ASPN

AMERICAN SOCIETY of PAIN & NEUROSCIENCE

ADVANCING COMPETENCY:

BUILDING THE FUTURE OF INTERVENTIONAL SPINE CARE

IN THIS ISSUE

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CHAIRMAN'S CORNER

Competency

As I reflect on the current state of interventional spine and nerve treatment and the challenges facing the specialty, I believe that the most formidable task is meeting the need for competency as new or modified procedures come to the forefront of pain medicine.
I have heard many potential solutions raised in recent months:

1. Create a two-year fellowship that could promote supplemental competency.
2. Create additional non-ACGME accredited fellowships to meet the needs of the "real world," where fellows work in the private setting to receive hands-on mentoring.
3. Train the program directors at major teaching institutions to do more advanced methods so that fellows have better and more modern training in MIS and advanced neuromodulation.
4. Require a minimum number of MIS and neuromodulation procedures in fellowship training to officially complete the program.
5. Create a post-fellowship mentoring and certification program to assure doctors understand patient selection, procedures, and postoperative care.

For each of these answers, more questions arise:

1. Do two years in a mediocre fellowship make you better than one year in a mediocre fellowship?
2. Do NASS fellowships and other private fellowship programs meet a standardized training regimen that can adapt to future safety and efficacy needs and provide better patient selection?
3. Many program directors face "turf" battles and cannot obtain credentialing for more advanced procedures that is now desired by most employers.
4. Why did ACGME accredited programs do away with a minimum number of neuromodulation procedures in fellowship? Did they lack candidates, surgical time, proper faculty?
5. Who will do the credentialing and who will offer mentoring?

CHAIRMAN'S CORNER, CONT.

These issues and questions are unquestionably complex. While I have an opinion on each of the five potential solutions, I can answer one with certainty: solution 5 pertaining to certification.

At ASPN and ISPN, we have developed a credentialing plan that includes significant planning and structure. This plan, chaired by Dr. Dave Dickerson, former chair of the American Society of Anesthesiology Committee on Pain Medicine, will bring together mentors who have privileges to do these new or established methods and combine spine surgeons, anesthesiologists, PM&R physicians, and interventional radiologists.

This group of mentors will teach anatomy, mechanical balance, and spine dynamics to those candidates accepted for certification. This program will include case review, imaging review, and post-surgical analysis with the mentee and mentor.

The program, which has 39 accepted candidates from a diverse specialty base from both the United States and international community, will conclude with a written and practical examination in Miami led by an amazing team of physicians including chairs Tolga Suvar and Pankaj Mehta.

In addition to these 39 candidates, all mentors will be required to complete the exam, and this group of orthopedic spine, neurosurgery, interventional radiology, and interventional pain medicine physicians will represent part of the first group who have established themselves as MIS certified.

This represents the first step in improving patient safety and efficacy, while offering less invasive methods when indicated. We will be at the forefront of this patient-centered revolution.

TIMOTHY R. DEER, MD

Chairman

MIS CERTIFICATION UPDATE

Minimally invasive spine (MIS) treatments are rapidly transforming pain management. Techniques such as percutaneous decompression, endoscopic spine surgery, minimally invasive fusion, and advanced image-guided interventions offer faster recovery, fewer complications, and more durable relief than traditional steroid-based approaches.

As patient demand increases and technology advances, providers are expected to deliver sophisticated spine care without open surgery. Yet formal training has not kept pace, with many clinicians still relying on industry workshops or informal mentorship, leading to variability in competency and outcomes.

To support the field's rapid growth, structured education and standardized training pathways are essential. The American Society of Pain and Neuroscience (ASPN) is committed to serving as the foundational source for this training. Through evidence-based curricula, hands-on instruction, and competency-based certification, ASPN is establishing the gold standard in MIS education.

The pendulum has clearly swung. Today's interventional pain physicians are increasingly recognized as interventional spine physicians focused on treating underlying pathology, not just symptoms.

PANKAJ MEHTA

Ex Officio, Advisors to the President and Chairman

DEPARTMENT OF AI & MEDICAL TECHNOLOGY UPDATE

The ASPN Department of AI and Medical Technology is an inaugural and developmental project created in anticipation of the rapid technological advances transforming modern medicine. The department's first initiative is the launch of the ACCESS AI Initiative (Accelerating Clinical Collaboration, Education, and Strategic Sponsorship in AI).

Its mission is to position ASPN as the global hub for applied medical AI by connecting clinicians, innovators, and industry partners to shape the next generation of AI-driven pain care. The department is finalizing leadership appointments, sponsor partnerships, and the inaugural ACCESS AI Webinar Series, beginning in Q1 2026 with the topic "The Role of AI in Optimizing PNS Access and Outcomes."

Future technology tracks will broaden to encompass a wide range of innovations within the neurosciences. Through collaboration with leading device manufacturers and AI innovators, ASPN seeks to educate, unify, and empower the field toward safer, smarter, and more predictive models of patient care. The future of medicine is undeniably data driven, and ASPN is poised to lead that transformation by staying ahead of the rapidly evolving landscape driven by artificial intelligence.

ROBERT MOGHIM, MD

Chairman, AI and Medical Technology

RESIDENT PERSPECTIVE

Attending my first ASPN conference in 2024 was a transformative moment for me, and I was struck by how innovative, multidisciplinary, and collaborative the field of interventional pain has become. Through ASPN conferences and webinars, I have gained mentorship, expanded my knowledge, and built connections that continue to shape my training.

Moving forward, I believe ASPN can have an even greater impact on trainees by creating more hands-on learning opportunities and continuing to build strong mentorship pathways. With ASPN's mission to advance pain and neuroscience through education, innovation, and inclusivity, I am passionate about increasing specialty diversity, particularly incorporating the unique perspective of emergency medicine.

I also hope to contribute to ASPN's global reach as well by supporting broader international access to pain procedures and education through collaborative efforts. ASPN has felt like a great community to grow with as the field evolves.




CAROLINE TWUM, DO

Emergency Medicine Resident Physician

FELLOW PERSPECTIVE

From Fellowship to Independent Practice: Lessons from the Early Months

Transitioning from fellowship to independent practice has been one of the most rewarding and eye-opening experiences of my career. After completing my interventional spine and pain management fellowship at the Cantor Spine Center at the Paley Orthopedic and Spine Institute under Dr. Anthony Giuffrida, I felt well prepared procedurally and clinically. Yet, stepping into my role as an attending in private practice in South Florida brought new challenges that extended far beyond the fluoroscopy suite.

Every day, I'm learning more about the business side of medicine—understanding compensation models, navigating billing and coding, and recognizing how referral patterns form and evolve. Building genuine relationships with referring physicians and finding authentic ways to market both myself and the practice takes time and consistency. Leading a clinical team and developing efficient workflows requires patience, clear communication, and humility.

Like many new attendings, I experience moments of imposter syndrome. What keeps me grounded is trusting the foundation built during fellowship—the repetition, mentorship, and attention to detail—and applying those same principles in my daily practice. Staying connected with mentors and colleagues remains invaluable; their guidance helps me navigate unfamiliar situations with confidence.

Most importantly, I remind myself that it's never a weakness to ask questions. The willingness to keep learning ensures that every decision is guided by what matters most: doing what's best for the patient.

JOHN H GALLAGHER MD, MS

Vice Chair, Social Media Committee

ACGME SPOTLIGHT

The Growing Divide.

Pain Management has undergone many reinventions since inception. From the focus on opioids to interventions to neuromodulation and now to minimally invasive spine (MIS). These areas of focus, and treatment delivery, have grown from industry innovation and partnership, capitalizing on the skill sets of well-trained individuals to execute new therapies, either through the forms of studies, either investigational device exemption (IDE) studies or single arm prospective studies or through 510K approval pathways to commercial use.

The training, historically, was grounded under the banner of continued medical education (CME). In this phase of specialty treatment advancement, although necessary, the heavy lifting of procedure candidacy and training is performed by industry, which offers complexities of potential bias and the unavoidable conflict with sales, with branding, and messaging that promotes use. However, this is the necessary beginning. With the expectation that more formal training will be integrated into unbiased programs, namely through the vehicle of the ACGME.

But there, unfortunately, is a problem.

To follow the maturation of a specialty, integrating a skillset and training of the therapy to integration into formal training as a requirement, let's use the case example of Spinal Cord Stimulation (SCS). We all know the story. Developed in 1967, significant data was generated to demonstrate treatment success, in IDE prospective, multicenter studies, and countless others, highlighting the importance of its use to manage severe refractory pain of the trunk and limb.

At the beginning, due to the paucity of trained physicians able to perform the procedure, industry sought out physicians with the foundational training to perform the procedure, and they were trained by industry with Medtronic leading the charge. As commercial use grew, the acceptance grew, and additional companies came to the market, including Advanced Neuromodulation Systems and Advanced Bionics.

Spinal Cord Stimulation then became commercially used in 1968 but was not first commercially available as an implantable system in the United States until 1981 and was formally integrated into ACGME training on July 1, 2014.

The predicate training program for medical specialty and practice, within the United States, is the American Counsel of Graduate Medical Education (ACGME). As stated by the ACGME, it has a simple mantra: train folks to do the things that are representative of the specialty in the real world.

ACGME SPOTLIGHT, CONTINUED

Recently, the confidence of graduating ACGME fellows from Pain Management Fellowship Programs was surveyed. The results are alarming to many but not surprising to those exposed to this group. Approximately 1/3 of fellows were uncomfortable with interventional therapies like sympathetic nerve blocks and SCS implants, while 70% were uncomfortable with intrathecal pump implants vertebral body augmentations. Even more so, 80% were uncomfortable with basivertebral nerve ablations. We can argue that competence and confidence are different.

That said, the identifying reason was exposure in the fellowship program. More cautionary is that ACGME recently removed, as of September 2025, procedure volume requirements for Spinal Cord Stimulation, and although, clearly, tissue management intraoperative surgical training is required to avoid both intraoperative and post-operative complications, offered no more formal surgical training. The oncoming potential problems of complications leading to explant may further jeopardize the system. Further, even the basic skill sets are lacking in many settings with many fellows not being trained on even common practice techniques.

A few strategies (or schemes) can be gleaned from this training approach. Either the members creating the guidelines for training within ACGME programs don't believe in the these treatment modalities, blaming industry-driven studies as not being scientifically valid (despite following the rigor of the scientific method and with FDA and IRB oversight) and working within their ivory towers, not actually doing the critical work to identify data or knowledge gaps and creating scientific inquires to fill it (as academic institutions should do), but instead shifting our specialty focus to medication management. Or we have a challenge with the competency of the trainer. Or we have an execution problem with patient access due to inter-specialty politics. Or maybe it is a combination of this stew of complex issues. Nevertheless, the impact puts the specialty at risk and puts a spotlight on deficiencies of current ACGME fellowship programs.

For certain, as was the evolution of interventional cardiology to cardiothoracic surgery, these minimally invasive spine techniques, including percutaneous decompression, interspinous process fusion and indirect decompression, facet fusion, sacroiliac joint fusion, basivertebral nerve ablation, vertebral body augmentation, peripheral nerve stimulation, dorsal root ganglion stimulation, and spinal cord stimulation are here to stay.

The growing divide is real. Unaccredited programs are becoming more popular, as they are outpacing the training development and are more representative for preparing clinicians to practice within the real-world scope of pain management. Even more, training programs have been created specifically for "filling the gap" from ACGME programs, commonly executed at the societal level. However, exposure and competence are vastly different.

ACGME SPOTLIGHT, CONTINUED

Society training programs, based on volunteerism, are filling the divide, along with CME quality programs, to not only offer exposure but also training to the level of competence. These programs are under development and some are already being executed. The question remains: Will ACGME answer the call?

Perhaps the only path forward is an interventional pain residency since two years in fellowship that many have suggested will not fill the gaps that exist unless we see a major overhaul of the programs as a whole. For now, we are seeing the divide between the academic center and the "real world" widen and that can only be remedied by a meeting of the minds to bring the field forward.

JASON E. POPE, MD, DABPM, FIPP

Senior Advisor Executive Board
Past President The American Society of Pain and Neuroscience

TIMOTHY R. DEER, MD

Chairman, The American Society of Pain and Neuroscience
Chairman, The International Society of Pain and Neuroscience

ACGME SPOTLIGHT, CONTINUED

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DIVERSITY COMMITTEE

ASPN is dedicated to fostering inclusion and mentorship across all levels of our specialty. My own journey, from engaged member to panelist, moderator, and now Vice-Chair of the Diversity Committee, reflects how ASPN cultivates growth and leadership. Our committee aims to support the development of members, especially trainees and early-career physicians who represent the next generation of interventional pain leaders.

In the year ahead, we will continue to expand mentorship opportunities, develop trainee-focused online programming, and create spaces where unique perspectives are valued and representation is the norm. We believe that diversity drives innovation and enhances patient care across ASPN's initiatives.

The Diversity Committee welcomes members who are passionate about shaping a more equitable future. Get involved, share your perspective, and help us build a society that reflects the full breadth of our professional community and the patients we serve.

LATRICE A. AKUAMOAH, MD, MPH

Vice-Chair, Diversity Committee

PRESIDENT'S CORNER

AI or human? What is the source? Possibly Pubmed? Is the content accurate? What is the level of evidence? Is this a procedure I can get comfortable with being marketed? What society is promoting this?

Being a fellow in this day and age is the most challenging exercise in the very dynamic online world we live in. We are all trying to find out our identify, distill disparate facts, and determine what matters in terms of patient care. Unlike any other time in pain medicine, we need consistent focus on fellow education. The amount of information from different and disparate platforms that are not PubMed or traditional reputable sources has pushed the envelope of information verification. In this environment, unlike any other in the past, we need good foundational didactics that emphasize quality education through various forums.

In that regard, it's great to see the launch and early success of our MIS certification course that will move through its inaugural class and course this year. Led by Dr. Dickerson and team, the MIS certification course is a critical first step to broadening and providing consistent education beyond the traditional one-year ACGME fellowship.

In addition, we must continue to emphasize the role of mentorship in our space. In no other time is this as important a service that can be done by elderly statesman in our specialty for the new generation than now. They need mentorship that is intentional and forward-thinking on career building in addition to clinical guidance. Hopefully this serves as a constant reminder of the impact that each of us can make on the future generation.

Mentorship is molding under high, intense pressure with a forward vision. Let's get at it!

KRISHNAN CHAKRAVARTHY, MD, PHD

Executive Board President-Elect

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