AMERICAN SOCIETY OF PAIN EDUCATORS

PAIN VIEW

Vol.2 N°.1

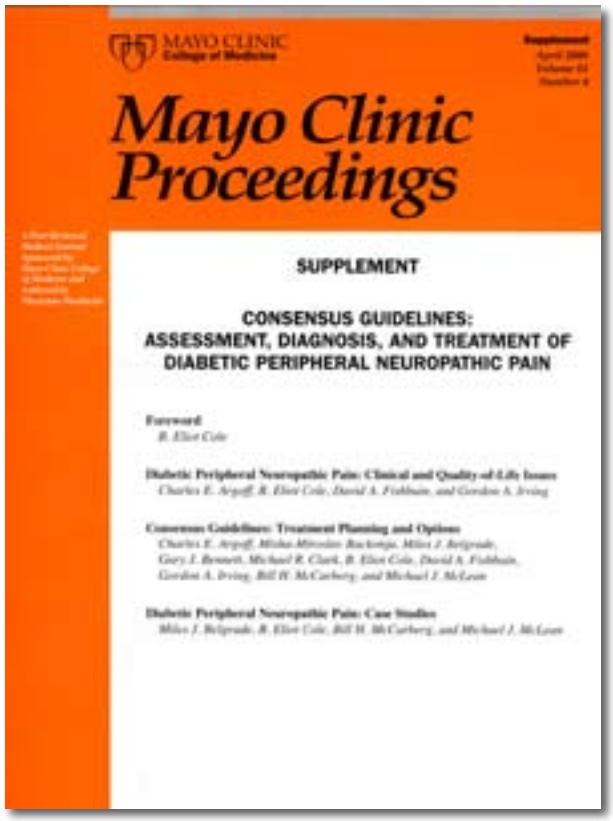
www.paineducators.org

2006

THIS ISSUE

ASPE RELEASES FIRST *EVER* TREATMENT GUIDELINES FOR DIABETIC PERIPHERAL NEUROPATHIC PAIN

The American Society of Pain Educators (ASPE) Consensus Guidelines for the treatment of diabetic peripheral neuropathic pain (DPNP) were published by the *Mayo Clinic Proceedings* in April and sent to every ASPE member. For the first time, pain practitioners will have a definitive, consistent treatment strategy for the management of the pain associated with diabetes. The ASPE guidelines for DPNP were developed to help improve treatment outcomes and minimize medical errors for the estimated 1 million people who are known to suffer from chronic and debilitating DPNP.



"Until now, diabetic peripheral neuropathic pain has fallen under the radar despite the growing public health issue with obesity and diabetes," says the ASPE Executive Director, B. Eliot Cole, MD, MPA. The value of the guidelines is to assure that patients achieve less or resolved pain and less likelihood of side effects from treatment. Physicians who adopt the ASPE guidelines for DPNP will follow recently approved pharmacotherapies as recommended first-line treatment, promoting improved quality of life and physical functioning for patients.

"The ASPE fulfilled one key aspect of its mission: to identify pain-producing diseases and disorders for which there are no treatment guidelines and to develop needed diagnostic and treatment recommendations to improve patient outcomes and minimize medical errors for people with pain," says Dr. Cole.

The Consensus Guidelines for DPNP, developed under an educational grant from Eli Lilly and Company, were jointly sponsored by the Johns Hopkins University School of

(continued on page 7)

Vol.2 N°.1

PainView© 2006 is published quarterly by the American Society of Pain Educators (ASPE). More information on the ASPE can be found at www.paineducators.org. Correspondence can be sent to the American Society of Pain Educators at 7 Oak Place, Suite 7, Montclair, NJ 07042. (973) 233-5570

Executive Director Letter

B. Eliot Cole, MD
Executive Director
American Society of Pain Educators

Being the first is always something to be proud of. The American Society of Pain Educators (ASPE) has developed pain management guidelines that were published in the *Mayo Clinic Proceedings* (Vol. 81S, No. 4) that are being sent to more than 100,000 subscribers with our CME supplement, *Consensus Guidelines: Assessment, Diagnosis, and Treatment of Diabetic Neuropathic Pain*. This 32-page supplement contains 3 articles: the clinical and quality of life aspects of diabetic peripheral neuropathic pain (DPNP), treatment planning options, and case studies.

We are excited that these important guidelines are reaching a large group of primary care practitioners, with all healthcare providers having access at www.mayoclinicproceeding.com. Since the *Mayo Clinic Proceedings* rarely publishes supplements, requires the same peer-review process as the main journal, and has never previously published a case-based article, the ASPE is pleased to promote this accomplishment.

Equally exciting, the *Journal of Family Practice* requested an abbreviated version of the guidelines to appear as a supplement to their June issue, reaching even more practitioners. This is exciting news for any pain organization, but the ASPE is only 18 months old and already we are defining healthcare standards, advancing scientific scholarship, and making educational resources widely available to clinicians. Each member of the ASPE will receive a copy of the guidelines as a benefit of membership.

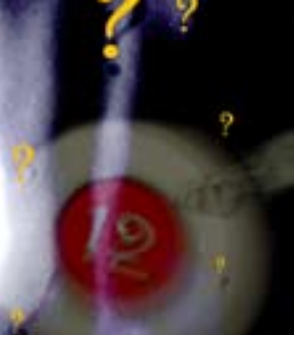
I urge you to participate in our job analysis for the pain educator credentialing examination. It is critical that we have your input in the development of the examination in order to build the core tasks needed by Credentialed Pain Educators (CPEs). Additionally, we cannot start the question-writing process until we determine how important each task is for the CPE. Please visit www.paineducators.org to participate in the survey and help us establish the core competencies.

Our attention is now focused on the 2006 Pain Educators Forum to be held in Philadelphia, July 20-23. The meeting brochure is on its way, and the faculty is preparing an unsurpassed curriculum. We will offer two distinct levels this year: a repeat of the first-year curriculum and an interactive second-year curriculum for those who are preparing to become CPEs. The first-year track provides 6 hours of experiential breakout sessions and 26 hours of plenary lectures. The second-year track offers 23 hours of breakout sessions and 9 hours of keynote lectures. For all, the first and last sessions of each day features a timely subject of common interest presented by top subject-matter experts.

Unlike other pain programs, the Pain Educators Forum blends hands-on training with demonstrations of teaching techniques, use of technology, and will continuously challenge the knowledge base of even the most senior pain practitioner. We are very pleased to bring you this wonderful learning opportunity. Please register today!

I will conclude by saying that the ASPE is uniquely positioned to help all interests find a voice, to use educational efforts as the preferred action, and to keep members informed of new trends. As always, I am interested in hearing your ideas and suggestions, and I look forward to seeing you in Philadelphia.

B. Eliot Cole



Spotlight on Pain Advances

Anthony Delitto, PhD, PT
Chair, Department of Physical Therapy
Comprehensive Spine Center
University of Pittsburgh Medical Center
Pittsburgh, Pa

Back pain will not resolve without early, targeted intervention.

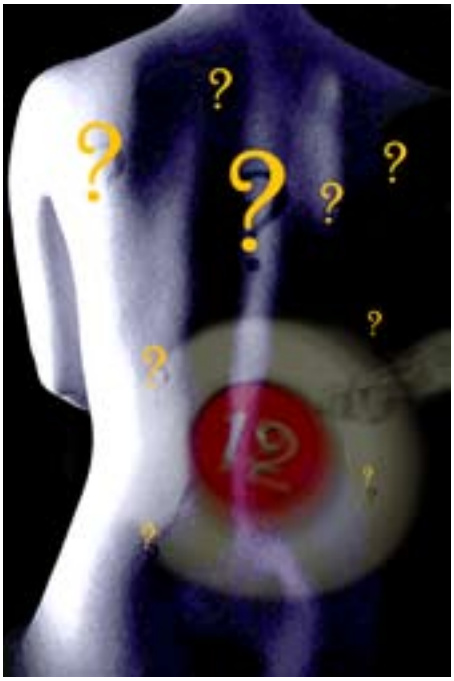
Predictive rules should drive therapeutic decisions.

The right regime promotes quicker pain relief with long-term results.

"We need to dispense with misconceptions like 'everyone will get better anyway'," says Dr. Delitto. Primary care physicians (PCPs) assume that because their patients stopped calling or don't return for follow-up, they're feeling better. The generally accepted notion is that 90% of back pain will resolve on its own, which is contrary to the evidence that people can remain in pain for up to a year after seeking relief, and those who are not disabled by their back pain tend to accept it, choosing to work through the pain.

"We've come a long way in understanding the best way to alleviate back pain," says Dr. Delitto. Bed rest is no longer recommended beyond 1-2 days. Popular routes such as chiropractics, core strengthening (eg, Pilates), and McKenzie exercises have become popular methods for back pain management. A second major shift in practice is driven by insurance limitations on the number of visits permitted.

"Whereas the PT used to try a variety of exercises and manipulations until one seemed to work, we must now get it right the first time," says Dr. Delitto. "Our practice goal is to assess which patients will respond to what therapy and to manage patients early and appropriately in the acute setting to reduce the chance that they will transition to chronic pain," says Dr. Delitto. The Pittsburgh team relies on prediction rules studies[1,2] to match back pain patients to the appropriate treatment. In effect, they are applying outcomes data to determine treatment decisions. This approach offers practitioners a road map that reduces treatment variability and targets the right treatment to patients. By categorizing back pain signs and symptoms, patients are matched to one of 3 therapeutic strategies:



- Manual therapy (manipulation; mobilization, grade 5 thrust), which is most effective for patients who are hypomobile and have 2 findings: short duration of symptoms and no pain below the knee,
- Stabilization (core strengthening), which works for patients who have recurrent pain and fail an instability test,
- Specific exercises (McKenzie), which are effective for patients who have compression nerve root pain. (eg. sciatica)

"The benefits of early, targeted intervention have been validated," says Dr. Delitto, "in that we get patients better sooner and by achieving a quicker positive result, there is a lasting effect."

There is another piece to the Pittsburgh team's methodology–they utilize a disability score[3]. This assessment tool provides a measure of pain intensity and functional independence. The score provides an initial benchmark as well as progress reports since the score is recalculated weekly.

"Pain educators can redefine their role by promoting reliance on evidenced-based outcomes data rather than the current trial-and-error method to more efficiently direct back pain patients to the right treatment approach," says Dr. Delitto. While the Pittsburgh physical therapy group did not make a major treatment discovery, their therapeutic advance comes from recognizing that targeted regimes promote quicker, long-lasting back pain relief. One wonders why this approach is not common practice but Dr. Delitto believes that it has to do with the chasm between research and clinical practice. Our system doesn't recognize or reward best practices–but pain educators can. ☐

1 Wand BM, Bird C, McAuley JH, Dore CJ, MacDowell M, De Souza LH. Early intervention for the management of acute low back pain: a single-blind randomized controlled trial of biopsychosocial education, manual therapy, and exercise. *Spine*. 2004;29(21):2350-6.

2 Brennan GP, Fritz JM, Hunter SJ, Thackeray A, Delitto A, Erhard RE. Identifying subgroups of patients with acute/subacute "nonspecific" low back pain: results of a randomized clinical trial. *Spine*. 2006;31(6):623-31.

3 Fairbank, JC, Couper, J, Davies, JB, O'Brien, JP. The Oswestry low back pain disability questionnaire. *Physiotherapy*. 1980;66:271-273.

Healthcare Organization Profile

Nancy Kupka, DNSc, MPH, RN
Project Director
Division of Standards and Survey Methods
Oakbrook Terrace, Ill

Joint Commission on Accreditation of Healthcare Organizations

As the primary resource, pain educators can direct the interpretation and implementation of guidelines.

Pain educators can lead the institutionalization of pain management standards of practice.

Everyone in the healthcare setting has a role and responsibility to get involved in the assessment of pain. However, the level and capability of the assessment is determined by the scope of the services they provide.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) identified effective pain relief as an essential part of competent health- care. Since 2000, all organizations accredited by JCAHO have been required to meet new standards for assessing and managing pain. To comply, institutions must approach pain relief as a fundamental part of patient care and develop a system-wide commitment to pain management. Yet, 6 years later, the issue of inconsistent and inadequate assessment and management of pain persists.

"JCAHO pain standards grew out of the realization that practitioners, across the board, didn't know when or how to evaluate pain nor were they consistently applying the assessment process to all patients," says Dr. Kupka. "Unfortunately, some institutions misinterpreted the standards such that everyone thought they were supposed to assess every person for pain. Thus, we needed to clarify that the intention was not for everyone who comes in contact with a patient to be conducting a formal pain assessment." Rather, the goal is for staff and technicians who encounter a patient in pain to understand their obligation with regard to pain assessment. Sometimes, just reporting observations to appropriate individuals to promote patient follow-up is all that is needed.

"While we recognize the necessity of more practitioners becoming pain specialists, the purpose of the pain standards is to require competency of all staff working with patients who have pain," says Dr. Kupka. "We need a way to better educate all practitioners so they are able to assist in the provision of pain relief."

"A credentialed pain educator who is working with the health care team to optimally respond to patient pain needs would fulfill a critical and timely need," says Dr. Kupka. "I'm delighted to learn about existence of the American Society of Pain Educators (ASPE) as the ASPE and JCAHO have very compatible missions." If the ASPE can advance more consistent and appropriate pain control through credentialed pain specialists, practitioners will be better able to recognize a problem and act, and patients will suffer less pain and get better relief, sooner. ☐

Resource:

Gordon D, Dahl JL, Stevenson KK. *Building an institutional commitment to pain management* 2nd ed. Madison, WI: University of Wisconsin-Madison Board of Regents; 2000. Available at http://wiscinfo.doit.wisc.edu/trc/.

Under the revised pain standards, organizations accredited by JCAHO are required to meet the following:

- Recognize patients' rights to assessment and management of pain
- Assess the nature and intensity of pain in all patients
- Establish safe medication prescription and ordering procedures
- Ensure staff competency and orient new staff in pain assessment and management
- Monitor patients post-procedurally and reassess patient problems appropriately
- Educate patients on the role of pain management in treatment
- Address patients' needs for symptom management during the discharge planning process
- Collect data to monitor performance

My View of Pain

A Patient Perspective

Helen Dearman

Founder,
National Chronic Pain Society (NCPS)
www.ncps-cpr.org

Listen. *If your patient says, she's in pain, believe her. When you truly hear her, you will be in a better position to help.*

Examine your patients' bodies, really. *Unless you view your patients disrobed (albeit gowned), you won't have a full picture of their condition.*

Make the office comfortable. *The environment—from patient interactions to the furniture-- should aim to ease pain–not enhance it.*

Patient Profile: *I have had chronic pain ever since falling from a ski lift nearly 31 years ago. Since I was able to walk, only my arm was x-rayed. My broken arm mended, and I looked fine, but I was still in constant pain. Fearful of getting addicted to drugs, I opted for surgery, undergoing 6 spinal fusion procedures by 4 different doctors.*

After 17 years, I found a pain specialist who diagnosed 3 fractures to my lumbar spine, confirming an origin to my unrelenting pain, and gave me an intrathecal pain therapy pump to manage my pain.

The sheer joy of being taken seriously and having my pain addressed inspired me to found the National Chronic Pain Society (NCPS), www.ncps-cpr.org, an advocacy group that informs people about treatment options and how to cope with chronic pain.

Your pain went untreated for so long, what can you tell clinicians so that others might fair better? It's crucial that pain educators reinforce the need to look at the patient not as a chart but as a person with pain. Humanizing the experience can go a long way to fostering a good physician-patient relationship. For example, on my first visit, the pain specialist greeted me by first name, putting me at ease and indicating that she cared about me not just the problem that brought me to her office.

Did you voice your expectations to your clinicians? Each complaint was met with "What do you expect?!" or "We see this a lot in women!" They were telling me how I was supposed to feel rather than hearing my cry for help. Physicians may discount the severity of pain in their female patients without realizing it. Pain sufficient to drive us to the doctor should be heeded. We are not looking for drugs, disability, or attention, just relief from unrelenting pain.

What can you say about your fear of drug addiction? I needed reassurance that achieving relief was reasonable, even possible without the risk of getting addicted to drugs.

The fear of addiction provides a wonderful teaching moment; explain the difference between addiction, pseudo addiction, tolerance and physical dependence. Understanding that physical dependence happens to nearly everyone and only 6.4% of people taking opioids get addicted finally put me at ease. I was able to accept drug therapy as a responsible way to gain control over my pain.

What can make doctor visits more efficacious? Physicians who teach about pain, and those who practice it, can do their patients a huge service by offering a comfortable, pain-free environment, such as:

- Limit the ups and downs of waiting. Create a check-in process at the desk that is accomplished before the patient sits down: sign in, complete paperwork and copy insurance card. Once the patient is seated, she shouldn't get up, until it's time to see the doctor.
- Provide comfortable furniture. No one who is in pain should have to sit in an uncomfortable chair or exam table indefinitely.
- Put the patient at ease. Address the person by name and acknowledge the pain as the reason for the visit.

A parting thought... Patients are unlikely to return if they leave in more pain than when they arrived. Reducing pain is not just about drugs and therapeutic interventions, it's about reducing the patient's pain in every way possible. ☐

In Memoriam

Richard J Kroening, MD, PhD. was a pioneer in the modern field of pain management, promoting clinical care and professional training long before there was common acknowledgment about the importance of pain and its management. Dr. Kroening completed a fellowship in rheumatology, going on to serve as director of the Pain Management Center at UCLA School of Medicine (1980-85). He left to co-found the Sierra Pain Institute in Reno, NV. He was described by a colleague as "...the most influential person in my professional career." He will be missed by the many people whose lives he touched.

A Legal View of Pain

Jennifer Bolen, JD
Founder
J. Bolen Group, LLC, and The Legal Side of Pain®

Employing Consultations and Referrals for Chronic Pain

Most states have guidelines or regulations governing the use of controlled substances to treat pain, which typically contain 5 clinical interactions between the physician and patient: medical history and physical examinations; treatment plans; informed consent and agreements for treatments; periodic review; and, consultations and referrals.

The unfortunate reality of our healthcare system is a severe lack of support for referral resources–both financial (proper reimbursement) and professional (addiction and psychological professionals) for pain management. The lack of resources hinders a clinician's ability to provide quality pain management consistent with standards of care and applicable legal/regulatory requirements. As pain educators, we must work to increase the knowledge surrounding use of consultations and referrals in pain management and to develop community resources that improve a provider's ability to comply with the requirements.

Key Documentation Points

To improve the use of consultations and referrals, clinicians need to understand legal/regulatory expectations. Many states have adopted, wholly or in part, the Federation of State Medical Boards' *Model Policy for the Use of Controlled Substances for the Treatment of Pain* (May 2004), which reads:

"*The physician should be willing to refer the patient* as necessary *for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients."*

The 'as necessary' directive is important because it suggests physicians should use consultant and referrals liberally when managing patients with chronic pain, especially those considered at risk for medication "misuse, abuse, or diversion. This directive also suggests that physicians have the discretion to channel patients to other healthcare professionals who can address clinical issues as and when discovered during the course of the physician-patient relationship. Unfortunately, the lack of resources will only frustrate clinicians who attempt to follow state guidelines and regulations on consultations and referrals. As pain educators, we have a duty to help pain practitioners cultivate key relationships and to document for success–in compliance and patient care.

Document your rationale for all consultations and referrals, and review related reports. Consider the value of consultations and referrals early on in patients who have chronic or intractable pain, especially in complex cases and for patients who have a history of substance abuse, an active addiction, or coexisting psychological disorder.

Overcoming Stumbling Blocks

Professional medical organizations should raise the issue of resources to the attention of the state medical board to encourage development of a network and to cultivate compliance, emphasizing that health plans should not be permitted to put clinicians in the position of choosing between network privileges and their license. A quick reference chart relating to this article is available at www.legalsideofpain.com under "ASPE PainView Checklist."☐

Ms. Bolen and her colleagues work with clinicians nationwide on compliance and regulatory issues relating to the use of controlled substances to treat pain. From January 1990 until May 2003, Ms. Bolen served as an assistant United States attorney with the US Department of Justice.

Note: This article is intended to provide only basic information about legal/regulatory issues on the use of controlled substances to treat pain. If you desire specific legal information, contact an expert at www.legalsideofpain.com.

ASPE releases guidelines

(continued from page 1)

Medicine and the ASPE. They were published as a continuing medical education supplement in the Mayo Clinic Proceedings (www.mayoclinicproceedings.com), a peer-reviewed medical journal of the Mayo Clinic College of Medicine (April 2006;81[4, suppl:S12-S25]).

Methodology & Recommendations

The ASPE Consensus Guidelines were developed during a process in which clinical trial outcomes were examined and strengths and weaknesses assessed, and the expert panel's own practical experience with various medications was considered. This led to a ranking of the medications into first-tier and second-tier. Those few medications with strong support for relieving DPNP were deemed first-tier (eg, duloxetine, oxycodone controlled-release, pregabalin and all tricyclic antidepressants) while those with strong support for the relief of other types of nerve damage pain were deemed second-tier.

"The ASPE guidelines for the treatment of diabetic peripheral neuropathic pain offer a positive alternative to the way patients are currently treated," says Dr Cole. "In the absence of guidelines, physicians have relied on a combination of antidepressants, anticonvulsants and various analgesics based on their experience and comfort level. Now, they have a clear consensus on how to help alleviate the pain of patients with DPNP."

Comorbid Conditions of DPN & DPNP

About half of all people with diabetes mellitus have some form of neuropathy (nerve damage). The most common type is diabetic peripheral neuropathy (DPN), affecting the arms and legs. Symptoms may include numbness, tingling, muscle weakness and pain. DPN and DPNP are closely associated with a number of co-morbid

(continued on page 8)

Silent Pain Sufferers

Mary Lynn McPherson, PharmD
Professor, University of Maryland, School of Pharmacy

Do not limit your query to the presence of "pain"; instead, ask about any soreness, pressure, tingling or other discomfort that patients are more likely to acknowledge.

The significant number of silent pain sufferers makes this a conspicuous unmet healthcare need.

As pain educators, we need to lead the effort to identify patients who experience chronic pain. Watkins and colleagues explored the proportion and characteristics of people suffering from chronic pain, who did not seek treatment in Minnesota and found that 64% of the population experienced pain, yet 22% never mentioned it to their physician; 70% reported moderate to severe pain; and, about 50% experienced pain more than 8 days per month[1]. One-fourth of adults had pain that interfered at least modestly with both general activity and sleep. Silent pain sufferers tended to be young and male.

Pain educators should follow the dictum: "seek and ye shall find". Just inquiring about pain in the joints, head, and back, is likely to net a significant return. Similarly, asking patients about aches or soreness, rather than "pain" per se, is likely to elicit a positive response.

Pharmacists frequently encounter patients who are taking multiple medications, allowing them to observe any difficulties with ambulation or guarding and identify patients who are selecting over-the-counter pain medication. As part of the Medicare Part D prescription drug benefit, pharmacists are compensated for providing medication therapy management, which includes reviewing medications, and identifying and resolving drug-related problems, such as pain.

Given the high incidence of silent pain sufferers, practitioners can explore health beliefs about pain and correct any misconceptions; a pre-emptive strike is a move in the right direction. ☐

1 Watkins E, Wollan PC, Melton L,Yawn BP. Silent pain sufferers. *Mayo Clin Proc* 2006;81(2):167-171.

ASPE releases guidelines

(continued from page 7)

conditions, including diabetic retinopathy, depression and sleep disturbances, progressive muscle weakness and foot ulceration. DPN is the leading cause of foot ulcers, which, in turn, are a major cause of amputation in the United States. Other co-morbidities associated with DPNP that are also associated with chronic pain include: sleep disruption, depression and interference with activities of daily living.

"When treating DPNP, it is critical that patients and caregivers become partners with their clinicians to better manage their disease and more fully understand treatment options and outcomes," suggests Dr. Cole.

What pain educators must recognize is that diabetes, like other chronic diseases, plays out over 20 to 25 years. There are millions of people with pre-diabetes or undiagnosed diabetes who at risk for the neuropathic pain associated with this condition. While most people may think diabetes is 'just an inconvenience,' it is slowly destroying many systems and organs along with their quality of life, according to Dr. Cole. ☐

In Search of Pain Relief...

Chronic Pain and Too Little Sleep: Part I

Common Bedfellows

The more severe the pain, the more likely it is to interfere with sleep.

Promoting restorative sleep is critical to effective pain management.

There is an acknowledged reciprocal relationship between pain and sleep. When these two conditions collide, as they often do, pain educators are faced with a magnified management challenge. Consider that pain is the leading cause of insomnia: 75% of pain sufferers have trouble falling asleep, and at least half of adults identify pain as the cause[1]. Patients with at least one diagnosed pain condition typically sleep less than 6 hours a night, and experience at least one symptom of a sleep disorder.

"As such, pain practitioners would do their patients a huge service if initial sleeplessness were prevented from progressing to a chronic sleep condition," say Lynette A. Menefee, PhD, assistant professor of anesthesiology at the Jefferson Pain Center at the Jefferson Medical College, Philadelphia, Pa. The therapeutic stakes rise given that both conditions commonly occur simultaneously, and are often under-treated or ignored. People tend to "tough it out' rather than seek medical care for pain or insomnia, and when they do, adequate relief is not often realized.

"Additionally, patients who struggle with both pain and sleeplessness can develop a psychophysiologic insomnia (a state of worry at being unable to fall asleep) that further perpetuates the pain-sleep cycle," says Dr Menefee. "It's imperative to help patients break this cycle to avoid a more persistent insomnia from developing."

There are a number of etiologies for sleep problems, such as depression and anxiety, which are dismissed as an expected consequence of pain, according to the experts[2]. These co-morbid conditions likely contribute to a patient's dysfunctional sleep, necessitating attention in order to maximize pain management. Activity level during the day, basic sleep hygiene, and rules to promote better sleep should be addressed with every pain patient so that sound sleep can be promoted or restored..

"Physical functioning, age and pain duration were found to be more important predictors than pain intensity and depressed mood in contributing to overall sleep quality," says Dr. Menefee.[3] This is consistent with studies of sleep and physical activity, in which the more sedentary a person, the greater the sleep disturbance experienced. ☐

1 National Sleep Foundation. 2005 Sleep in America Poll. Washington, DC: National Sleep Foundation. March 2005. Available at: www.sleepfoundation.org

2 Roehrs T, Roth T. Sleep and Pain: Interaction of Two Vital Functions. Semin Neurol. 25(1):106-116.

3 Menefee, L.A., Frank, E.D., Doghramji, K., Picarello, K., Park, J.J., Jalali, S., Perez-Schwartz, L. (2000). Self-reported sleep quality and quality of life for individuals with chronic pain conditions. Clinical Journal of Pain, 16, 290-297.

In next issue–

Chronic Pain and Too Little Sleep: Part II

The Treatment Conundrum

Indie Cooper-Guzman, RN

Clinical nurse consultant and educator
Pain management consultant and educator for WebMd
Board certified in pain management

Time For Formal Pain Education

Unrelieved pain remains a significant problem in our country, with needless suffering and system abuse occurring every day. The problem is growing and can be attributed, in part, to 3 major limitations: a lack of formal education related to pain and its management, a need for standards to properly assess and treat pain syndromes, and a commitment to seek and receive the training necessary to become competent and effective in the delivery of pain relief.

Most medical schools do not offer focused pain management instruction, and there is little direct experience in pain control offered during internships or residencies. This may go a long way toward explaining the fear and hesitancy common among many physicians when faced with challenging pain patients

In addition, pain management is gaining attention from many regulatory agencies and there is or will be legislation proposed at the state level, which provides another reason for practitioners to gain the training necessary to promote effective pain management.

Clearly, the climate requires qualified, credential pain educators (CPEs). We are running out of time to prepare enough clinicians to take on the monumental task of educating our professional interdisciplinary healthcare workforce.

One way of enlarging our pain educator population is to leverage existing resources. If every pain specialist were to become a CPE, we would be ready and able to fulfill the growing demand for effective pain management. Since education is a natural part of all practitioners ongoing responsibilities, becoming a CPE can be an opportunity to lead by sharing one's expertise in pain medicine with peers, patients and their families.

Professionals already credentialed in pain management can bring great value to the medical community. Considering patient challenges and being able to share insights gleaned from actual practice can enable any pain practitioner to be most effective in the role of a pain educator. By preparing more CPEs, we will foster the continued preparation of pain educators who will be able to meet the anticipated demands for aggressive pain care. What if every pain clinician became credentialed as a pain educator and recruited just one colleague? **Be One-Bring One**. Think about the synergistic effect that this type of recruitment practice would afford. When talking with colleagues, tell them about the American Society of Pain Educators (ASPE) and explain that the ASPE is the only entity that provides the means to become a CPE. In its two-year existence, the ASPE has been expanding the opportunities for continuing education with the goal of preparing pain educators for the credentialing examination to be offered in 2007.

The time has come to expect more accountability for the standards of practice in pain management. Practitioners must seek out and gain formalized pain education. While pain education can take a variety of approaches, a blended plan seems most efficient given the universal limitations on time. Online courses, traditional on-site courses, teleconferences, and mini-lectures, should all be considered as ways to obtain a standardized curriculum. A major advantage to the variety of educational opportunities is the ability to tailor materials and examples to different practitioners so specific practice needs are met.

At this point, anyone active in the delivery of patient care should become effective in recognizing and addressing their patients' pain. Toward this end, every practitioner can become better prepared to meet both current needs and the growing demand for pain control. Think about it and, if you haven't already, consider becoming a credentialed pain educator today! For information about becoming a CPE, please visit www.paineducators.org. ☐

ASPE Membership Benefits

We believe that there is a growing demand for credentialed pain educators (CPEs) in primary care practices, HMOs, hospitals, long-term care facilities, and other clinical environments. Working in an increasingly regulated world, the CPE will quickly become vital and necessary in these clinical settings.

Membership benefits of the ASPE include:

- Discounted registration to the Pain Educators Forum and other meetings
- Professional development in pain management education with the option of preparing for certification as a credentialed pain educator
- Printed subscription to PainView – the official newsletter of the ASPE
- Personal paineducators.org email address
- Custom ASPE business cards – let clients, patients, and colleagues know that you belong to the ASPE and that you are a Pain Educator
- Access to the ASPE Membership Directory
- Email alerts for newly published articles on pain-related topics
- Networking support
- Negotiated member discounts on travel, entertainment, and more

Register now for the 2006 Pain Educators Forum www.paineducators.org

In an ongoing effort to provide members with practical and useful clinical tools, the ASPE presents this patient care checklist. Please feel free to copy and use at your discretion.

ASPE Pain Checklist

Pain Checklist for: _____ _____
(Patient's name) (Date completed)

☐ **Prior medical records**
- ☐ Requested: _____
- ☐ Received: _____
- ☐ Not applicable

☐ **Patient history**
- ☐ Chief complaint
- ☐ Pain problem
- ☐ Past medical history
- ☐ Mental health
- ☐ Substance use/abuse
- ☐ Family medical history
- ☐ Review of pertinent systems

☐ **Physical examination**
- ☐ Area of pain now experienced
- ☐ General state of health
- ☐ Mental status

☐ **Initial pain-related diagnosis**

☐ **Screening instruments needed**
- ☐ *Pain*
  - ☐ Brief Pain Inventory (BPI)
  - ☐ McGill Pain Questionnaire (MPQ)
  - ☐ Neuropathy-specific questionnaire
  - ☐ Other: _____
- ☐ *Depression*
  - ☐ Beck Depression Inventory (BDI)
  - ☐ Zung Self-rating Depression Scale
  - ☐ HAM-D
  - ☐ Other: _____
  - ☐ Not applicable
- ☐ *Anxiety*
  - ☐ HAM-A
  - ☐ Other: _____
  - ☐ Not applicable
- ☐ *Substance abuse*
  - ☐ CAGE
  - ☐ Trauma screening
  - ☐ Drug abuse screening test
  - ☐ Other: _____
  - ☐ Not applicable

☐ **Function/Quality of life**
- ☐ Quality of life scale
- ☐ Pain Disability Index (PDI)
- ☐ Other: _____
- ☐ Not applicable

☐ **Referrals needed**
- ☐ Mental health
- ☐ Substance abuse/Addiction
- ☐ Neurology/Neurosurgery
- ☐ Physical Medicine & Rehabilitation
- ☐ Anesthesiology
- ☐ Internal Medicine/Subspecialist
- ☐ Other: _____
- ☐ Not applicable

☐ **Imaging studies needed**
- ☐ Plain x-rays: _____
- ☐ CT: _____
- ☐ MRI: _____
- ☐ US: _____
- ☐ Other: _____
- ☐ Not applicable

☐ **Electrodiagnostic studies needed**
- ☐ EMG
- ☐ NCV $^{+}/_{-}$ F-waves & H reflexes
- ☐ SSEP
- ☐ Not applicable

☐ **Goal setting & treatment planning**
- ☐ Function and goal setting
- ☐ General consent for treatment
- ☐ Long-term controlled substance therapy for chronic pain agreement
- ☐ Other: _____

☐ **Patient/Clinician communication**
- ☐ Use a generic pain diary
- ☐ Experience co-incident insomnia
- ☐ Manage expected side effects
- ☐ Frequently Asked Questions
- ☐ Other: _____

Modified with permission from Chronic Pain Network form AVIN449-NP 04/05

A Dose of Laughter

Joel Goodman, EdD
Founder, President
The Humor Project
Editor
Laughing Matters

Place humorous stimuli in the waiting room, and exam rooms, to make the wait pass more pleasantly.

Use humor that fits your style and personality.

Write regular laughter "prescriptions" at every visit.

HUMOR: USE IT, SHARE IT!

Nearly five million individuals saw a physician for chronic pain in 1999. In the same year, more than four in ten people experiencing moderate to severe pain were unable to get adequate pain relief, according to The Chronic Pain in America: Roadblocks to Relief survey†. Pain educators might consider that a little levity can go a long way when faced with these challenges.

Laughter as good medicine entered the general psyche with Norman Cousins' best-selling book, *Anatomy of an Illness as Perceived by the Patient: Reflections on Healing and Regeneration*. He attributed, in part, a daily dose of Marx brothers to his recovery from ankylosing spondylitis. Since then, there has been a growing appreciation for the mind/body connection, and the role of humor has amassed sufficient scientific integrity to have outgrown its status as a fad.

Having a sense of humor is important for practitioners who aim to promote effective pain relief. After all, a physician's attitude and demeanor have an immense influence on patient compliance and, ultimately, on patient outcome. This doesn't mean that physicians should don a clown nose or start every conversation with a joke. Rather, it is meant to remind you that pain educators can have a profound influence on patient care and that humor presents another tool for successful pain management.

Since 98% of people admit that they can't tell a joke, there are more effective ways of inviting a laugh or a smile. Consider the waiting room: physicians often get backed up, leaving patients to simmer in their pain. Why not offer some humorous stimuli (eg, books, cartoons, props, posters) to ease the pain of waiting? Your effort could be as simple as having a joke-a-day calendar or daily cartoon available in addition to the typical magazines. This kind of good-will gesture can have long-term resonance.

Just A Spoonful of Sugar... Sometimes, pain can be eased but not completely alleviated. Giving fellow pain practitioners and their patients a laugh will make the pill (or the treatment plan) easier to swallow! Why not write a laughter prescription? This script may suggest reading a favorite comic before breakfast each day or tuning in to a favorite sitcom before going to bed.

Beyond delivering strategies for optimal pain relief, humor may improve practitioners' chances of having patients leave the office feeling better cared for and more cared about. By prompting laughter, you are treating patients as people–not as pain locations. This is the value of humor.

Humor Whys:

- Humor is the tonic everyone can afford.
- Intersperse humor with costly medical treatments since humor is priceless, and the only side effects are pleasurable.

For a more fun ideas and laughter tools, you can request your very own Humor Sourcebook. (www.HumorProject.com). ☐

†This survey was conducted by Roper Starch Worldwide on behalf of the American Pain Society and the American Academy of Pain Medicine (AAPM) co-sponsored with Janssen Pharmaceutica, Inc

Patient Advocacy Group Appeals for Support

Pain Relief Network (PRN) supports the appeal of physicians wrongly convicted under the Controlled Substances Act (CSA). The law is deeply flawed, making it nearly impossible for physicians to defend themselves against wrongful prosecution. The CSA violates the right to due process for physicians and their patients, which must be constitutionally tested.

The long sentences imposed upon those found guilty of violating the CSA has caused physicians to become uncomfortable prescribing opioids to their patients. Fearing investigation, physicians may refrain from providing appropriate pain relief. This situation should not be permitted in the US. PRN seeks to enjoin the federal government from prosecuting physicians under the CSA and intends to challenge the constitutionality of the law itself. To achieve this, financial support is needed. Please consider contributing to PRN in support of our efforts to stop the US Department of Justice's campaign against opioid prescribers. PRN is a 501 c3 non-profit organization so contributions may be tax deductible. All of the money raised will go directly to this effort.

Make check payable to Pain Relief Network (on the memo line write "Legal Defense Fund") and mail to PO Box 231054, New York, NY 10023 or donate online at wwwpainreliefnetwork.org.

ASPE Continuing Education Opportunities

Beginning in April 2006, members can look for the following publication and programs:

Consensus Guidelines: Assessment, Diagnosis and Treatment of Diabetic Peripheral Neuropathic Pain

A continuing medical education supplement to the *Mayo Clinic Proceedings*
(April 2006;81[4, suppl:S12-S25]) View at www.mayoclinicproceedings.com.

New Approaches to Pain Management in a Polypharmacy Environment

A continuing education forum on polypharmacy–a therapeutic approach of combining different medications in order to lessen toxicity of any single drug. 4.5 continuing education credits are provided by the Johns Hopkins University School of Medicine, the University of Arizona College of Pharmacy, the University of Texas Health Science Center at San Antonio, and the ASPE.

Symposia Schedule

Saturday, April 29, 2006
Hilton Anatole
Dallas, Tex

Saturday, May 6, 2006
The Palmer House
Chicago, Ill 60603

Saturday, June 3, 2006
Doubletree Hotel Los Angeles (Westwood)
Los Angles, Calif

Saturday, August 12, 2006
Sheraton Yankee Trader Hotel
Ft. Lauderdale, Fla

For more information on the Polypharmacy Symposia, contact Dawn Powers at dp@paineducators.org or (973) 233-4457.

The Polypharmacy continuing education program is made possible by an unrestricted educational grant from Eli Lilly & Co.

PAINVIEW
2006
Vol.2 No.1
7 Oak Place Suite 7
Montclair NJ 07042