Vision and Purpose: AAPM Members Lead National Initiative to Improve Pain Care, Education, and Training

In the fall of 2007, American Academy of Pain Medicine’s (AAPM) Strategic Planning Committee hosted a retreat with AAPM executives, staff, and outside consultants to develop a vision for the AAPM in the coming years. The result of that meeting was an identification of the critical issues facing AAPM, a list of the goals and objectives to be pursued over the next 2 years, and a set of action steps to achieve those goals and objectives. The Strategic Plan 2008–2010 has served as AAPM’s roadmap ever since, and we are delighted to be able to report on significant progress made during 2009 on those goals and objectives, as well as important new developments for 2010. As will be discussed in more detail below, we are very thankful for the leadership of our members who serve on the committees doing the work of the AAPM to move our specialty forward. Please let us know of your interest in working on any committees and give us your ideas.

Premier Pain Medicine Organization

The first goal of the Strategic Plan is to develop AAPM into the voice of pain medicine and to establish AAPM as the premier pain medicine organization. We have completed several important steps that go a long way in accomplishing this goal:

**Pain Medicine Summit**

The long-planned American Medical Association (AMA) Section Council Pain Summit of the Pain and Palliative Medicine Specialty Section was held on November 5 in conjunction with the AMA House of Delegates (HOD) meeting in Houston. The Summit was held in response to AMA Resolution 321-A08 that was introduced and adopted by the HOD in June 2008 with the purpose “to improve pain care in US,” as follows:

“RESOLVED, That our American Medical Association express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine (Directive to Take Action); and be it further”

“RESOLVED, That our AMA encourage relevant specialists to collaborate in studying the following:

(1) the scope of practice and body of knowledge encompassed by the field of pain medicine;

(2) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care;

(3) appropriate training and credentialing criteria for this multidisciplinary field of medical practice;

(4) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.”

More than 30 organizations representing multiple medical specialties and other groups from the pain medicine community participated in the following process.

Step 1 involved a Delphi process online to identify key areas for discussion and decision. There was 80% agreement about the five most important questions/concerns to be further discussed in-person facilitator-led breakout sessions:

1. What should ALL physicians know about pain medicine?
2. How should pain medicine be taught?
3. What are the parameters that define the field of pain medicine?
4. What mechanisms do we need to establish the competency of a physician who wishes to practice pain medicine?
5. What are the barriers that prevent patients from receiving adequate pain care?

Step 2 involved breakout sessions discussing the following parameters related to pain medicine: “present state,” “desired state,” “future state,” “bridges from present state to desired state,” “obstacles to achieving the desired state,” “conclusions,” and “next steps.”

Step 3 involved presentations of each group’s findings and discussion by all participants followed by a summary of next steps. While we await a final, detailed report, it is important to note where consensus was reached. First, we need national standards for medical student education about pain medicine. To do this we must inculcate medical school curricula with the new science and vocabulary of pain medicine, including an understanding of the concepts of acute pain (eudynia) and persistent pain (maldynia), and their underlying pathophysiology, and foster a culture of understanding and respect for
patients with persistent pain (maldynia). We must develop evaluative criteria for medical school deans including establishing pain medicine questions on national examinations of the National Board of Medical Examiners. Going forward, AAPM’s Medical Student Education Committee, chaired by Beth Murinson from Johns Hopkins, will continue to pursue a collaborative project with the Association of American Medical Colleges (AAMC) and use the Summit group as a sounding board.

A second consensus was that medical students and residents in many specialties are not exposed to role models with competency in pain medicine at the level appropriate for their specialty. Thus, each specialty residency must develop its core pain medicine competencies and teach and role model these for medical students and residents.

A third consensus was that pain medicine fellowships are inadequate for training physicians to the scope of care needed to practice and teach pain medicine. Training must be lengthened to accomplish this. Two options were presented: first, to lengthen present fellowships to 2 years; and second to develop pain medicine residencies under separate medical school departments. The latter was seen to be preferable for two reasons: 1) spending 2 years learning material and competencies not related to pain medicine practice or scholarship is very expensive at a time when we are trying to reduce the cost of medical education; and 2) specialty faculty and departments are needed in medical schools to assure uniformity of education and training, as in other specialty areas.

It was acknowledged that developing a new specialty would be difficult in fiscally challenging times. Yet the models of family practice and emergency medicine, the most recently recognized American Board of Medical Specialties, make this very feasible. Family practice residencies rapidly developed in smaller cities all over the country, particularly in the Midwest and West, and drew on the best and most experienced general practitioners, internists, and pediatricians in their respective communities to develop their faculty. Emergency medicine started with only two programs, in Cincinnati and in Philadelphia, again relying on seasoned physicians from the field for developing their faculty, adding others more gradually. Pain medicine could adopt either model successfully without additional costs.

Pain Medicine Position Paper

The AAPM also released its Pain Medicine Position Paper (published in Pain Medicine last fall and currently available at painmed.org), which calls for the establishment of pain medicine as a recognized medical specialty, the development of accredited residency programs in pain medicine, and the support for comprehensive, integrated pain care services for all citizens. The editors, Drs. Dubois, Lippe, and Gallagher, thank all those reviewers and collaborators who played such an important contributing role over more than a year in the development of this manuscript.

Legislation and Military/VHA Pain Medicine

AAPM continues to lead the fight for legislation of importance to pain care practitioners, primarily through our involvement in the Pain Care Coalition (PCC) and the American Pain Foundation (APF), whose Board is chaired by AAPM Board member and former president, Scott Fishman. Among the important victories in the past year was the enactment of military pain care provisions, as part of the 2010 military authorization bill, which requires the Department of Defense to develop a comprehensive pain control strategy throughout its health care system. Now that this requirement has been achieved for both the Department of Defense, and through earlier legislation, the Department of Veterans Affairs, our hope is that both health care systems will develop a unified pain care approach that will improve pain care for all who use the two systems. It is anticipated that the large number of residents who train in these systems will internalize the comprehensive pain care strategy and take those lessons learned with them when they practice elsewhere, further seeding pain care strategies throughout the country. These legislative successes are made possible only through the cooperative efforts of so many of our members, our Washington-based lobbyists, and our allies in the pain medicine community, especially our collaboration with our colleagues in the PCC and the APF.

Indeed, in step with this legislative process, the Surgeon General of the Army convened the Army Pain Management Task Force in August 2009, which includes representatives of the Army, Navy, Air Force, and Veterans Health Administration (VHA). I am privileged to represent the VHA on the Task Force. The Army representation includes one of the co-editors of the Acute Pain Medicine Section of our journal, Pain Medicine, Col. Chester (Trip) Buckenmaier, who is also the Chairman of the Defense Veterans Pain Management Initiative that spearheaded the development of the Task Force. Col. Kevin Galloway of the Office of the Surgeon General has skillfully shepherded the Task Force, which has initiated a series of site visits to military, VHA, and civilian hospitals and facilities to establish “best practices” that will inform a comprehensive strategy for developing a continuum of effective pain management from “battlefield to bedside and back home.”

In the meantime, in response to the congressional mandate in October 2009, the Undersecretary for Health Affairs of the Department of Veterans Affairs, Gerald Cross MD, issued a Pain Management Directive calling for a stepped care, biopsychosocial model of pain management to be carried out throughout all 152 VHA hospitals and facilities. The plan emphasizes developing pain management competencies and system supports at the primary care level that is supported by access in all facilities to competent and accessible pain medicine consultation and in each of the 22 VISNs (regional administrative organizations) of the VHA, access to advanced pain medicine treatment, and CARF-accredited pain rehabilitation programs. The plan will be implemented under the direction of the VHA’s National Pain Management Office, where
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AAPM member Robert Kerns (also Senior Editor for Pain Medicine) is Director and rollin Gallagher is Deputy Director. The Office is advised by the VHA’s National Pain Management Strategy Coordinating Committee, where AAPM member Matt Bair (Primary Care Section Editor for Pain Medicine) plays a key role. Matt’s and Editorial Board member Steve Dobscha’s studies published in JAMA and in Pain Medicine provide key evidence for the potential success of the stepped care approach. I am hopeful that as facilities develop their pain medicine programs, AAPM members will be attracted to this opportunity.

Local Initiatives

On fronts closer to home, AAPM has continued to develop its Local Initiatives plan, with the goal of establishing a representative in every state that supports AAPM’s local legislative goals. We have had numerous successes at the federal level, and have considerably augmented local legislative efforts. There are currently representatives in 48 states, the District of Columbia, and in the military, and we are looking for additional support. For a full list of all state representatives and to find out how you might be able to help, go to http://www.painmed.org/member/local.html. Thanks to all those members who have agreed to serve as local representatives and to Lynn Webster, MD, for organizing this effort as chair of the Local Initiatives Committee.

Leadership Development

The Strategic Plan’s second goal is to strengthen leadership development. We have worked closely with our Board of Directors to improve the leadership recruiting process, to establish better leadership training, and to clarify specific leadership tracks. Specifically, beginning this February at our Annual Meeting in San Antonio, we will begin providing an annual Board orientation seminar for new Board members, under the leadership of Immediate Past President Ken Follett and with the assistance of AAPM Staff and our long term Counsel, Jack Bierig.

The organization has reached out to past presidents for their guidance to achieve several organizational infrastructure objectives. For example, we are enhancing the current committee structure by asking all board members to identify and recruit new committee members. We have also created a more robust board election process by enhancing the nomination process. AAPM has delineated expectations for leadership advancement by establishing minimum tenure requirements for board service and has developed a presidency pathway by identifying specific positions necessary for governance advancement. And, finally, we are attempting to do a better job of benefiting from the experience of past presidents, board members, and committee members.

Significant leadership progress was made in 2009 and will continue to be made throughout the coming year. We wish to express our appreciation for the efforts of our excellent team, and thank those past presidents who have devoted their time and energy to this important project.

Double the Membership

The Strategic Plan’s third goal is to double our membership. This goal has two components: increasing existing membership and improving retention rates.

Led by Tom Yearwood, MD, PhD, and our Membership Committee, AAPM has undertaken outreach efforts that provide Affiliate Memberships to nonphysician health care providers. These efforts helped pushed the membership count over 2,000 by early 2009, and we have continued to grow. Our membership retention is also at its highest percentage, another great sign that we are continuing to meet members’ needs. Thanks again to all those who have joined AAPM, and thanks especially to those who are able to contribute extra time and expertise to AAPM efforts. As a result of those extra contributions, the number of members actively involved in our committee work has greatly increased—a critical part of any organization’s success.

The Membership Committee has also identified tactics to increase new membership totals, including recruitment from other specialties, recruitment of Fellows, showcasing our job placement service, and providing excellent resources to our members. We will continue to recognize our members’ accomplishments, and constantly strive to improve the manner in which the value of membership is extended to our members.

Looking Forward

As we continue to build on our 2009 accomplishments, we will also be implementing two new Strategic Plan goals in 2010: establishing AAPM as the premier provider for professional educational activities for pain medicine and examining AAPM’s long-term financial security.

Educational Activities

The educational programs currently in development are designed for three primary stakeholders: the AAPM members, the non-AAPM members of the medical community, and the public. For our members, we look forward to continued collaboration with other pain care organizations such as the American Academy of Family Physicians, the Center for Practical Bioethics, and the Federation of State Medical Boards, among others. For both non-AAPM members and members, we intend to develop courses in pain management that will be applicable to their pain practices. For the public, we have developed pain care resources available through our Website, including how to find a pain medicine physician. AAPM members should, of course, link from their personal Websites to the information on the AAPM Website. We are gratified by the prospects of bringing all of these educational opportunities to our members and other stakeholders.
Financial Security

AAPM has appointed a “blue ribbon” committee under Treasurer and President-Elect Perry Fine to closely review our long-term financial stability and opportunities for growth in a rapidly changing and challenging environment for professional medical organizations. The committee is charged with identifying initiatives that offer positive revenue potential in conjunction with quality programming consistent with the AAPM mission and will guide the AAPM board on selecting new initiatives.

There is much promise for the organization and pain medicine in the coming year. We look forward to working with the AAPM membership to build upon these successes and provide our members and their patients with the information, the tools, and the resources they need. On behalf of your AAPM leadership, we thank you for your continued support of AAPM and greatly appreciate those individuals who continue to volunteer their time and efforts to our cause.

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