AAPM and Health Care Reform: Your Voice Is Needed

The debate these days is not so much about whether health care is going to be reformed, but how. Undoubtedly, there will be reform; the discussion now is the format in which it will materialize. With the focus on health care reform at the national level taking center stage, this moment in time offers pain care practitioners the ideal opportunity to continue our push for pain care reform. There are many activities in which the American Academy of Pain Medicine (AAPM) members are providing leadership to this effort. Particularly noteworthy is the activity of our Committee for Legislative Affairs, spearheaded by Scott Fishman, MD, Chair of AAPM’s Legislative Committee and Past AAPM President, Perry Fine, MD, AAPM Treasurer, and Phil Saigh, AAPM Executive Director. Ongoing news on this subject can be found on our Website at http://www.painmed.org/advocacy.

Consider, for example, the National Pain Care Policy Act, an important piece of legislation that AAPM has been advancing since 1998 with its original partners, the American Pain Society (APS), the American Headache Society, and more recently, the American Society of Anesthesiologists (ASA), which joined the Pain Care Coalition (PCC) in 2004. As you may recall, the Act would authorize an Institute of Medicine conference on pain care, promote pain research at the National Institutes of Health (NIH), provide comprehensive pain care education and training for health care professionals, and institute a public awareness campaign on pain management. The National Pain Care Policy Act came extremely close to being passed into law in the fall of 2008; it was then reintroduced in both Houses early in 2009. It has passed the House and now sits in a Senate committee, where it will likely remain until the health care reform debate is completed. The earliest that anyone suggests that the health care reform debate will be over is late summer.

Meanwhile, however, there is much that we can do to help shape the debate. AAPM continues its work to push for pain care reform. Our members can also do their part by contacting Senate committee members to urge that they support the National Pain Care Policy Act. A full list of committee members is available in the Advocacy section of the AAPM Website under National Pain Care Policy Act at http://www.painmed.org/advocacy/national_pain.html. I urge you to take a few minutes from your schedule and to let the senators know that the National Pain Care Policy Act is a law worth supporting. Also, let Lynn Webster, MD, and our State Initiative Committee know if you are interested in representing Pain Medicine and AAPM in your state—these activities synergistically increase our influence on these important issues. Please let our staff know by sending them an e-mail at info@painmed.org when you (or your friends and relatives) send your letters of support so we can document our activity—it only takes a few minutes, but it means a lot to our Congress when many voice concern about the undertreatment of pain and the need for better training and research.

In addition to our efforts with the National Pain Care Policy Act, AAPM continues to work to make pain care reform a part of the health care reform debate. Our hope is that the reform package ultimately agreed upon between the Obama administration and Congress includes a pain care reform component, consistent with the priority being given to pain medicine in the Veterans Affairs Health System (VA) and military health systems. Ideally, the package would contain those provisions called for in the National Pain Care Policy Act, thus obviating any need to get that legislation passed separately. Again, our members can also play a significant role in this debate by contacting senators and urging them to include pain care reform in the health care reform package. Please contact your senators and ask them to support these measures—and let us know you did.

Food and Drug Administration and Opioids

As the health care debate plays out, a second process with important implications for pain practice and for our patients is unfolding on the regulatory side. As we are all aware, a debate exists between law enforcement, which wants to curb prescription drug abuse, and the medical profession, which wants to be able to appropriately and safely prescribe opioid analgesics for pain without fear of administrative sanction or criminal
prosecution. So far, finding the right balance between the competing interests has proven challenging. Fortunately, pain medicine and addiction medicine are now working more closely together to address these challenges. The AAPM continues to work with the Center for Practical Bioethics (http://www.practicalbioethics.org/), which under the leadership of Myra Christopher has convened practitioners, regulators, and prosecutors in a working group to better define this problem, to document its nature and extent, and to develop educational programs to heighten awareness of problems such as the “chilling effect” and inadequate training of all groups (Goldenbaum et al. Pain Medicine 2008;9(6):737–47. Available at: http://www3.interscience.wiley.com/cgi-bin/fulltext/120848348/PDFSTART).

A second forum has been opened up in that debate, this time with the Food and Drug Administration (FDA). Congress has asked the FDA to address the problem of prescription abuse, misuse, and diversion of slow-release opioids. The FDA’s only real leverage is with the drug manufacturers, and it has begun a process that will require the manufacturers to follow as-yet-underdetermined steps that will be designed to reduce abuse, misuse, and diversion of their drugs.

The medical community, including AAPM, has asserted itself in this discussion of what requirements should be imposed on drug manufacturers, with the FDA’s blessing. The rules imposed by the FDA could have enormous impact on how medicine is practiced by those who prescribe opioids. The medical community would like to ensure that the FDA requirements are not onerous and do not discourage the appropriate and safe use of opioid prescriptions, and that legitimate patients in pain do not have unnecessary obstacles to access of these medications.

The response of AAPM and the medical community has been to ask the FDA to include three elements in its plan: 1) the development of functioning and fully connected prescription monitoring programs (PMPs) in every state; 2) an extension of the FDA plan to include all opioids, not just slow-release opioids; and 3) an education program designed by medical experts on a variety of subjects, including the dangers of opioid abuse, misuse, and diversion, and the proper use of PMPs. AAPM believes that implementation of these three measures would help the FDA achieve its congressional mandate. Read the AAPM’s and the PCC’s formal letters to the FDA about this issue (http://www.painmed.org/pdf/remS_comments.pdf).

**Rockefeller Bill**

Another potentially significant piece of federal legislation, the Methadone Treatment and Protection Act of 2009, was recently introduced in the Senate by Senators Jay Rockefeller (D-WV) and Bob Corker (R-TN). It was introduced in response to reports finding an increase in methadone-related deaths. It too is on hold while the attention of the Congress is diverted to health care reform.

The bill is significant as some of its provisions tie nicely with what AAPM and the medical community are requesting of the FDA. For example, National All Schedules Prescription Electronic Reporting (NASPER), which became law in 1995, called for the development of PMPs but was never funded. The Rockefeller bill would provide $25.5 million in funding for PMPs through NASPER. The Rockefeller bill also calls for opioid education by requiring physicians who renewed their DEA registration to show evidence of special training in opioid management.

**Ongoing Efforts**

AAPM continues to work with others in the pain care community to develop workable solutions to the very real problem of abuse and misuse of prescription drugs. AAPM representatives (Scott Fishman, MD, Perry Fine, MD, Howard Heit, MD, Phil Saigh, and others) will continue to attend meetings with other medical community representatives, with the FDA and DEA, as well as with leaders in the Senate and House of Representatives.

We are also continuing our Washington lobbying efforts through the Pain Care Coalition and from within the Pain Care Forum (PCF), an informal pain care group think tank that includes nonprofit groups such as the American Pain Foundation, the Pain Care Coalition (AAPM, American Headache Association, American Pain Society, and ASA), the National Pain Foundation, the American Chronic Pain Association, the device and drug manufacturing representatives, and others from the pain care community. PCF participants have begun to develop ideas for combating drug abuse and misuse that would not unduly restrict access for legitimate opioid users. AAPM will continue to examine and promote viable reform ideas and to work from within the pain care community to address this problem. We are thankful to Will Rowe, President of the American Pain Foundation, for his leadership of the PCF, and to Bob Saner, who guides the PCC.
These next few months are a crucial time for pain care practitioners. Please join me in doing all that we can to ensure that our shared goals for improving pain care are reflected in these important measures.

**Pain Summit at the American Medical Association**

Responding to a mandate of American Medical Association (AMA) Resolution 321, the AAPM has been heavily involved in the planning and implementation of convening a Pain Summit Conference. Although the Academy is only one of some two dozen stakeholder organizations included in the project, it has assumed a leadership role in the strategic and operational planning of this project.

The responsibility for convening the Pain Summit has been delegated to the AMA Pain and Palliative Medicine Specialty Section Council (PPMSSC), which is chaired by AAPM’s Executive Medical Director Philipp M. Lippe, MD. Details of planning have been assigned to an Advisory Committee (AC) and an Implementation Committee (IC), chaired by former AAPM President Bert Ray, MD.

Under the leadership of Dr. Lippe, the AC has worked diligently over the past several months conducting its business over the Internet. Over 20 organizations have engaged in ongoing dialogue deliberating over such issues as summit goals and objectives, place and time of meeting, format and length of the meeting, and participants invited to the summit. Notably, the members of the AC were of the opinion that the AAPM should not bear the sole fiscal responsibility of the Pain Summit. Accordingly, this matter was referred to the IC, which is engaged in seeking funding from other organizations and industry.

In order to facilitate pre-conference planning and assure an effective organized summit meeting, it had been decided to retain the services of a consulting firm. This decision will be discussed next week at the PPMSSC meeting held in Chicago in conjunction with the AMA House of Delegates (HOD).

To date, the cooperation and support of participating organizations have been exemplary. This bodes well in assuring a successful meeting. The present plan is to convene a Pain Summit in conjunction with the AMA HOD meeting, most likely in November. This will allow for sufficient time to engage all stakeholder organizations, prepare position statements, achieve consensus, and provide adequate resources.

**AAPM’s Academic Publishing Partners**

I am pleased to announce that *Pain Medicine* will be published by Wiley-Blackwell for 5 more years! Moreover, regarding our journal partners, I am also delighted to announce that AAPM has reached an agreement with the International Spine Intervention Society (ISIS) to continue *Pain Medicine* as its official journal for the next 5 years. A journal executive task force, consisting of Immediate Past President Ken Follett (Chair), Executive Director Phil Saigh, and myself as President, completed several months of discussion with representatives of Wiley-Blackwell and ISIS that has culminated in a 5-year agreement that all parties believe will further strengthen the intellectual content and performance of the journal in a rapidly evolving academic publishing environment. ISIS President Paul Dreyfuss was most helpful to this process, working with his Board and with Nik Bogduk, Co-Editor of the Spine Section of *Pain Medicine*, who helped me negotiate our original ISIS agreement. As President, I recently visited the Faculty of Pain Medicine (FPM) of the Australian and New Zealand College of Anaesthetists at their annual meeting in Cairns, Queensland. This steadily growing organization of pain medicine specialists, trained through its rigorous curriculum and examination process, also has re-endorsed *Pain Medicine* as its official journal. Our discussions started in 2002, when Michael Cousins, through an introduction from Peter Wilson, invited me to their Board meeting in Brisbane. I am pleased to note that Milton Cohen, long-time FPM Board Member and Past President, has agreed to be Senior Editor of *Pain Medicine*, and we are most grateful for the service of Colin Goodchild, first FPM Senior Editor, who will continue on the Editorial Board in the Translational Research Section. Finally, the first Chinese edition of *Pain Medicine* is in press, with Chinese translations of several articles from our 2008 issues. Our journal’s growing international associations emphasize that populations in pain know no geopolitical boundaries but share a common humanity of suffering. Around the world persons in pain will benefit from pain medicine’s rapid growth as a specialty and our special knowledge and expertise.

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