Pain Education and Training: Progress or Paralysis?

The time has come for organized medicine, led by the American Academy of Pain Medicine (AAPM) working with other pain organizations, to address systematically and rigorously the need for standards in pain education for all medical schools and relevant training in pain management for all clinical specialties. This education and training needs to be provided by faculty uniformly and reliably trained in pain medicine, and these faculty must be supported by academic medical centers and training facilities. In this issue, two of our leaders in developing pain curricula in medical schools present their important work. Dr. Hui-Ming Chang reviews and comments on the progress that has been made in medical school education, including her and her colleagues' work at the University of Texas in Houston. Dr. Debra Weiner and Gregory Turner at the University of Pittsburgh present their systematic development of a curriculum in pain medicine for the elderly, using a modified Delphi method.

The AAPM and Medical Education The AAPM, representing the medical specialty of pain medicine, must continue to encourage and support medical school faculty to lead medicine in this mission. The AAPM's Long-range Planning Committee first articulated a concern about the unevenness of medical student education in pain in 1997, laying the groundwork for the AAPM's appointment in 1998 of the Undergraduate Education Committee, co-chaired by this editor and Dr. Chang. We were convinced that by establishing a standing committee with its sole objective to improve and standardize medical student education (and therefore the education of all future physicians — "preaching to the choir!") we would maintain a continuity of focus and work that would eventually lead to progress and success. The legitimacy of this mission, which was already established by epidemiological studies demonstrating the high incidence of inadequately treated pain in hospitals (over 50%) and in the general population, was further supported by a national movement outside of the medical schools calling for improved medical student education, as noted by Dr. Chang in her editorial. Because of public frustration with a lack of progress in medical schools to address this issue, as representatives of a concerned general pubic, some state legislatures (e.g., California) have even taken the step of mandating medical student education in pain management. The AAPM has also responded by initiating the TOP project, which is developing a web-based educational program and model curricula to assist medical schools in achieving proficiency in teaching medical students about pain. These new curricula will need to be evaluated for their effectiveness in improving medical student knowledge and skills in a way that translates into better medical care for Americans. The leadership efforts of Dr. Chang, Dr. Weiner and their colleagues are models for the field.

Training of Faculty However, as Dr. Chang notes, a key barrier to success in this mission is the difficulty in identifying and supporting well-trained faculty to teach in medical schools. AAPM can help develop these faculty by providing support and concrete assistance to AAPM members who teach in medical schools, and by working with other key medical organizations to address the organizational politics that maintain the barriers to developing faculty for better medical student education. The American Board of Medical specialties, led by the American Board of Anesthesiology, has agreed with the position of the American Board of Pain Medicine that the present system of one year fellowships in pain management after primary specialty training has failed to effectively address the public health problem of inadequately treated pain. This process created the false impression that uniformly trained pain doctors were credentialed by an examination (that until recently almost exclusively tested the knowledge and skills of regional anesthesiology) to provide the medical care needed by patients with pain. Instead the public got whatever the practitioner was trained to do, not necessarily what the patient needed, and the results were, not surprisingly, usually poor. Because the ABA policy, as followed, did not accept non-anesthesiologists into pain training programs or into its examination, what was created over a ten-year period was a large group of sub-specialists in anesthesiology pain management, with their practice focused on regional anesthesiology, and a small group of non-anesthesiologists, who because of their practice experience and academic work identified themselves as pain medicine physicians. After finishing formal training, many of the practitioners in both groups, by virtue of responding to their patients' diverse clinical needs, remedied some of their formal training deficiencies by participating in continuing education programs made available by the AAPM and other organizations. These individuals make up the AAPAM. The ABA, supported by some other ABMS Boards, has recently proposed an expansion of the fellowship training in pain management to a 2-year fellowship. This would mean that all specialists would continue to receive their initial specialty training first, then...
spend an additional two years completing training in pain medicine. The AAPM and ABPM are advocating for pain medicine residencies as the only way to both standardize training and to efficiently train practitioners and future faculty.

The present ABA plan is flawed for several reasons. First, it adds the barrier of time and expense to the development of a pain medicine specialist. When there should be a well-trained pain medicine specialist in every community hospital to respond to the societal demand for better access to pain treatment and there is a need for more faculty trained in pain medicine, this strategy would reduce the flow of trained practitioners by creating a powerful economic disincentive to doctors wishing to enter the field. Why spend 3 years of residency training in anesthesiology, psychiatry, neurology or PM & R learning skills and procedures with little direct relevancy to the practice of pain medicine, when those three years could be spent learning all the demanding skills of pain medicine? Moreover, pain medicine doctors would have to complete two residencies, essentially, in the face of falling reimbursement rates for pain procedures and general economic uncertainty in medicine, while often bearing large educational loans from college and medical school. In this debt-burdened scenario, there would be a strong incentive for these doctors to do for the patient what makes money, rather than what is right for the patient — and in debt-burdened academic medical centers, they would be encouraged to do this as well. Mark Lema, MD, PhD, Professor and Chairman of Anesthesiology at SUNY Buffalo and Roswell Park Cancer Center, recently wrote an editorial in the American Society of Anesthesiology (ASA) Newsletter outlining some of the pitfalls of this system of education and treatment (Lema MJ. Pain and anesthesiology: What’s the Name of the Game? *ASA Newsletter*; Vol. 66, May 2002), and the challenges facing the field in the future. As Dr. Lema points out, given these economic pressures, there will be incentives to fill training programs with less competitive residents, many that will return to their countries of origin.

A second problem with the present ABMS plan is that it requires wasteful retraining. When a doctor receives training in a specialty, he or she is indoctrinated into the clinical reasoning skills, culture and identity of that specialty. It is very difficult to unlearn those biases when retraining in pain medicine, which is founded on its own unique basic and clinical sciences and weaves together training aspects of several specialties into a unique tapestry of clinical reasoning skills and procedures that we call our specialty. Over the years I personally have trained fellows with specialty backgrounds in anesthesiology, psychiatry, neurology, PM & R, and family practice. Each came into the training with their own biases and even erroneous information about the nature of pain, its assessment and its management. Each had to unlearn these in order to learn pain medicine.

**Community Pain Physicians as Faculty** So where will the faculty come from to teach pain medicine and to form pain medicine departments in medical schools? The departmentalism of medical schools has generally prevented the development of faculty in one department or another with the requisite broad range of skills in this emerging specialty. The family practice experience as a new specialty in the 1970’s and 1980’s is a model we should consider for our specialty. When departments of family practice were being rapidly developed in American medical schools to meet a national need for primary care physicians in the community, only a few faculty were drawn from other departments in the medical schools, such as pediatrics and internal medicine. Many of the first generation of family practice faculty were recruited from the group of experienced general practitioners and other primary care physicians in the community, where they had learned the lessons of community family practice that medical centers had little experience with. Our AAPM membership in many ways resembles this group of experienced clinicians in the community, doctors who practice skills have evolved to meet the needs of a community, not subject to the political and economic constraints on practice in medical centers, as mentioned by Dr. Lema. These practitioners may be best qualified to teach clinical pain medicine, and to lead the development of faculty and departments in teaching hospitals and medical schools.

Those responsible for policy in medical education will respond best to results, not promises. The AAPM needs to focus on helping develop medical student education that is effective and efficient, by conducting research of innovative curricula, such as the TOP program, and by supporting faculty in teaching roles. Responsible individuals from all relevant medical organizations must work together with the AAPM to overcome the political barriers, based on self-interest, that are preventing progress in education to meet the needs of the public. Together we can develop efficient training of pain medicine specialists who will provide both reliable care to the public and quality education for medical students and other trainees.

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