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Point/Counterpoint

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To Train or Not to Train: Admission of Pediatricians into Pediatric Rehabilitation Medicine Fellowships

CASE SCENARIOS

1. A second-year pediatric resident in a large residency program enjoys working with children with disabilities and is considering applying to Developmental Pediatrics fellowships. She begins pursuing electives that will help her in that specialty. She has minimal familiarity with Physical Medicine and Rehabilitation (PM&R). However, after some discussion with her residency program coordinator and reassurance that there is overlap with Developmental Pediatrics, she takes a 1-month elective in pediatric rehabilitation medicine (PRM) which is available at her institution. She discovers that she enjoys the emphasis on function, the team-based approach to care, and the procedures. She asks you how she can enter training in the field of PRM.
2. A pediatric hospitalist in a large university hospital is approached by her employer to see if she is interested in a position as the medical director for an inpatient pediatric rehabilitation unit located in a freestanding rehabilitation hospital. There is no outpatient clinic associated with this position. She is aware that there are no pediatric physiatrists in her city and the closest one is a 4-hour drive away. She accepts the position and finds that she enjoys caring for children admitted to her pediatric rehabilitation unit. There are 2 PM&R specialists who typically see adults but have agreed to act as consultants for inpatients only. The pediatric hospitalist starts giving her private cell phone number to the family of children discharged from her unit so they can contact her for assistance for follow-up. She realizes she could do much more for these children if she were board certified in PRM and starts contacting PRM fellowship programs. She asks you how she can enter training in the field of PRM.

For both scenarios, Dr Louise Spierre will argue for admitting pediatricians into PRM fellowship training programs, and Dr Robert Rinaldi will argue against admitting pediatricians into PRM fellowship training programs.

Louise Spierre, MD, Responds

In the roughly 30 years since the American Board of Physical Medicine and Rehabilitation (ABPMR) and the American Board of Pediatrics (ABP) first established combined residency programs in PRM, much has been learned about best practices for treating disabling disorders of childhood. Many treatments for childhood-onset conditions, such as cerebral palsy, spina bifida, and hip dysplasia, are unique to children. The goals of care differ for children in comparison to adults. Even the term itself, "rehabilitation medicine," has a different meaning when applied to children and adults. An adult attempting to walk after a stroke can be said to be "rehabilitating" by regaining previous functions.

However, in children with cerebral palsy, walking is not about recovery of a lost function, it is about gaining new functional milestones while coping with the effects of a neurologic injury. Children with physical impairments face different obstacles than adults because of the plasticity of the pediatric brain, and as such they have greater potential to overcome impairments [1].

Every child with a disability has a right to be seen in a timely fashion by a physician with specialized training and knowledge of the medications, surgeries, and procedures that will allow them to reach their fullest potential [2]. These children need to be cared for by a qualified pediatric physiatrist. The alternative, a child

having to live with lifetime disabilities because of lack of access to care during a critical developmental period, is unthinkable. Unfortunately, the unthinkable is the norm in this country because of a severe and chronic lack of pediatric physiatrists. There are an estimated 5.9 million children in the United States struggling with limitations in at least 1 functional domain due to chronic illness [3]. It is stunning to consider that for these children there are only 246 physicians with board certification in PRM [4]. The needs of these children could only be met if the average pediatric physiatrist had a practice size of more than 20 000 children. Even to meet the extremely limited goal of providing rehabilitation care to only the estimated 764 000 individuals living with cerebral palsy in the United States, the average pediatric physiatrist would be caring for more than 3000 children on their patient panel.

Why are there so few pediatric physiatrists relative to the need? Why are there hospitals that have been advertising for years to find a pediatric physiatrist—while children go without care? The answer lies in ABPMR policies that govern training programs in PRM. At the turn of the millennium, a research survey sounded the alarm about the lack of providers of PRM. At that time, when 14 states had no pediatric physiatrists practicing within their borders, combined programs in Physical Medicine and Rehabilitation (PM&R) and Pediatrics (then the only way to train for the field) had decreased from a peak of 21 (1997) to 7 (2000) [5].

At the same time, PM&R residencies were becoming increasingly adult-focused. The number of PM&R training programs that included 6 months or more of preparation in pediatric rehabilitation fell nearly 8-fold from 15 of 60 (25%) in 1989 to 2 of 82 (2%) in 2000. The percentage of PM&R training programs with a pediatric focus decreased by a factor of 12 [5]. Thus, most physiatrists graduating from PM&R residency programs have little knowledge of how to care for children with disabilities. The need for physiatrists with subspecialty pediatric training is increasing concurrent with the closure of PRM training programs because of a lack of applicants.

In response to the pressing need for providers skilled in PRM, the first fellowship programs in PRM were developed by the ABPMR in 2002—but curiously, they were only open to diplomates of the ABPMR (~10 000)—only a few of whom had substantial pediatric training during residency. The fellowship was not offered to diplomates of the ABP (~100 000), half of whom seek subspecialty training. This stands in sharp contrast with other subspecialties accredited by the American Board of Physical Medicine and Rehabilitation, such as Brain Injury or Spinal Cord Injury, which are open to graduates of many specialty boards.

Fellowships programs that would allow pediatricians to train in PRM have been proposed [6,7], but never developed and implemented. In 2018, there are 20 ACGME-accredited fellowship programs in Pediatric Rehabilitation Medicine [8]. Despite the increase in the

number of children with disabilities [3,9], the number of pediatric fellowship positions has decreased. Moreover, with the exception of 2017, fellowship programs in PRM over the past 4 years have a fill rate of 70% or less [7]. Although the number of PRM training programs are decreasing, and some of the remaining ones are unfilled, ABPMR policy is preventing pediatricians, who could contribute to the care of these children, from applying.

It is impossible to know how large the potential pool of pediatric applicants would be if PRM fellowships and/or other paths to PRM board certification were opened to pediatricians. Given the dearth of pediatric physiatrists, few pediatric residents have exposure to PRM academic faculty and practitioners, and fewer still have the opportunity to rotate through rehabilitation hospitals or units. Developing a pathway for pediatricians to enter the specialty would increase the number of pediatric physiatrists who would in turn help increase exposure to and knowledge of PRM for pediatric residents, leading ultimately to more pediatrician applicants.

The 2 physicians described in the vignettes are everyday examples of pediatricians who have come to know and appreciate the practice of PRM during and after completing their residencies. These 2 case scenarios represent providers who planned to either delay starting practice or leave their clinical practice to complete training in PRM. These providers made serious attempts to identify a pathway for training and certification in PRM—and failed when they encountered obstacles to training they could not overcome.

Currently, the only possible path for someone who has started a pediatrics residency to become subspecialty trained and board certified in PRM is to first complete 3-year training in pediatrics, and then complete a 3-year PM&R residency that offers 6 months of PRM training. Because of recent changes in Medicare funding for residencies, federal funding support for these residents would be extremely limited. Medicare rules now mandate that a physician can complete only 1 fully funded residency program. The number of years of funding is based on the number of years of the initial residency. Once a pediatrician has started a residency, she has only 3 total years of full Medicare funding for any residency. The only realistic path to further training for any physician who has completed a residency is to enter a fellowship. As previously noted, diplomates in pediatrics are not eligible for fellowship training in PRM. Providers such as the two described must pursue other disciplines—much to the detriment of the children they could have served.

It is critically important that alternate paths for board certification in PRM be established for board-certified or eligible pediatricians. A background in pediatrics offers many advantages to PRM fellowship training. Pediatricians would enter the field with a deep understanding of child development, how to work with the family as a unit, and how to be effective in pediatric systems of care.

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