Physiatrists as Pain Medicine Physicians

Anthony E. Chiodo, MD

Pain management is a fundamental area of importance in the practice of the physical medicine and rehabilitation (PM&R) physician. Whether a result of trauma, disease, congenital disorder, work injury, or sports participation, pain is a symptom that requires attention and management from the physiatrist to meet the fundamental goals of maximization of function and independence. Within the past decade, as pain management has evolved as a recognized subspecialty, physiatrists have struggled to define their position and role within this disparate and sometimes confusing area of medicine. At times, dialogue has been stressful and intense. With calls for better and more humane pain management, more rational control of opioid prescription and evidence-based support for current pain management techniques, the pressures on the field, its physicians, and its representative organizations mount. This editorial is a compilation of my observations during 10 years of private practice and 10 years of academic practice and PM&R community service.

The role of physiatrists in the pain management arena has had a tortuous path during the last 30 years, and the volatility of the current health-care debate suggests that uncertainty will continue. But to be clear, physiatrists are involved and strongly interested in this subspecialty field, as evidenced by the greater than 1000 members already involved in the newly developed American Academy of Physical Medicine and Rehabilitation Pain Council. As the heated discussions through this council's listserv have indicated, there are many issues of intense concern to these practitioners, such as reimbursement for spine interventional procedures, credentialing for such spine procedures, and professional development in our national organization. These concerns are echoed in the many physician and trainee blogs that can be found on the Internet.

Despite the trend of increasing physiatric involvement in formal pain medicine, this is not a new area of interest for physiatrists. The specialty of physical medicine and rehabilitation started in the 1930s with an emphasis on physical medicine and modalities for treating pain and other musculoskeletal conditions. World War II and the 1950s polio epidemic caused shifting of the emphasis of the field, with rehabilitation taking on a much larger role. But regardless of whether one is primarily interested in physical medicine or rehabilitation, issues such as quality of life, community participation, vocational reintegration, and managing pain interference are extremely important to the physiatric approach. Today, there are common threads to musculoskeletal physiatry and neurorehabilitation, including emphasis on reducing the impact of pain on functional outcomes. Whether managing spinal pain or shoulder pain in patients with spinal cord injury, radiculopathies or complex regional pain disorder, phantom limb pain or pain associated with cancer, physiatrists are regularly called upon by their colleagues, including rehabilitation brethren, for expert help.

Spine care has been a natural "fit" for physiatrists, that is, an area with the complexity of multidimensional assessment and treatment of a large number of patients with chronic pain or work-related functional decline. This fit is coupled with the fact that other specialties did not readily embrace spine work and created a vacuum that was easy for physiatrists to fill. There was little competition until physiatrists extended their expertise in peripheral injections and electromyography to the complementary practice of spine interventional procedures. As demand for spine surgeries has lessened and the growth of free-standing pain procedure clinics has increased, the physiatrist has now encountered much competition in the marketplace. And although physiatrists have proven capable of rising to the top with expertise in musculoskeletal medicine, kinesthiology, injection therapy, and team management, the cost has been a shifting of care away from academic centers to private (propri-

A.E.C. Department of Physical Medicine and Rehabilitation, University of Michigan Health Systems, Ann Arbor, MI 48109. Address correspondence to A.E.C.; e-mail: tchiodo@med.umich.edu

Disclosure: nothing to disclose

etary) facilities, thus reducing the investment in the research necessary to provide supporting scientific evidence.

Until the fountain of youth (ie, genetic engineering) is perfected, there is no question that baby boomers and subsequent generations will require pain management/interventional services. In fact, the external pressures on pain physicians—from patients and society as a whole—to aggressively treat pain is high. Industry-touted pharmaceuticals, devices, and procedures encourage patients to seek out the "latest and greatest" tool for treating acute and chronic pain. Yet, there is also a strong message from payers to physicians to move from empiricism to controlled trials or risk increased third-party regulation. One may wonder why the evidence base in pain interventions is so thin, but this may be best explained by the ethical barriers of designing such trials for pain interventional treatments; when in pain, patients generally do not wish to be potentially randomized to a placebo group. In the end, however, patient expectations must be tempered by thorough assessment, sound judgment, available science, and a multidisciplinary approach—the ideal role for the physiatrist.

Historically, pain medicine training programs (fellowships) have not met the needs of musculoskeletal physiatrists interested in the field. Most Accreditation Council for Graduate Medical Education (ACGME)-accredited fellowships are directed by anesthesiology departments with an emphasis on nonspinal interventions and pharmacological training—areas with limited relevance to most physiatrists. The interventional training is an additional certification within the pain fellowship and the exposure to spine procedures is frequently inadequate to train physiatrists interested in musculoskeletal pain management. Even with such training, physiatrists are at a distinct disadvantage when trying to maintain a pain practice in academics or private-practice settings because the field is largely controlled by anesthesiology.

Pain medicine has many different advocates. Some extremists believe that pain is a distinct entity requiring a unique residency training program. This is the same group that supports pain as the fifth vital sign. But pain medicine as a primary specialty has some unique problems. First, pain and pain care are ubiquitous in most existing surgical and nonsurgical specialty areas. Understanding the symptom of pain as it has an impact on patient treatment and outcome is of fundamental importance in patient management, not a distinct ailment that only one type of physician should be managing. Second, it would require an integration of curricula regarding pain medicine techniques and management strategies in a way that has not been accomplished even with the forced multidisciplinary pain management fellowship. Third, most pain physicians are interested in procedures, not the principles or practice of complex multidisciplinary pain management.

A different strategy would lengthen the existing pain fellowships to accommodate the vast amount of material that needs to be covered in an academic fellowship, including the need for individual research. However, the emphasis remains on nonspinal interventions and pharmacology, and not areas such as functional anatomy and biomechanics, manual medicine and therapy techniques, ultrasound and fluoroscopic-guided procedures, and multidisciplinary team management. Although pharmacology is integral to pain management, as a sole strategy it is too limited to be effective, especially true for treating musculoskeletal pain.

Other models of pain medicine training can be considered. For example, the residency curriculum can be modified so that basic interventional procedures are taught at the resident level, reserving fellowship training for advanced skill development. Another option would be to create a musculoskeletal fellowship program that meets the specific needs of the subspecialty of physical medicine and rehabilitation.

The direction to follow might depend of whether pain or other additional certification is likely to be necessary in the future to treat patients with or without interventional procedures. Currently, some academic medical centers require ACGME pain medicine subspecialty board certification. In some of these academic centers, this is done specifically to control the type and numbers of physicians doing procedures. Because current pain certification does not require demonstrated expertise in interventional techniques, some medical centers are basing credentialing on demonstration of training experience indicated in procedure logs and recommendation letters. However, with the increased national scrutiny with emphasis on board certification and subspecialization, and the continued turf battles over the field, I suspect it will be necessary for all physicians doing these procedures to have demonstration of proficiency through some type of certification. Given the consistent standards required for ACGME certification and the high variability of non-ACGME certifying organizations, it would seem that ACGME certification will be the gold standard.

Another critical issue will be measuring competency: who measures it and how is it measured? Developing technical and contextual skills are both important. The expert clinician with limited technical skills is still a valuable team member, a diagnostician who can help to identify pain generators and manage patients while guiding others' interventional technical skills. The expert interventionalist without the clinical (ie, contextual) skills is the much-dreaded "needle jockey." It is from this group that we have seen the abuses in billing and procedure-oriented practices come from, and the group to whom the payers are directing their cost-cutting efforts, with unfortunate consequences to the rest of the pain medicine fraternity. It will also continue to be important to use maintenance of certification and licensing to remediate these skills, and for states and licensing accreditation organizations to develop effective strategies to assure competency and to eliminate from the rolls those who do not meet practice standards.

So, what should be done? First, the field must develop methods for evaluating competency; if we don't do it, it will be done for us. Then, the field must develop means to identify methods for remediation. The critical point then is to have an established method to deal with these persons once identified. This is an area in which medicine has not done well, being overly concerned about being sued for taking away credentials or licensing in the face of such abuses. This problem likely involves a small minority, but our inability to identify and take care of these practitioners is a blight on our intended purpose of protecting the public. If the public cannot trust us to remedy this problem, our existence as viable organizations is in question.

The field of pain medicine is a fundamental one in the general physiatric practice and in the practice of the many physiatrists who have board certification in pain medicine. At this time of rapid change in health care, the field needs continued firm leadership from physiatrists to ensure that our patient and practice needs are met. New educational strategies regarding pain management and interventional procedures must be defined and implementation measured to ensure competency for those completing training programs and seeking certification/maintenance of certification. I implore my colleagues to continue to be engaged with the AAPM&R Pain/Neuromuscular Council and Musculoskeletal Council to work on these areas of importance to all of us. In addition, inform your PM&R colleagues who have strayed to other organizations that their expertise and leadership are needed at AAPM&R as well. Many of these problems are very complex; by working together to create quality education programs, conduct advocacy, and create our future research agenda, we will be working together to decide the best ways to ensure quality education, competency, and professional development in the area of physiatric pain medicine.