clearly possible to complete an accredited pain medicine program and practice substandard quality medicine.

Having said that, the nonaccredited track unfortunately has a wide variation in the nature and quality of training. Some of these fellowships are community based with a single mentor and may lack a formal method for assessing safety and proficiency; others are at academic institutions with a multidisciplinary staff of attending physicians and with a strong educational organization. This variability is exactly what the ACGME process and accreditation is meant to reduce.

Adding spinal procedures to a sports medicine program is a more supportable scenario. These programs do have educational standards, and, if there are faculty members who can

provide the necessary education, then this could be included in the competencies and assessments that are already part of that program, in examinations, and in recertification procedures. However, many of these patients require ongoing care. Sports medicine practitioners would thus have to prepare to be longer-term resources to their patients than may often be the case in this field.

There are standards. We may argue about those standards, but having them is essential to providing a consistent quality product. In this case, that product is physicians who will be doing high-risk procedures. We owe it to society to produce physicians who meet standard criteria for safety and effectiveness. However we get there, that is essential to our duty to not harm our patients.

Web Poll Question

For the case scenario presented in this issue, which fellowship option would you suggest?

- a. non-ACGME fellowship
- b. ACGME sports medicine fellowship
- c. ACGME pain fellowship

To cast your vote, visit www.pmrjournal.org

Results of May's Web Poll

For the case scenario presented in Is the Combined Sensory (Robinson) Index Routinely Indicated for All Cases of Suspected Carpal Tunnel Syndrome Undergoing Electrodiagnostic Evaluation? which approach would you recommend?

30% - Full combined sensory index is routinely indicated for all cases of suspected carpal tunnel syndrome.

70% - Full combined sensory index is not needed in all cases of suspected carpal tunnel syndrome.