

November 21, 2019

Oregon Health Authority
Public Health Division
Attn: Brittany Hall, Administrative Rules Coordinator
800 NE Oregon Street
Suite 930
Portland, OR 97232

via Email: PublicHealth.Rules@state.or.us

Re: Prerequisite Training for the Performance of Spine Interventions

To Whom It May Concern:

Representatives of 10 medical specialty societies, comprising physicians who utilize and/or perform interventional spine procedures to accurately diagnose and treat patients suffering from spine pathologies, have convened to review and comment on the Oregon Health Authority's Public Health Division's proposed regulations that would expand opportunities for advanced practice providers to supervise procedures performed under fluoroscopic guidance. We would like to take this opportunity to share the attached *Position Statement on Prerequisite Training for the Performance of Spine Interventions* as well as the American Medical Association's Pain Management Practice Parameter (H-410.950) *Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy*.

Fluoroscopy is used to guide needle placement and ensure target-specific percutaneous delivery of medications and different forms of energy for the purpose of diagnosing and treating spine pain. It is not a distinct imaging modality separate from procedure performance. As such, we ask that you carefully review the attachments in order to appreciate the importance of extensive training to prevent, immediately recognize, and appropriately handle any serious complications that can unfortunately occur during interventional spine procedures. Ensuring that individuals performing or supervising fluoroscopically-guided interventional spine procedures have obtained the requisite training helps protect patients from avoidable clinical complications and poor outcomes.

We hope that this information will assist Oregon in adopting regulations that ensure appropriate training requirements for the performance of fluoroscopically-guided interventional spine procedures. If you have any questions or wish to discuss our comments, please contact Belinda Duszynski, Senior Director of Policy and Practice at the Spine Intervention Society, at bduszynski@SpineIntervention.org.

Sincerely,

American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Society of Anesthesiologists
American Society of Neuroradiology
American Society of Regional Anesthesia and Pain Medicine

American Society of Spine Radiology
North American Neuromodulation Society
North American Spine Society
Society of Interventional Radiology
Spine Intervention Society

Attachments:

1. Spine Intervention Society *Position Statement on Prerequisite Training Requirements for Spine Interventions*
2. American Medical Association Policy H-410.958 *Interventional Pain Management; Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers*
3. Accreditation Council for Graduate Medical Education *Program Requirements for Graduate Medical Education in Pain Medicine*
4. American Society for Anesthesiologists *Statement on Privileging for Chronic Pain Management*
5. American Medical Association Policy H-410.950 *Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy*

**Spine Intervention Society
Position Statement on Prerequisite Training for the
Performance of Spine Interventions**

The Spine Intervention Society is a multi-specialty association of over 2,800 physicians dedicated to the development and promotion of the highest standards for the practice of interventional procedures in the diagnosis and treatment of spine pain. The field of spine intervention involves target specific percutaneous delivery of medications and different forms of energy for the purpose of diagnosing or treating spine pain. Patient safety and treatment effectiveness depend on appropriate patient selection and technical execution of these interventions. Patient selection requires a deep knowledge base in medicine including neurologic, vascular, and musculoskeletal anatomy, as well as physical examination, pathophysiology, medical imaging, and pharmacology. This knowledge base is required to 1) identify indications and contraindications for diagnostic or therapeutic interventions, 2) safely perform the intervention when indicated, 3) conduct and interpret medical imaging in real-time, and 4) rapidly diagnose and manage any complication or adverse event that can occur.

Given the real potential for serious life altering complications such as paralysis and other permanent neurological injury, it is mandatory that healthcare professionals who perform spine interventions have sufficient training to accurately select patients and to safely execute their procedures. Furthermore, these complications must be immediately recognized and evaluated in order to deliver appropriate treatment in a time-frame that may not allow for consultation of a supervising provider or other specialist. We assert that the knowledge necessary to accomplish this in the United States is only acquired by suitable training that is documented by completion of and subsequent board certification from an accredited allopathic or osteopathic medical residency in an ABMS or an AOA accredited specialty whose curriculum encompasses the necessary educational content. This includes the following U.S. specialties or their international equivalents: Anesthesiology, Neurology, Neurosurgery, Orthopedic Surgery, Physical Medicine and Rehabilitation, and Radiology. Additionally, given advances in procedural techniques and medical knowledge, the current standards strongly recommend an additional year of fellowship training in spine interventions to safely and effectively perform these procedures. Collectively this training amounts to thousands of hours of direct hands-on experience. Training that does not meet these minimum requirements is insufficient to support the safe and effective performance of spine interventions, and places patients at greater risk of serious complications or adverse events.

To conclude, we emphasize that our position on this topic is in agreement with the AMA's Policy *H-410.958 Interventional Pain Management; Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers*, the ACGME's *Program Requirements for Graduate Medical Education in Pain Medicine*, and the ASA's *Statement on Privileging for Chronic Pain Management*.

Original statement (adopted September 25, 2006) updated and approved by the Spine Intervention Society on August 27, 2018.

Practice Parameters

Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers H-410.958

Topic: Practice Parameters **Policy Subtopic:** NA

Meeting Type: Annual **Year Last Modified:** 2013

Action: Reaffirmed **Type:** Health Policies

Council & Committees: Board of Trustees



Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that **interventional pain management** of patients suffering from chronic **pain** constitutes the practice of medicine; and (2) will work to ensure that **interventional pain management** is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in **pain management** and palliative care offered by nursing programs and medical schools in order to demonstrate adherence to current standards in **pain management**.

Policy Timeline

Res. 903, I-07 Reaffirmed: BOT Rep. 16, A-13



Accreditation Council for
Graduate Medical Education

**ACGME Program Requirements for
Graduate Medical Education
in Pain Medicine
(Anesthesiology, Child Neurology, Neurology, or Physical Medicine
and Rehabilitation)**

ACGME-approved: February 14, 2006; effective: July 1, 2007

Revised Common Program Requirements effective: July 1, 2007

Revised Common Program Requirements effective: July 1, 2011

Revised Common Program Requirements effective: July 1, 2013

ACGME approved focused revision with categorization: September 29, 2013; effective: July 1, 2014

ACGME approved correction: December 15, 2014

Editorial revision: February 7, 2015

Revised Common Program Requirements effective: July 1, 2015

Revised Common Program Requirements effective: July 1, 2016

At its May 28, 2015 meeting, the Review Committee for Anesthesiology voted to allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A. Thus, Requirements III.A.3. and III.A.4. have been revised.

Revised Common Program Requirements effective: July 1, 2017

ACGME approved focused revision: June 11, 2017; effective: July 1, 2017

ACGME Program Requirements for Graduate Medical Education in Pain Medicine

Common Program Requirements are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Pain medicine is the discipline of medicine that specializes in the management of patients suffering from acute or chronic pain, or pain in patients requiring palliative care. The management of acute and chronic pain syndromes is a complex matter involving many areas of interest and different medical disciplines. Clinical and investigative efforts are vital to the progress of the specialty. Fellows may originate from different disciplines and approach the field with varying backgrounds and experience. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation, and coordination of a multiple modality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team. Therefore, the didactic and clinical curriculum of the pain program must address attainment of these competencies.

Int.C. The educational program in pain medicine must be 12 months in length. ^(Core)

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites. ^(Core)

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. ^(Core)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. ^(Core)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows; ^(Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; ^(Detail)

I.B.1.c) specify the duration and content of the educational experience; and, ^(Detail)

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment. ^(Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). ^(Core)

I.B.3. Only multidisciplinary programs will be accredited. A multidisciplinary program in pain medicine must be conducted in an institution and/or its affiliates that sponsor(s) ACGME-accredited residencies in at least two of the following specialties: anesthesiology, child neurology/neurology, and physical medicine and rehabilitation. ^(Core)

I.B.4. There must be an institutional policy governing the educational resources committed to pain medicine that ensures cooperation of all the involved disciplines. There must be only one ACGME-accredited pain medicine program within a sponsoring institution, and a single multidisciplinary fellowship committee to regularly review the program's resources and its attainment of its stated goals and objectives. ^(Core)

II. Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. ^(Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. ^(Core)

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. ^(Detail)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; ^(Core)

II.A.3.b) current certification in the subspecialty by the American Board of Medical Specialties, or subspecialty qualifications that are acceptable to the Review Committee; ^(Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment; and, ^(Core)

II.A.3.d) subspecialty certification in pain medicine with both certificates recognized by the American Board of Medical Specialties, or qualifications that are acceptable to the sponsoring Review Committee. ^(Core)

II.A.4. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. ^(Core)

The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; ^(Core)

II.A.4.b) approve a local director at each participating site who is accountable for fellow education; ^(Core)

II.A.4.c) approve the selection of program faculty as appropriate; ^(Core)

II.A.4.d) evaluate program faculty; ^(Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; ^(Core)

- II.A.4.f)** monitor fellow supervision at all participating sites; ^(Core)
- II.A.4.g)** prepare and submit all information required and requested by the ACGME; ^(Core)
- II.A.4.g).(1)** This includes but is not limited to the program application forms and annual program fellow updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; ^(Detail)
- II.A.4.i)** provide verification of fellowship education for all fellows, including those who leave the program prior to completion; ^(Detail)
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, ^(Core)
- and, to that end, must:
- II.A.4.j).(1)** distribute these policies and procedures to the fellows and faculty; ^(Detail)
- II.A.4.j).(2)** monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; ^(Core)
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, ^(Detail)
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. ^(Detail)
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; ^(Detail)
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows; ^(Detail)
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; ^(Detail)

- II.A.4.n) obtain review and approval of the sponsoring institution's GMC/DIO before submitting information or requests to the ACGME, including:** ^(Core)
- II.A.4.n).(1) all applications for ACGME accreditation of new programs;** ^(Detail)
- II.A.4.n).(2) changes in fellow complement;** ^(Detail)
- II.A.4.n).(3) major changes in program structure or length of training;** ^(Detail)
- II.A.4.n).(4) progress reports requested by the Review Committee;** ^(Detail)
- II.A.4.n).(5) requests for increases or any change to fellow duty hours;** ^(Detail)
- II.A.4.n).(6) voluntary withdrawals of ACGME-accredited programs;** ^(Detail)
- II.A.4.n).(7) requests for appeal of an adverse action;** ^(Detail)
- II.A.4.n).(8) appeal presentations to a Board of Appeal or the ACGME; and,** ^(Detail)
- II.A.4.n).(9) proposals to ACGME for approval of innovative educational approaches.** ^(Detail)
- II.A.4.o) obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** ^(Detail)
- II.A.4.o).(1) program citations, and/or,** ^(Detail)
- II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.** ^(Detail)
- II.A.4.p) together with the teaching staff, prepare and comply with written goals for the program. All educational components of the program should be related to the program goals. The program design must be approved by the Review Committee as part of the regular review process. A written statement of the educational objectives must be given to each fellow; and,** ^(Detail)
- II.A.4.q) ensure that pain medicine conferences be held regularly.** ^(Detail)
- II.A.4.q).(1) These should include morbidity and mortality conferences, journal reviews, and research seminars.** ^(Detail)

II.A.4.q).(2) There should be active participation in the planning and presentation of these conferences by fellows and faculty members. ^(Detail)

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location. ^(Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of fellows, and, ^(Core)

II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas. ^(Core)

II.B.2. The physician faculty must have current certification in the subspecialty by the American Board of Medical Specialties, or possess qualifications judged acceptable to the Review Committee. ^(Core)

II.B.2.a) Faculty members must also possess subspecialty certification in pain medicine, with both certificates recognized by the American Board of Medical Specialties, and the faculty as a whole must possess expertise across the domains of acute and chronic pain, and pain in patients who require palliative care. At least three faculty members with expertise in pain medicine must be involved in pain medicine subspecialty education, and these must equal at least two FTEs. These numbers include the program director. ^(Core)

II.B.2.b) There must be a ratio of at least one FTE faculty member (salaried or non-salaried) to two fellows. ^(Core)

II.B.2.c) Qualified physicians with specialty expertise from three of the four cooperating disciplines involved in pain medicine must have a continuous and meaningful role in the fellowship. ^(Core)

II.B.2.d) Program faculty members from the disciplines of anesthesiology, child neurology/neurology, physiatry, and psychiatry must be from programs accredited by the ACGME. ^(Core)

II.B.2.d).(1) These faculty members must have qualifications acceptable to the Review Committee. ^(Core)

II.B.2.e) Image/study identification training shall be verified by a faculty member from an ACGME-accredited residency program in child

neurology/neurology, neurological surgery, or radiology, or by a faculty member with qualifications acceptable to the Review Committee. ^(Detail)

II.B.2.f) The faculty must include psychiatrists or clinical psychologists who have documented experience in the evaluation and treatment of patients with chronic pain. ^(Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. ^(Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. ^(Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. ^(Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; ^(Detail)

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; ^(Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, ^(Detail)

II.B.5.b).(4) participation in national committees or educational organizations. ^(Detail)

II.B.5.c) Faculty should encourage and support fellows in scholarly activities. ^(Core)

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. ^(Core)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements. ^(Core)

II.D.1. Space and Equipment

A pain center offering subspecialty education must be located within a hospital/medical office complex, and must be designed specifically for the management of pain patients. Space for research and teaching conferences in pain medicine must be available. Appropriate monitoring and life support equipment must be immediately available wherever invasive pain management procedures are performed. There must be appropriate on-call facilities for all fellows and faculty members. ^(Core)

II.D.2. Support Services

The following functions and support must be available:

- II.D.2.a) appropriate radiologic imaging facilities; ^(Core)
- II.D.2.b) psychiatric/psychological services, including behavioral modification; ^(Core)
- II.D.2.c) physical and/or occupational therapy; ^(Core)
- II.D.2.d) social services; and, ^(Core)
- II.D.2.e) appropriate electrodiagnostic facilities. ^(Core)

II.D.3. Patient Population (Clinical Resources)

There should be, within the patient population, a wide variety of clinical pain problems to allow fellows to develop broad clinical skills and knowledge required for a specialist in pain medicine. The program must be able to provide each fellow with the following clinical experiences: ^(Core)

- II.D.3.a) continuity of care (longitudinal outpatient experience), including managing chronic and cancer pain; ^(Core)
- II.D.3.b) inpatient experience, including managing chronic and cancer pain; ^(Core)
- II.D.3.c) experience managing acute pain; ^(Core)
- II.D.3.d) exposure to interventional pain procedures; and, ^(Core)
- II.D.3.e) a palliative care experience (longitudinal involvement with patients with pain who require palliative care). ^(Core)

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. ^(Detail)

III. Fellow Appointments

III.A. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. ^(Core)

Prior to appointment in the programs, fellows should have completed an ACGME-accredited residency program. ^(Core)

III.A.1. Fellowship programs must receive verification of each entering fellow’s level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. ^(Core)

III.A.2. Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, who does not satisfy the eligibility requirements listed in Sections III.A. and III.A.1., but who does meet all of the following additional qualifications and conditions: ^(Core)**

III.A.2.a) Assessment by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and ^(Core)

III.A.2.b) Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and ^(Core)

III.A.2.c) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; ^(Core)

III.A.2.d) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, ^(Core)

III.A.2.e) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency

based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. ^(Core)

III.A.2.e).(1)

If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. ^(Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.A.3.

The Review Committee for Anesthesiology does allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A. ^(Core)

III.A.4.

The Review Committees for Neurology and Physical Medicine and Rehabilitation do not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A. ^(Core)

III.B.

Number of Fellows

The program's educational resources must be adequate to support the number of fellows appointed to the program. ^(Core)

III.B.1.

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. ^(Core)

III.C.

Fellow Transfers

III.C.1.

Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow. ^(Detail)

III.C.2.

A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who may leave the program prior to completion. ^(Detail)

III.D.

Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows' education. ^(Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. ^(Detail)

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must make available to fellows and faculty; ^(Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form; ^(Core)

IV.A.3. Regularly scheduled didactic sessions; ^(Core)

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and, ^(Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: ^(Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows: ^(Outcome)

IV.A.5.a).(1).(a) must demonstrate the following competencies in neurology: ^(Outcome)

IV.A.5.a).(1).(a).(i) eliciting a directed neurological history; ^(Outcome)

IV.A.5.a).(1).(a).(ii) performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in fifteen patients; and, ^(Outcome)

- IV.A.5.a).(1).(a).(ii).(a) Faculty members must verify this experience in a minimum of five observed patient examinations. ^(Core)
- IV.A.5.a).(1).(a).(iii) identifying significant findings of basic neuro-imaging. ^(Outcome)
- IV.A.5.a).(1).(a).(iii).(a) Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computerized tomography (CT) of the spine and brain on a minimum of 15 CT and/or MRI studies. ^(Core)
- IV.A.5.a).(1).(a).(iii).(b) Neuro-imaging studies must be drawn from the following areas: brain, cervical, thoracic, and lumbar spine. ^(Core)
- IV.A.5.a).(1).(b) must demonstrate the following competencies in physical medicine and rehabilitation: ^(Outcome)
- IV.A.5.a).(1).(b).(i) performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain problems; ^(Outcome)
- IV.A.5.a).(1).(b).(i).(a) Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients. ^(Core)
- IV.A.5.a).(1).(b).(ii) developing rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; and, ^(Outcome)
- IV.A.5.a).(1).(b).(ii).(a) Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of five patients. ^(Core)
- IV.A.5.a).(1).(b).(iii) integrating therapeutic modalities and surgical intervention in the treatment algorithm. ^(Outcome)
- IV.A.5.a).(1).(c) must demonstrate the following competencies in psychiatry: ^(Outcome)

IV.A.5.a).(1).(c).(i)	carrying out a complete psychiatric history with special attention to psychiatric and pain comorbidities; (Outcome)
IV.A.5.a).(1).(c).(ii)	conducting a complete mental status examination; and, (Outcome)
IV.A.5.a).(1).(c).(ii).(a)	A complete mental status examination must be conducted on a minimum of 15 patients. (Core)
IV.A.5.a).(1).(c).(ii).(b)	Each fellow must demonstrate this ability in five patients to a faculty observer. (Core)
IV.A.5.a).(1).(c).(iii)	explaining psychosocial therapy to a patient and making a referral when indicated. (Outcome)
IV.A.5.a).(2)	Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows: (Outcome)
IV.A.5.a).(2).(a)	must demonstrate the following competencies in anesthesiology: (Outcome)
IV.A.5.a).(2).(a).(i)	obtaining intravenous access; (Outcome)
IV.A.5.a).(2).(a).(i).(a)	Intravenous access must be obtained in a minimum of 15 patients (Core)
IV.A.5.a).(2).(a).(ii)	basic airway management; (Outcome)
IV.A.5.a).(2).(a).(ii).(a)	This must include a minimum of mask ventilation in 15 patients; (Core)
IV.A.5.a).(2).(a).(iii)	endotracheal intubation; (Outcome)
IV.A.5.a).(2).(a).(iii).(a)	Endotracheal intubation must be performed on 15 patients. (Core)
IV.A.5.a).(2).(a).(iv)	basic life support and advanced cardiac life support; (Outcome)
IV.A.5.a).(2).(a).(v)	management of sedation; and, (Outcome)

- IV.A.5.a).(2).(a).(v).(a) This must include direct administration of sedation to a minimum of 15 patients. ^(Core)
- IV.A.5.a).(2).(a).(vi) administration of neuraxial analgesia, including placement thoracic or lumbar epidural injections using an interlaminar technique. ^(Outcome)
- IV.A.5.a).(2).(a).(vi).(a) A minimum of 15 thoracic or lumbar epidural injections using an interlaminar technique must be completed. ^(Core)

IV.A.5.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows: ^(Outcome)

must demonstrate knowledge of the following areas through a formal structured didactic program, including: ^(Outcome)

- IV.A.5.b).(1) assessment of pain; ^(Outcome)
- IV.A.5.b).(1).(a) anatomy, physiology and pharmacology of pain transmission and modulation; ^(Outcome)
- IV.A.5.b).(1).(b) natural history of various musculoskeletal pain disorders; ^(Outcome)
- IV.A.5.b).(1).(c) general principles of pain evaluation and management including neurological exam, musculoskeletal exam, psychological assessment; ^(Outcome)
- IV.A.5.b).(1).(d) indicators and interpretation of electro-diagnostic studies: X-Rays, MRI, CT, and clinical nerve function studies; ^(Outcome)
- IV.A.5.b).(1).(e) pain measurement in humans, both experimental and clinical; ^(Outcome)
- IV.A.5.b).(1).(f) psychosocial aspects of pain, including cultural and cross-cultural considerations; ^(Outcome)
- IV.A.5.b).(1).(g) taxonomy of pain syndromes; ^(Outcome)

IV.A.5.b).(1).(h)	pain of spinal origin, including radicular pain, zygapophysial joint disease, and discogenic pain; (Outcome)
IV.A.5.b).(1).(i)	myofascial pain; (Outcome)
IV.A.5.b).(1).(j)	neuropathic pain; (Outcome)
IV.A.5.b).(1).(k)	headache and orofacial pain; (Outcome)
IV.A.5.b).(1).(l)	rheumatological aspects of pain; (Outcome)
IV.A.5.b).(1).(m)	complex regional pain syndromes; (Outcome)
IV.A.5.b).(1).(n)	visceral pain; (Outcome)
IV.A.5.b).(1).(o)	urogenital pain; (Outcome)
IV.A.5.b).(1).(p)	cancer pain, including palliative and hospice care; (Outcome)
IV.A.5.b).(1).(q)	acute pain; (Outcome)
IV.A.5.b).(1).(r)	frequent psychiatric and pain co-morbidities, which include substance-related mood, anxiety, somatoform, factitious, and personality disorders; (Outcome)
IV.A.5.b).(1).(s)	the effects of pain medications on mental status; (Outcome)
IV.A.5.b).(1).(t)	assessment of pain in special populations, including patients with ongoing substance abuse, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired; and, (Outcome)
IV.A.5.b).(1).(u)	functional and disability assessment. (Outcome)
IV.A.5.b).(2)	treatment of pain; (Outcome)
IV.A.5.b).(2).(a)	Drug Treatment I: opioids; (Outcome)
IV.A.5.b).(2).(b)	Drug Treatment II: antipyretic analgesics; (Outcome)
IV.A.5.b).(2).(c)	Drug Treatment III: antidepressants, anticonvulsants, and miscellaneous drugs; (Outcome)
IV.A.5.b).(2).(d)	psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy,

	psychosocial therapies and treatment of psychiatric illness; (Outcome)
IV.A.5.b).(2).(e)	prescription drug detoxification concepts; (Outcome)
IV.A.5.b).(2).(f)	functional and vocational rehabilitation; (Outcome)
IV.A.5.b).(2).(g)	surgical approaches; (Outcome)
IV.A.5.b).(2).(h)	complementary and alternative treatments in pain management; (Outcome)
IV.A.5.b).(2).(i)	treatments that comprise multidisciplinary cancer pain care; (Outcome)
IV.A.5.b).(2).(j)	strategies to integrate pain management into the treatment model; (Outcome)
IV.A.5.b).(2).(k)	hospice and multidimensional treatments that comprise palliative care; and, (Outcome)
IV.A.5.b).(2).(l)	treatment of pain in pediatric patients. (Outcome)
IV.A.5.b).(3)	general topics, research, and ethics; including: (Outcomes)
IV.A.5.b).(3).(a)	epidemiology of pain; (Outcome)
IV.A.5.b).(3).(b)	gender issues in pain; (Outcome)
IV.A.5.b).(3).(c)	placebo response; (Outcome)
IV.A.5.b).(3).(d)	multidisciplinary pain medicine; (Outcome)
IV.A.5.b).(3).(e)	organization and management of a pain center; (Outcome)
IV.A.5.b).(3).(f)	Continuing Quality Improvement, Utilization Review, and Program Evaluation; (Outcome)
IV.A.5.b).(3).(g)	patient and provider safety; (Outcome)
IV.A.5.b).(3).(h)	designing, reporting, and interpreting clinical trials of treatment for pain; (Outcome)
IV.A.5.b).(3).(i)	ethical standards in pain management and research; and, (Outcome)
IV.A.5.b).(3).(j)	animal models of pain, ethics of animal experimentation. (Outcome)
IV.A.5.b).(4)	interventional pain treatment, including; (Outcome)

- IV.A.5.b).(4).(a) selection criteria for a broad range of interventions and an understanding of the risks and potential advantages of these interventions; (Outcome)
- IV.A.5.b).(4).(b) airway management skills; (Outcome)
- IV.A.5.b).(4).(c) sedation/analgesia; (Outcome)
- IV.A.5.b).(4).(d) fluoroscopic imaging and radiation safety; (Outcome)
- IV.A.5.b).(4).(e) pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and steroid preparations; (Outcome)
- IV.A.5.b).(4).(e).(i) This must include treatment of local anesthetic systemic toxicity. (Outcome)
- IV.A.5.b).(4).(f) trigger point injections; (Outcome)
- IV.A.5.b).(4).(g) peripheral and cranial nerve blocks and ablation; (Outcome)
- IV.A.5.b).(4).(h) spinal injections including epidural injections: interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections; (Outcome)
- IV.A.5.b).(4).(i) discography and intradiscal/percutaneous disc treatments; (Outcome)
- IV.A.5.b).(4).(j) joint and bursal injections, including sacroiliac, hip, knee, and shoulder joint injections; (Outcome)
- IV.A.5.b).(4).(k) sympathetic ganglion blocks; (Outcome)
- IV.A.5.b).(4).(l) epidural and intrathecal medication management; (Outcome)
- IV.A.5.b).(4).(m) spinal cord stimulation; and, (Outcome)
- IV.A.5.b).(4).(n) intrathecal drug administration systems. (Outcome)

IV.A.5.c)

Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

(Outcome)

Fellows are expected to develop skills and habits to be able to meet the following goals:

- IV.A.5.c).(1)** identify strengths, deficiencies, and limits in one's knowledge and expertise; ^(Outcome)
- IV.A.5.c).(2)** set learning and improvement goals; ^(Outcome)
- IV.A.5.c).(3)** identify and perform appropriate learning activities; ^(Outcome)
- IV.A.5.c).(4)** systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; ^(Outcome)
- IV.A.5.c).(5)** incorporate formative evaluation feedback into daily practice; ^(Outcome)
- IV.A.5.c).(6)** locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; ^(Outcome)
- IV.A.5.c).(7)** use information technology to optimize learning; and, ^(Outcome)
- IV.A.5.c).(8)** participate in the education of patients, families, students, fellows and other health professionals. ^(Outcome)

IV.A.5.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. ^(Outcome)

Fellows are expected to:

- IV.A.5.d).(1)** communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; ^(Outcome)
- IV.A.5.d).(2)** communicate effectively with physicians, other health professionals, and health related agencies; ^(Outcome)
- IV.A.5.d).(3)** work effectively as a member or leader of a health care team or other professional group; ^(Outcome)
- IV.A.5.d).(4)** act in a consultative role to other physicians and health professionals; and, ^(Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

IV.A.5.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Fellows are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; and, (Outcome)

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

IV.A.5.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Fellows are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality; and,** ^(Outcome)

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions.** ^(Outcome)

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) Each fellow must have a distinct clinical experience in each of the of the four cooperating disciplines involved in pain medicine (anesthesiology, child neurology/neurology, physical medicine and rehabilitation and psychiatry), with the exception of the fellow's primary discipline. ^(Core)

IV.A.6.b) Fellows must have education in specific areas of pain medicine practice, and many of these experiences will be undertaken in parallel. These experiences must include: ^(Core)

IV.A.6.b).(1) Outpatient (Continuity Clinic) Pain Experience; ^(Core)

IV.A.6.b).(1).(a) Continuity experience will provide the fellow with supervised experience in the ongoing management of a diverse population of patients with chronic pain, including cancer pain. The experience allows interaction with other specialists in a multidisciplinary model of chronic pain management. To this end, the pain medicine fellow should attend a supervised outpatient clinic, approximately weekly, throughout the year of the program. Fellows may be absent from continuity clinic experience only if the rotation site is more than one hour from the core institution. The maximum allowable time away may be no more than four months. This will provide a minimum of eight months experience (full-time equivalent of at least 60 half-days). ^(Detail)

IV.A.6.b).(1).(b) Primary responsibility for 50 different patients followed over at least two months each should be documented. ^(Detail)

IV.A.6.b).(2) Inpatient Chronic Pain Experience; ^(Core)

IV.A.6.b).(2).(a) Inpatient chronic pain experience should be supervised on a pain team responsible for the assessment and management of inpatients with chronic pain including cancer pain. Patients should be seen through either a consultation team or while on a designated inpatient pain medicine service. ^(Detail)

- IV.A.6.b).(2).(b) To establish this experience, the fellow should document involvement with a minimum of 15 new patients assessed in this setting. ^(Detail)
- IV.A.6.b).(3) Acute Pain Inpatient Experience; ^(Core)
- IV.A.6.b).(3).(a) Acute pain inpatient experience should be supervised in the assessment and management of inpatients with acute pain. ^(Detail)
- IV.A.6.b).(3).(b) To establish this experience, the fellow should document involvement with a minimum of 50 new patients. ^(Detail)
- IV.A.6.b).(4) Interventional Experience; ^(Core)
- IV.A.6.b).(4).(a) The ACGME recognizes that interventional pain medicine is an evolving discipline. Programs shall not be required to offer all techniques to their trainees. However, the program director of an ACGME-accredited Pain Medicine Training Program must demonstrate that fellows are exposed to a didactic curriculum that includes topics in Interventional Pain Treatment (see *Medical Knowledge*), and that fellows receive direct, hands-on experience with a range of interventional pain treatment techniques. At the conclusion of the training period, the program director must prepare a final report for each fellow that clearly documents the specific interventional techniques with which fellows demonstrate competence. ^(Core)
- IV.A.6.b).(4).(b) To establish this experience, the fellow must document involvement with a minimum of 60 patients who undergo interventional procedures in the following categories: ^(Core)
- IV.A.6.b).(4).(b).(i) at least 25 image-guided spinal intervention; ^(Detail)
- IV.A.6.b).(4).(b).(ii) at least 10 trigger point injection; ^(Detail)
- IV.A.6.b).(4).(b).(iii) at least 10 neuroablative procedures; ^(Detail)
- IV.A.6.b).(4).(b).(iv) at least five joint and bursa injections; ^(Detail)
- IV.A.6.b).(4).(b).(v) at least five neuromodulation; and, ^(Detail)
- IV.A.6.b).(4).(b).(vi) at least five nerve blocks, including a variety of blocks such as intercostal blocks,

ilioinguinal blocks, genitofemoral blocks,
and lateral femoral cutaneous blocks. ^(Detail)

IV.A.6.b).(5) Cancer Pain; ^(Core)

IV.A.6.b).(5).(a) Cancer pain experience should be a supervised, longitudinal experience in an ambulatory or inpatient population that requires care for cancer pain, and may be integrated with continuity or inpatient experiences. The objectives should include: ^(Detail)

IV.A.6.b).(5).(a).(i) The fellow must document longitudinal involvement with a minimum of 20 patients. ^(Detail)

IV.A.6.b).(6) Palliative Care Experience; and, ^(Core)

IV.A.6.b).(6).(a) Palliative care should be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care. It may be integrated with continuity experience or inpatient experience. ^(Detail)

IV.A.6.b).(6).(b) To establish this experience, the fellow must document longitudinal involvement with a minimum of 10 patients who require palliative care. ^(Core)

IV.A.6.b).(7) Pediatric Experience. ^(Core)

IV.A.6.b).(7).(a) Experience with the assessment and treatment of pain in children is strongly encouraged. ^(Detail)

IV.B. Fellows' Scholarly Activities

IV.B.1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. ^(Core)

IV.B.2. Fellows should participate in scholarly activity. ^(Core)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities. ^(Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. ^(Core)

- V.A.1.a)** At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)
- V.A.1.a).(1)** The program director may appoint additional members of the Clinical Competency Committee.
- V.A.1.a).(1).(a)** These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows in patient care and other health care settings. ^(Core)
- V.A.1.a).(1).(b)** Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. ^(Core)
- V.A.1.b)** There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)
- V.A.1.b).(1)** The Clinical Competency Committee should:
- V.A.1.b).(1).(a)** review all resident evaluations semi-annually; ^(Core)
- V.A.1.b).(1).(b)** prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, ^(Core)
- V.A.1.b).(1).(c)** advise the program director regarding resident progress, including promotion, remediation, and dismissal. ^(Detail)
- V.A.2.** **Formative Evaluation**
- V.A.2.a)** The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. ^(Core)
- V.A.2.b)** The program must:
- V.A.2.b).(1)** provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; ^(Core)

- V.A.2.b).(2)** use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); ^(Detail)
- V.A.2.b).(3)** document progressive fellow performance improvement appropriate to educational level; and, ^(Core)
- V.A.2.b).(4)** provide each fellow with documented semiannual evaluation of performance with feedback. ^(Core)
- V.A.2.c)** **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.** ^(Detail)
- V.A.2.c).(1)** These should include evaluations of attitude, interpersonal relationship skills, fund of knowledge, manual skills, decision-making skills, and critical analysis of clinical situations. ^(Detail)
- V.A.2.c).(2)** Fellows must obtain overall satisfactory evaluations at completion of 12 months of education to receive credit for the program. ^(Detail)
- V.A.2.d)** Periodic evaluation of patient care (quality assurance) is mandatory. ^(Detail)
- V.A.2.e)** Subspecialty fellows in pain medicine should be involved in continuous quality improvement, utilization review, and risk management. ^(Detail)
- V.A.3. Summative Evaluation**
- V.A.3.a)** **The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program.** ^(Core)
- V.A.3.b)** **The program director must provide a summative evaluation for each fellow upon completion of the program.** ^(Core)
- This evaluation must:**
- V.A.3.b).(1)** **become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy;** ^(Detail)
- V.A.3.b).(2)** **document the fellow's performance during the final period of education;** ^(Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision; and, ^(Detail)

V.A.3.b).(4) clearly document the specific interventional techniques with which each fellow demonstrates competence. ^(Core)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. ^(Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the fellows. ^(Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; ^(Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, ^(Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. ^(Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. ^(Core)

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; ^(Core)

V.C.2.b) faculty development; ^(Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; ^(Core)

V.C.2.d) program quality; and, ^(Core)

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and ^(Detail)

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. ^(Detail)

V.C.2.e) progress on the previous year's action plan(s). ^(Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)

VI. The Learning and Working Environment

Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- ***Excellence in the safety and quality of care rendered to patients by fellows today***
- ***Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice***
- ***Excellence in professionalism through faculty modeling of:***
 - ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***
 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***

- ***Commitment to the well-being of the students, residents/fellows, faculty members, and all members of the health care team***

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

**VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.
(Core)**

**VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care.
(Core)**

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. ^(Core)

VI.A.1.a).(3)

Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a)

Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i)

know their responsibilities in reporting patient safety events at the clinical site; ^(Core)

VI.A.1.a).(3).(a).(ii)

know how to report patient safety events, including near misses, at the clinical site; and, ^(Core)

VI.A.1.a).(3).(a).(iii)

be provided with summary information of their institution's patient safety reports. ^(Core)

VI.A.1.a).(3).(b)

Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. ^(Core)

VI.A.1.a).(4)

Fellow Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.

VI.A.1.a).(4).(a)

All fellows must receive training in how to disclose adverse events to patients and families. ^(Core)

VI.A.1.a).(4).(b) Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^(Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)

VI.A.1.b).(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) Fellows must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)

VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. ^(Detail)

VI.A.2. Supervision and Accountability

VI.A.2.a) *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1)

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.
(Core)

Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient. (Detail)

VI.A.2.a).(1).(a)

This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b)

Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b)

Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.

VI.A.2.b).(1)

The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.c)

Levels of Supervision

To promote oversight of fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1)

Direct Supervision – the supervising physician is physically present with the fellow and patient. (Core)

- VI.A.2.c).(2)** **Indirect Supervision:**
- VI.A.2.c).(2).(a)** **with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)**
- VI.A.2.c).(2).(b)** **with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)**
- VI.A.2.c).(3)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)**
- VI.A.2.d)** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)**
- VI.A.2.d).(1)** **The program director must evaluate each fellow’s abilities based on specific criteria, guided by the Milestones. (Core)**
- VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)**
- VI.A.2.d).(3)** **Fellows should serve in a supervisory role to residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)**
- VI.A.2.e)** **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)**
- VI.A.2.e).(1)** **Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)**
- VI.A.2.f)** **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow**

and to delegate to the fellow the appropriate level of patient care authority and responsibility. ^(Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. ^(Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; ^(Core)

VI.B.2.b) be accomplished without excessive reliance on fellows to fulfill non-physician obligations; and, ^(Core)

VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)

[As further specified by the Review Committee]

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. ^(Core)

VI.B.4. Fellows and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; ^(Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; ^(Outcome)

VI.B.4.c) assurance of their fitness for work, including: ^(Outcome)

VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, ^(Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. ^(Outcome)

VI.B.4.d) commitment to lifelong learning; ^(Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, ^(Outcome)

VI.B.4.f) **accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.** (Outcome)

VI.B.5. **All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.** (Outcome)

VI.B.6. **Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents/fellows, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.** (Core)

VI.C. **Well-Being**

In the current health care environment, fellows and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of fellowship training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of fellow competence.

VI.C.1. **This responsibility must include:**

VI.C.1.a) **efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;** (Core)

VI.C.1.b) **attention to scheduling, work intensity, and work compression that impacts fellow well-being;** (Core)

VI.C.1.c) **evaluating workplace safety data and addressing the safety of fellows and faculty members;** (Core)

VI.C.1.d) **policies and programs that encourage optimal fellow and faculty member well-being; and,** (Core)

VI.C.1.d).(1) **Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.** (Core)

VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)

VI.C.1.e).(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; ^(Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, ^(Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)

VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a fellow may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the fellow who is unable to provide the clinical work. ^(Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; ^(Core)

VI.D.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, ^(Core)

VI.D.1.c) encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in

the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.1.a) An optimal clinical workload allows fellows to complete the required case numbers and develop the required competencies in patient care with a focus on learning over meeting service obligations. (Detail)

VI.E.2. Teamwork

Fellows must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that fellows are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. ^(Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)

VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods. ^(Detail)

VI.F.2.b).(1) There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

VI.F.2.c) Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. ^(Core)

VI.F.2.d) Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. ^(Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. ^(Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. ^(Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a fellow during this time. ^(Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; ^(Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, ^(Detail)

VI.F.4.a).(3) to attend unique educational events. ^(Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

The Review Committees will not consider requests for exceptions to the 80-hour limit to the fellows' work week.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. ^(Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. ^(Core)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety. ^(Core)

VI.F.5.b) Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. ^(Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. ^(Core)

VI.F.7. Maximum In-House On-Call Frequency

Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). ^(Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. ^(Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. ^(Core)

VI.F.8.b) Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. ^(Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf

STATEMENT ON PRIVILEGING FOR CHRONIC PAIN MANAGEMENT

Committee of Origin: Standards and Practice Parameters

Committee of Oversight: Pain Medicine

(Approved by the ASA House of Delegates on October 16, 2013)

Chronic pain is a complex disease entity, and the practice of pain medicine encompasses evaluation, diagnosis and management including therapeutic interventions that entail substantial risk. Optimal management of the patient with chronic pain requires coordinated care from multiple providers, with each provider having an important role. The practice of pain medicine requires extensive diagnostic skills and integration of knowledge across multiple disciplines of medicine. Recognizing this, the profession of anesthesiology has been instrumental in defining the training and competencies required for physicians to provide safe and effective evaluation and treatment of chronic pain. It is in the best interests of the public to maintain the standards for training and competency established by anesthesiologists and other physicians specializing in the treatment of chronic pain, in order to balance the risks and benefits of potential therapies to yield the safest and most effective treatment for the patient suffering from chronic pain.

Appropriate education and training for all chronic pain practitioners should include comprehensive didactic knowledge with documentation of the knowledge gained, and a comprehensive portfolio of supervised cases to demonstrate competency and safety in all aspects of patient care, including pharmacologic management and interventional procedures, before beginning independent practice.

Practice Parameters

Pain Management H-410.950

Topic: Practice Parameters **Policy Subtopic:** NA
Meeting Type: Annual **Year Last Modified:** 2013
Action: NA **Type:** Health Policies
Council & Committees: Board of Trustees

Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

Policy Timeline

BOT Rep. 16, A-13