PRESIDENT’S MESSAGE

Can We Improve Access to Quality Pain Care for Patients?

For many of us, board certification is important in order to practice in our field. The certification process usually involves medical school, residency, perhaps a fellowship, passing a series of exams, continuing medical education and demonstration of competency through periodic exams. While there can be exceptions, this process does help ensure reasonably well qualified physicians.

In Pain Medicine, this process is available through an ACGME fellowship program and a subspecialty certificate via the American Board of Medical Subspecialties (ABMS). The American Board of Pain Medicine also provides a certificate in pain medicine through an examination that, in at least two states (California, Florida), is considered equivalent to the subspecialty certificate.

Despite (or perhaps in part because of) these two mechanisms, confusion exists for the public about who is a pain specialist. Chiropractors, acupuncturists, naturopaths and many other providers can claim and – sometimes – advertise expertise in pain management. The American Academy of Pain Management uses an examination to qualify applicants and presents a certificate. While we desperately need more pain providers, being sure that patients have access to appropriately trained clinicians, whom the public can rely on, is more important.

The ACGME/ABMS process recently added emergency medicine, radiology and family medicine as a pathway of obtaining appropriate training and recognition of pain competence. Unfortunately, few providers can drop out of an income producing practice for 1 year to pursue the needed fellowship.

Yet there remains interest in and need for expertise in pain management especially in primary care. Could the AAPM be instrumental in educating and providing a type of certificate for a broad group of clinicians? The Academy already offers the Essential Tools for Treating the Patient in Pain™ program. Over the past decade, this course has educated thousands of clinicians, many of whom count primary care medicine as their specialty area. Is it time to expand this effort – time to sweeten the pot by offering some sort of credential to suggest additional training. The ACGME process is modeled after the certificate of added qualification (CAQ). Should the AAPM explore development of a “modified” CAQ for pain management but aimed at the primary care provider? We could control the type of education needed, the required follow up process and monitoring of competence. The goal would be more providers with appropriate education thereby helping to ensure better patient care, whether through the primary care clinician or via referral to the pain specialist for evaluation, interventions, and interdisciplinary comprehensive care.

As reasonable as the above argument might sound, the unintended consequences must be considered. As mentioned above, there is already confusion in the general public about what is a pain expert. With few exceptions (e.g. New York), anyone can advertise expertise in pain. Will another certificate, even if vetted through a reputable organization (ABPM) lead to more confusion, or will it result in more appropriate care? For many of us, this discussion has hard financial consequences as nurse anesthetists are being certified in some states to perform many of the injections that support our livelihood. I have not studied the credentialing process for the various groups offering certificates, but I do know the education required by fellowship training and the exam process through ABPM/AAPM. It is wide-ranging and rigorous, emphasizing the broad scope of patient presentations and the needed for comprehensive interdisciplinary care. This training does not come from a few online courses or weekend training. We should be proud of the recognized ABMS/ABPM certificate. Despite the need for more providers, quality patient care is more important and the public should know who are the well-trained pain providers.

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