

In 1995, APS again drew media attention to its meeting and to the topic of pain, with broadcast media conducting numerous interviews with speakers and spokespersons attending the meeting. The resultant publicity for APS and, what is more important, for the field of pain will appear in the professional healthcare media as well as in the general media. The society continues to field numerous media inquiries sparked by the ever-increasing attention to issues and debates on quality of care, chronic disease, old age, and suffering.

The annual meeting draws a substantial number of new members to APS each year. In 1995, more than 300 nonmember registrants joined the society. The 1996 Scientific Program Committee, headed by Mark Jensen, PhD, is already at work preparing to deliver another exceptional program that will further enhance the status of the APS Annual Scientific Meeting as the premier meeting in the field of pain. The 1996 meeting will be held November 14–17 in Washington, DC, at the Sheraton Washington Hotel.

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## **A** PS 1995 Presidential Address

*James N. Campbell*

*Note: APS's 1994–1995 president, James N. Campbell, MD, presented the following address on Sunday, November 12, 1995, at the Century Plaza Hotel in Los Angeles, during the 14th Annual Scientific Meeting of the American Pain Society.*



James N. Campbell, MD

At the outset I wish to make a confession. I have attended scientific and medical meetings for well over 20 years. I believe, however, that it was not until sometime last year that I ever attended a presidential address. I always considered the presidential address a good time to go to the gym for a workout. It was about the time that I was elected president of the American Pain Society that my attitude changed altogether. From that time forward, I have taken every opportunity to attend a presidential address. I have to tell you that the addresses have tended to be a bit dull, and they have been concerned with a topic that seems already somewhat worn. That topic is managed care. I, too, will talk a bit about managed care today. But please do not leave. I will keep my remarks brief.

When the Wright brothers made it possible for man to fly, there were interesting reactions. One was that the undertakings of the Wright brothers were evil, that it was a violation of nature: If man were meant to fly, he would have been given wings. As one East Coaster put it, "If man was meant to fly, why did God create the New Jersey turnpike?" From time to time, we encounter these attitudes with regard to other technologies. Some believe that it is evil to receive a blood transfusion. Some believe that life-support technology is evil. Some even believe that all life-preserving technologies are suspect and perhaps even evil.

In general, we are dismissive of these ideas. Most of us, with little thought, readily endorse and actively pursue life-preservation technology. Enormous healthcare resources are directed not only at preserving life, but also at seeking to do a better job of it. This is good; this is noble. We work earnestly at improving life-preservation technology. And we do it quite well. The average man lived to the age of 27 in London at the turn of this century. He now lives to 80.

We pursue longevity not just for the sake of others. By virtue of enormously strong instinctual drives, we seek life preservation for ourselves. It preoccupies us at every moment. We seek always to forestall the inevitable, to delay it. And we are quite successful compared to just a few decades ago.

But let me ask you to pause for a moment. What would you do if the object of pursuit were in fact granted? Let us say that you discover ways to alter the genetic code that would enable you to preserve life indefinitely. We would then all have the capacity to live forever.

Many of us would consider this to be an ultimate triumph, but no matter how you felt, such a discovery would have to give you pause. We now pursue perpetuation of life knowing that everybody ultimately dies. We pursue life preservation without too much thought because, deep down, we believe the goal is unobtainable. Sometimes getting what we want ends up not

being what we really want. Imagine a world in which nobody dies, and life continues forever. Would we really want this? What would our attitudes be about bringing new life into the world? Break out your pencil and consider the date when our world would finally fill up completely with people. What would happen then? What then would be our beliefs about the sanctity of life?

We are dismissive of those who reject technology that perpetuates life. We reject allowing a person to die a natural death from an infectious disease, knowing that penicillin would allow that person to live. But those few in our world who are not so comfortable with science, with technology, with the airplane of the Wright brothers, with the technology of modern medicine, may ultimately have a point. We use penicillin to save lives routinely; this penicillin, discovered just a few years ago, has evolved into a legion of other, much more powerful drugs. What if our penicillin of today were to evolve into a medication that could correct all disease—that could indefinitely perpetuate life? Would we so easily accept this ultimate technology? Would we again be so dismissive of those very few in our midst who distrust technology and science? I do not know. I know that for a physician, saving a life is an ultimate goal. To do this for a 5-year-old child is a cherished privilege. I must confess to you, however, that I—and I think all health professionals who dare to take their head out of the sand—must wonder at the expenditure of enormous sums of healthcare dollars to save the life of the 90-year-old, riddled with disease, who has pneumonia that would respond to penicillin. If we question this, where do our questions stop?

Thirty years ago to this day, as a senior in high school poised to embark on a premed curriculum, I wondered about this. I wondered, too, as I pursued a career as a clinician-scientist, did I want to develop a cure for cancer? Or did I want to pursue the ultimate penicillin? All my instincts say that yes, this is right and this is the ultimate pursuit, the ultimate goal to be obtained, but another side—maybe a rational side—says that this pursuit may not be so right. (Let me add quickly that instincts win out every time—I fight for my own life and I unhesitatingly fight for life in others whenever I have any opportunity.)

But the intellectual struggle with this issue lays root to a reconciliation, a reconciliation that leads me to be here today and to serve with passion, without hesitation, and with earnest zeal the ultimate mission of this society. We are all here today because our mission is concerned with something that is more precious than simple perpetuation of life. What we as members of APS ultimately strive for is quality of life. That is our noble ambition. Needless suffering from pain is not acceptable. Some of us as researchers, some as

nurses, some as psychologists, some as physicians, and finally some as policy makers are regulators of pain in the interest of the public.

James Mill, the Scottish utilitarian philosopher said, “The lot of every human being is determined by his pains and pleasures, and...his happiness corresponds with the degree in which his pleasures are great and his pains are small.”

We know that when pain is controlled there are many benefits: fewer postoperative complications, earlier mobilization, and more patient satisfaction. There also is higher compliance. The patient is less likely to be afraid of hospitals and is more likely to be compliant with treatment programs. The patient who has a severely painful examination at the dentist’s office is less likely to return to the dentist for routine care. Yet, at the same time, we know that patients and the public are underserved with regard to treatment of pain. I am not talking just about the patient with five back operations who is crippled with back pain, and I am not talking about the patient who has breast cancer infiltrating to the brachial plexus. I am talking about everyday common experiences with routine operations, with acute exacerbations of back pain, with rheumatoid arthritis, and with myriad other diseases.

How well do surgeons in your community assess the severity of pain postoperatively? How often is the patient put in a position of seeming to ask for a favor of the primary care doctor to get adequate pain control for a simple backache? Patient-controlled analgesia teaches us that an incredibly simple 0 to 10 scale can be used easily to measure suffering from pain. We tell the patient to imagine that 10 is the worst pain you can imagine having and that 0 is no pain at all. High numbers mean the patient suffers. Today, nurses and physicians routinely assess the vital signs of pulse, blood pressure, core temperature, and respirations in evaluating patients. We should consider pain the *fifth vital sign*. When a patient says, “My pain is a 9,” this is like running a fever or like having a hypotensive crisis or atrial fibrillation. We know how to treat most pain. Someone once said that the greatest advance in pain care would be to implement better what we already know. We know how to take pain at a level of 9 and lower it to 3. Lowering pain from 9 to 3 is not unlike giving Tylenol to lower fever or giving fluids to raise blood pressure. We take vital signs seriously. If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly. We need to train doctors and nurses to treat pain as a vital sign. *Quality care* means that pain is measured. *Quality of care* means that pain is treated.

There have been great strides with regard to the development of techniques to treat acute pain and can-

cer pain. We continue to stumble a bit when the topic of chronic noncancer pain comes up. I want to tell you that I am not so sure that we serve our patients well by distinguishing chronic noncancer pain from chronic cancer pain. It was true in the past that cancer pain was special because the patients usually died within a short time frame. That certainly is no longer true. Cancer pain victims frequently live long periods. The boundaries between cancer pain and noncancer pain are thus blurred. I think also that we often overplay the distinction between acute pain and chronic pain. A colleague once said, "When you stub your toe on the door, that's acute pain. When your toe hurts an hour later, that's chronic pain." In some ways, it is as simple as that. Chronic pain is often said to be a complex phenomenon. Calling chronic pain a complex phenomenon may have the unintended effect, however, of establishing barriers to treatment. Chronic pain can be measured on a 0 to 10 scale as easily as acute pain. If pain is scaled high, this is a vital sign that the patient requires treatment, regardless of whether the patient has postoperative pain or more enduring chronic pain, and regardless of whether the patient has cancer pain, a flare-up of a chronic back pain problem, or chronic pain from rheumatoid arthritis.

I want to discuss now opioid medications for pain. Many patients with chronic pain do—and many more patients have the capacity to—benefit from use of opioid medications. This was a lesson learned years ago by our colleagues who treated patients with cancer. It became obvious to these clinicians that a patient did not necessarily have to have cancer to derive long-term alleviation of pain from the use of opioids. It has taken an embarrassingly long time for clinicians concerned with chronic noncancer pain to realize this. Misinformation about what addiction is and myths about liability for addiction in patients with pain have not been the only reasons for underuse. Fear of regulatory reproach by government is certainly another source of concern. Albert Brady, MD, David Joranson, MSSW, and numerous others on the APS Analgesic Regulatory Issues Committee have worked diligently with government agencies on behalf of APS to aid in the development of guidelines that will allow physicians to continue to use opioids for the treatment of pain and yet recognize the dangers of illicit drug use.

One of the active committees of the American Pain Society is the Quality of Care Committee. Under the leadership of Mitchell Max, MD, and with the help of many other individuals in our society, positive steps have been taken to make good care of pain a standard. The *Journal of the American Medical Association*, in December 1995, published the quality care guidelines developed by this committee to be used in hospitals. It

will be my suggestion that these guidelines be used as part of the overall guidelines for hospital accreditation. That is, that proper assessment and treatment of pain in the hospital will become part of the standard of care that hospitals must provide. Publication of the quality care guidelines in the *Journal of the American Medical Association* is a major achievement for APS and specifically for the members of the Quality of Care Committee. After publication, we will make these guidelines available to each APS member.

I said I would say something about managed care. The key word in this discussion is *access*. In the managed care environment, withholding care may be perceived to save dollars for the payer. Gatekeepers who lack knowledge about what might be offered by specialists often make the decisions regarding when referrals to pain specialists are to be made. In too many cases, patients are denied care. To give an example, we have a behaviorally based inpatient program for many of our most difficult pain problems at Johns Hopkins. We have good data that show that patients who go through the program, by and large, benefit. Demands for further health care, more often than not, decrease in the years after admission. Also, quality of life improves. Regardless of this, a substantial number of referred patients are denied admission to our program by payers. This is despite the fact that one full-time employee does nothing more than plead the case of individual patients with insurance carriers.

To address these concerns, APS this year created a Public Affairs Committee, chaired by David Joranson, MSSW, and Joel Saper, MD, FACP. The committee has identified the following targets: the public, the government, and the payers. Let us now consider them.

Our first target is the public. To enhance awareness of pain and to serve the public better, the APS Board of Directors, with input from the Public Affairs Committee, decided that a foundation should be created. The mission of the foundation will be to advocate for patients who suffer from pain, both acute and chronic. Whereas APS serves professionals, the foundation will serve the public. We will seek backing from industry and the public, as well as from APS members, to support the foundation. This foundation will take shape officially over the next year. It will be large, and it will have a scope similar to the National Arthritis Foundation. As one early initiative of the foundation, APS is looking into organizing a Pain Awareness Week to coincide with the meeting of APS next year in Washington, DC. Stay tuned—you will be hearing much more about this.

The second target is the government. Healthcare legislation and changes in Medicare will have profound implications with regard to the treatment of pain. We have joined forces with other organizations to have a Washington presence. We will closely monitor legisla-

tion concerned with health care and advocate for our patients when the opportunity arises.

Managed care is our third target. The CEOs that run the managed care companies have a great voice in determining what pain care patients receive. Albert Brady, MD, heads a task force on managed care specifically to address this issue. One goal is to create a dialogue with representatives of managed care and to establish minimum standards of care regarding treatment of pain. While it may be true that return on shareholders' equity is an important motive for the managed care industry, ultimately the managed care organizations that survive will be the ones that provide quality. I see one of APS's roles as being a monitor. When we see abuses, we need to make these concerns known to the managed care organization and ultimately to the patients and, where appropriate, to their employers. Consumer-driven report cards on the quality of treatment provided by managed care is one proactive step that may be taken. Quality therapy for pain needs to be part of that report card.

If we are going to influence managed care, we must understand its perspective. A frequent complaint we hear from managed care is that there are no clear standards that indicate what proper pain treatment is. The answer is twofold. We must, on the one hand, enhance the image of pain care. We advocate for treatment of pain based on solid scientific footings, and we advocate for care by experts well trained in the field of pain. The corner acupuncture store that advertises treatment of back pain cannot be part of what we advocate.

On the other hand, we must develop guidelines insofar as we can, based on the available literature, that represent a consensus of how pain should be treated. If, when we approach managed care, we can point to expert consensus that indicates a concordance regarding appropriate care, our mission will be greatly aided.

Guideline development must be rigorous and fair and must capture the state-of-the-art. Guidelines must reflect the quality of the data that support a particular treatment, with full recognition that randomized trials can be used only exceptionally to support a particular approach to a patient. Guidelines must be developed, insofar as possible, by individuals who will not be affected economically by the outcome. Ada Jacox, PhD, RN, an experienced developer of guidelines for the Agency for Health Care Policy and Research, heads the APS Clinical Practice Guidelines Committee and is working with colleagues to develop a methodology for guidelines development.

The American Pain Society serves a wonderful cause. These are indeed challenging times. We are confronted by static levels of support for research and massive changes in healthcare financing. We must know deep down though that what we do is good for

human beings. Adversity will, I think, draw us closer together. We will answer critics by doing better than which we already do. We will do more to measure outcomes in carefully done studies to show that what we do to help patients really does work and that these treatments have a sound scientific basis. We will continue to work for board certification with rigorous credentialing procedures appropriate to our individual disciplines, because we realize that credentialing really does raise the standard of care. We will work toward the development of rigorous guidelines, because guidelines will mandate payers to provide the care that patients deserve. We will work toward the development of new drugs, new scientific understandings, new operations, and new insights into the psychology of pain. We will do all of these things, and we will do them well. Thank you so much for giving me the privilege this year of serving as your president.

*James Campbell, MD, is director of the Blaustein Pain Treatment Center of Johns Hopkins Hospital and professor of neurosurgery at Johns Hopkins University School of Medicine in Baltimore.*

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## **A** PS Board Briefs

*Joan M. Romano*

The Board of Directors of the American Pain Society met on November 8 and 12, 1995, during the APS Annual Scientific Meeting at the Century Plaza Hotel & Tower in Los Angeles.

On November 8, the board voted on the following motions:

- Approved a proposal to offer a complimentary nonvoting membership to a single designated representative from each chapter of the International Association for the Study of Pain (IASP).
- Approved a 1996 budget.
- Approved proposed committee and task force structure and chair appointments.
- Approved a newly revised policies and procedures manual for the organization.
- Voted to fund not more than \$40,000 from APS reserves to begin the process of guidelines development and to seek additional funding from other sources for a general fund for further guidelines development.