The Evolution of Pain Medicine: Residency Training for Health Care Reform

For many years the American Academy of Pain Medicine (AAPM) has worked to improve pain care by seeking the American Board of Medical Specialties’ (ABMS) recognition of pain medicine as a medical specialty and by urging the Accreditation Council for Graduate Medical Education (ACGME) to accept residency programs in pain medicine. Although the changes sought in pain care have been undertaken to bring cohesion to a fragmented practice area, these changes have been viewed as revolutionary to other interests.

Our initial efforts, however, have been only shortcomings in the sense that they did not bring about a revolution in pain care. But revolution is not the only way to bring about change. The AAPM is achieving its goals and recognizes that the dedicated efforts throughout the years have begun to deliver tangible benefits. We are taking significant steps down the path that will lead to the necessary changes in pain medicine. We are changing pain care by evolution rather than by revolution. As outlined in the Pain Medicine Position Paper in this issue of Pain Medicine, a confluence of forces propels this evolutionary process.

First, there is the progression of our science, a rapid acceleration in our understanding of the physiology and treatment of acute pain, and the epidemiology, pathophysiology, and treatment of maladies, the diseases of chronic pain. We are challenged to translate this knowledge into an effective pain management strategy for the population we serve. We are gradually overcoming policies that perpetuate inadequate training and fragmented, cost-ineffective care.

Second, there is the public demand for better care, defined in this era as improved access to quality care at a lower cost. Taxpayers, employees, and employers are now burdened as a result of an inadequate management of pain in our population. Policy-makers are seeking leadership from organized medicine to achieve a solution. As one part of this solution, as outlined by the Position Paper, our specialty needs to continue striving to improve our own standards to meet the public’s need. Those of us trained before pain fellowships were instituted learned pain medicine through experience and through creating our own opportunities for learning through the development of organizations such as the AAPM and APS. The large majority of present fellowship-trained pain medicine physicians has had to overcome narrow, specialty-based residency and fellowship training perpetuated by economics that reinforced the learning of pain procedures at the expense of learning the skills of cost-effective comprehensive care. Primary care, other specialty physicians, and policy-makers alike should have confidence in the standards of evaluation and treatment that patients will receive from adequately trained pain medicine specialists. Policy-makers must have confidence that organized medicine is doing its best to develop standards of care for the public health. Besides the Pain Summit (see following section), the AAPM is working with ISIS, several other organizations, and policy-makers to establish public confidence in our specialty’s commitment to cost-effective care.

Third, there is growing recognition by health policy-makers that a chronic-disease management approach is needed to improve the cost-effectiveness of chronic pain care. Stepped-care pain management, by matching the level of complexity of care needed by a patient with the competencies of the different configurations of the health care team, will be needed, much like for other chronic diseases such as diabetes, cardiovascular disease, and depression. In a major step forward, the Veterans Affairs Health System is now embarking on a system-wide national standard based on the stepped-care model of chronic-disease management of pain, with a focus on developing an adequately trained workforce in primary care and specialty pain medicine, in conjunction with the appropriate integration of
behavioral health care. Other large, self-contained systems, such as Kaiser, are also examining such strategies. Core to this process will be the development of competencies in our future health care workforce, not just in pain medicine specialists but also through more generic strategies such as better medical student education, improved training in primary care, where most treatment is provided, and efforts at integrating principles of primary and secondary prevention through improved patient self-management. Pain medicine must collaborate with its primary care colleagues in designing and testing, through health services research, cost-effective strategies to implement stepped-care pain management. Recent articles in *JAMA* by the *Pain Medicine* Editorial Board members Matt Bair, MD, MS, and Steve Dobscha, MD, demonstrate the promise of this approach.

Presently, the AAPM is collaborating with other medical and public health organizations to speed this evolution in the service of health care reform for the betterment of our patients and the public health. The following section contains my report on our progress in several domains of activity.

**Pain Summit**

Our continued efforts will gather all the medical parties in pain care to the same table to discuss topics such as the scope of pain medicine practice, the adequacy of pain medicine education, and the certification and credentialing in pain medicine. As a result of a series of small but significant steps taken over several years, we are now poised for a meeting of stakeholders that is tentatively scheduled for November, most likely in conjunction with the AMA House of Delegates’ meeting in Houston.

The fact that this Summit is occurring at all is a significant accomplishment. The story of how it was achieved begins with a resolution in the California Medical Association House of Delegates asking the AMA to issue a report on pain medicine. It continues into the AMA House of Delegates, where the resolution was recast as a request that the interested parties in pain medicine convene a Pain Summit. It might have expired there, except that the AMA’s Pain and Palliative Medicine Specialty Section Council (PPMSSC) took up the cause and created an implementation committee and an advisory committee, both chaired by the AAPM members, to guide the process.

The Pain Summit has gained momentum in several ways. In regard to funding, the PPMSSC Advisory Committee, which is comprised of representatives from nearly 20 organizations, and the PPMSSC have both agreed that funding of the meeting should not be the sole responsibility of the AAPM. The PPMSSC Implementation Committee, chaired by Albert Ray, MD, is currently exploring other potential sources of funding.

Meanwhile, the PPMSSC Advisory Committee, chaired by Philipp M. Lippe, MD, is in the process of planning the Pain Summit, and they have decided to retain the services of a consulting firm to assist with this endeavor. Pre-Pain Summit responsibilities include developing as much consensus as possible from various interested stakeholders. The November meeting marks an exciting milestone in our efforts to gain recognition for pain medicine, and I congratulate everyone who has worked so hard over the years to make it a reality.

**Position Paper**

We will reach a second milestone this month with the publication of the Pain Medicine Position Paper that appears in this issue of *Pain Medicine*. This Position Paper represents the culmination of a significant effort to develop a pain medicine manifesto that defines the practice of pain medicine, describes its history and development, sets forth why the current state of pain care is fragmented and suboptimal, and makes recommendations for improving pain medicine. We are delighted that this document is being published, and we believe that it will play an important role in furthering the interests of pain medicine practitioners and in achieving the AAPM’s goals to improve the public health.

As well, the publication of the Pain Medicine Position Paper conveniently dovetails with the upcoming Pain Summit. Our hope is that the ideas set forth in the Position Paper can become the foundation upon which agreements reached at the Pain Summit are based. Although it should not be expected that all Pain Summit attendees will agree to everything stated in the Position Paper, we hope that its statements can serve as a starting point for finding consensus among those who may disagree. If, as we hope, pain medicine is to become a primary specialty, this Position Paper will play an important role. Once again, I urge all of you to read the Pain Medicine Position Paper in this issue and please e-mail your comments and questions to
The American Board of Pain Medicine Developments

The American Board of Pain Medicine (ABPM) is continuing its important work on behalf of pain medicine recognition and quality training. The ABPM has just published an executive summary by President Michel Dubois, MD, that sets forth the ABPM’s commitment to seeking the ABMS’ recognition of pain medicine and the ACGME’s recognition of pain medicine residency training programs, as well as its support for the Pain Summit. This document also serves as a resource for building consensus at the Summit. (http://www.abpm.org/pdfs/09_executive_summary.pdf)

While those efforts continue, the ABPM is working to offer the best possible guarantees of credentialing for diplomates. The ABPM transitioned to a computerized examination and has continued to work to make sure that the transfer does not compromise examination quality.

The ABPM has also begun looking into the expansion of its credentialing process and of its range of resources to those physicians who want to become pain medicine practitioners but who may not otherwise have access to those resources. Two groups that have been targeted are primary care physicians and specialists outside the traditional specialties that feed into pain medicine. Two separate ABPM task forces are currently working on the best approach for achieving this worthwhile goal.

Local Initiatives

For some time now, the AAPM has recognized the need to improve our grassroots support for pain medicine at the state level. At the federal level, we have achieved much to advance the interests of pain medicine via work within the Pain Care Coalition and in other important ways. Our work at the state level has now become a more prioritized focus. We are working to build a comprehensive, nationwide network of members working for the interests of pain medicine.

I am pleased to announce the Local Initiatives Report by Chairman Lynn Webster, MD, that outlines the significant progress we have made in identifying members who will serve as AAPM state representatives in each of the 50 states. At present, there are representatives from over 40 states and the District of Columbia. Representation is currently being sought in Delaware, New Mexico, Oklahoma, South Carolina, South Dakota, and Washington.

These state representatives will meet to strategize in San Antonio next January at our annual meeting in what will be the second annual state representatives meeting. I would like to thank all those who have agreed to serve as state representatives, and I urge all of you who want to get involved in promoting pain medicine to contact your state representative to find out about the activities in your state. The work is important and rewarding. A complete list of state representatives is available at http://www.painmed.org/member/local.html, and is appended at the end of this report with contact information. If you live in a state that is currently without an AAPM representative, please consider becoming your state’s representative for pain medicine.

Conclusion

I am hopeful that we may someday look back and acknowledge that the publication of the Position Paper and the convening of the Pain Summit were turning points in our efforts to obtain recognition of pain medicine as a specialty, an accomplishment that would provide an important contribution to health care reform in the service of our patients and the public health. Let us hope that we may come to see that all of the small steps taken along the way result in a significant impact. Let us wish the Pain Summit attendees well and hope that this meeting sets us on a path that will see us realize all of the goals that we have set for pain medicine and the care of our patients, goals that we have worked so hard to achieve.

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Appendix 1: The AAPM State Representatives

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