

**American Academy of Neurology (AAN)**  
**Subspecialty Strategic Plan for the**  
***Pain and Palliative Care Section***

**I. INTRODUCTION**

**A. Definition of the Subspecialty or Section**

Pain is a fundamental property of the nervous system. Most neurological disorders produce chronic neuropathic pain, among other symptoms. Thus, as health providers to the nervous system, neurologists should be fully informed of the taxonomy, epidemiology, pathophysiology, and treatment of pain. This Section exists to increase the knowledge of pain disorders and their treatment among the AAN's general membership, and to encourage other neurologists to develop competence in pain management and palliative care. The topic of Palliative Care was added to the Section after its creation as a forum for those interested in pain as it relates to terminal and end-of-life conditions. It requires little imagination to see the overlap of the two specialties, though the differences are obvious as well. The palliative care physician must be an expert in pain management, but the pain neurologist may choose not to address all health issues within the palliative arena.

**B. General statement on conditions it covers and pertinent procedures**

Neurologists who practice pain management or palliative care may treat acute or chronic pain whether it be post-operative or non-surgical, palliative, pediatric or adult, idiopathic or with known cause, neuropathic or not. Many neurologists manage pain only with medications, though an arsenal of interventional procedures is available to any neurologist with appropriate training. Just as the spectrum of pain disorders is broad, so must be the knowledge base for general neurologists who engage pain management as a part of routine practice.

**C. Overview of interaction with other specialties**

The neurologists in this Section should interact with specialists in anesthesiology, physical medicine, psychiatry, psychology, sleep management, non-neurological specialists in palliative care, and a variety of "mid-level" providers. In addition, the neurologist trained in pain management should receive exposure to and training in these disciplines. Though one might hope for significant interaction between our AAN and the national organizations of these other specialties, it rarely occurs if at all at the organizational level. It certainly occurs between individuals. Many members of this AAN section are also members of the American Pain Society, the International Association for the Study of Pain, the Society for Neuroscience, the American Academy of Hospice and Palliative Medicine, etc. Establishing official communication between these organizations should enhance pursuit of shared goals, whether clinical, educational, or research.

**D. Purpose of the document – Why is this needed?**

This document defines the Section: who we are and what we hope to accomplish. As guardians of the health of the nervous system, neurologists comprise a disproportionate fraction of the leaders in the field of pain research and pain management.

**E. Overall mission statement – In broad terms, what is the subspecialty trying to accomplish?**

The Pain and Palliative Care Section upholds multidisciplinary principles in pain management and palliation aimed at improving the well-being of patients with acute or chronic pain. Chronic pain is recognized to be a complex neurobehavioral syndrome amenable to pharmacologic, behavioral, rehabilitative, and procedural interventions that aim to reduce pain intensity and improve quality of life. We seek to educate, train, encourage, and cultivate all individuals who can improve pain and palliative research and pain management. The subspecialty, like other subspecialties, will define the minimum standards of knowledge of this area that all neurologists should have, regardless of their focus.

## **II. BACKGROUND/HISTORY OF SUBSPECIALTY OR SECTION**

**A. Landmark early works/milestones**

A group of pain neurologists first met at the 1995 AAN meeting in Seattle. Many were then, as now, involved in the treatment and research of pain syndromes, from peripheral and central nervous system injury and disease, and acute and chronic pain of any origin including cancer pain. They believed a forum beyond that offered by the Section on Headaches and Facial Pain was needed, and that it should be offered to the neurology community at large.

The AAN members who organized this section included: Charles Argoff, Miroslav Backonja, Bradley Galer, Marco Lacarenza, Dwight Moulin, C. James Otis, Marco Pappagallo, Michael Rowbotham, Jordi Serra, Sharon Weinstein, and Catherine Willner. AAN and section members also internationally active in pain research and therapy include Kenneth Casey, Howard Fields, Kathleen Foley, Shashidhra Kori, Richard Payne, Russell Portenoy, and Joel Saper. Support from many other AAN members made the formation of this section possible. The Pain Section was approved by the AAN in the summer of 1995.

The driving force behind this Section was to facilitate the exchange of information, knowledge, and experience between the fields of pain medicine and general neurology. One of the first efforts was to incorporate the pain management curriculum, established by the International Association for the Study of Pain, into general neurological training. That curriculum is now the foundation for the pain fellowship.

But before the Pain Section was able to concentrate on educational efforts, the Section became involved and represented the AAN in the process of certification in pain management (initiated by the American Board of Psychiatry and Neurology). It also upheld the multidisciplinary principle in management of pain and improving well being of patients with chronic pain. By 1999 Neurology joined three other specialties: Anesthesiology, Psychiatry, and Rehabilitation Medicine in forming the core group which co-certifies in pain medicine, available to neurologists from 2000. Section members continue to represent AAN and still participate in this important process. To join ranks and efforts with colleagues from the field of palliative care, a very closely related area, in 2003 the section formally changed its name to the Pain and Palliative Care Section.

From 1995 leaders of the Section included Miroslav “Misha” Backonja, Michael Rowbotham, Bradley Galer, Marco Pappagallo, Charles Argoff, Jerome E. Kurent, Don Bivins, and Thomas C. Chelimsky.

Through the years, Section members continued to contribute to the annual AAN meeting by leading educational courses. For our section, this was reflected in a relatively small number of programs approved for the presentations. However, it is our expectation that, with recent reorganization of the process for submission of programs, this Section will be successful in recruiting outstanding speakers who would present exciting, new knowledge in the rapidly expanding field of neuroscience and the practice of pain and palliative care. As a result of this effort, the Section anticipates the ability to attract sizable audiences at the annual meeting.

**B. Growth of the subspecialty or Section to current status**

Since inception, the Section has added members and now maintains a roster of approximately 220. Attendance at annual AAN meetings is much lower for unclear reasons. The high costs of attendance certainly are a factor. Attendees of the annual Section meeting tend to be academicians, with a strong clinical and research commitment. It is those same individuals who tend to serve on the Section’s executive committee, but they also admit that the AAN and the Pain & Palliative Care Section do little to meet their educational and career needs and goals. So, the leaders of the AAN’s Pain & Palliative Care Section are willing to serve the Section, but credit other professional organizations with better networking, more indepth presentation of educational materials appropriate to their careers, more exposure to peers with similar interests, and heightened access to research needs and funding opportunities. Historically, the members of the Section’s executive committee perceive that the AAN leadership has little interest in pain issues other than headache.

**C. Genesis of pertinent journals and societies (e.g. Neurology, Archives of Neurology, etc.)**

This section does not need or intend to create additional journals on pain management, pain research, or palliative care. Excellent journals are already published by other professional societies and several section members are on the Editorial Boards of these journals. It is also perceived that the opportunities to publish non-headache pain articles or palliative care articles in *Neurology* are limited.

These are the journals relevant to this Section:

*PAIN*, by the International Association for the Study of Pain  
*The Journal of Pain*, by the American Pain Society  
*Journal of Pain and Symptom Management*, by the National Hospice and Palliative Care organization  
*Pain Medicine*, by the American Academy of Pain Medicine  
*Pain Practice*, by the World Institute of Pain  
*Journal of Neuroscience*, by the Society for Neuroscience  
*Current Pain and Headache Reports*  
*Nature Neuroscience*  
*Anesthesia and Analgesia*  
*Clinical Journal of Pain*, by the Northeastern Pain Association

**D. Current Board certification and other subspecialty organizations/boards**

In March 1998, the American Board of Psychiatry and Neurology, Inc., (ABPN) and the American Board of Physical Medicine and Rehabilitation (ABPMR) joined the American Board of Anesthesiology (ABA) in recognition of pain medicine as an interdisciplinary subspecialty. The respective Boards have agreed on a single standard of certification and all have contributed to a certification exam. That certification exam is administered by the ABA, with the first exam given in 2000.

In recent years, the ACGME instituted new accreditation criteria for pain medicine fellowship programs. Two major points that have affected all existing fellowship programs are: 1) any medical institution that hosted a pain medicine fellowship could only host one fellowship, rather than different departments within the institution hosting multiple fellowships; and 2) the (first) year of training had to be multidisciplinary, to include neurology, psychiatry, physiatry, and anesthesiology.

Working together, the American Academy of Hospice and Palliative Medicine (AAHPM) and the American Board of Hospice and Palliative Medicine (ABHPM) achieved recognition for the subspecialty of hospice and palliative medicine by the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA). Beginning in 2008, cooperating boards within the ABMS will offer a subspecialty certificate in hospice and palliative medicine. A parallel certification will be offered by cooperating boards within the AOA. AAHPM will support ABHPM diplomats through the expiration of their ABHPM certificates.

**E. Other professional and disease-related organizations relevant to the subspecialty.**

American Pain Society  
The International Association for the Study of Pain  
The Eastern Pain Association  
The Society for Neuroscience  
The American Academy of Hospice and Palliative Medicine  
The American Pain Foundation and other numerous pain advocacy groups

**III. CURRENT STATE OF THE SUBSPECIALTY OR SECTION**

**A. Patient Care/Practice**

*Pain Medicine*

Although Pain Management is recognized as a subspecialty by the ABMS, any clinician may provide pain management without requirement for specialty training. It is desirable for all clinicians to have minimum basic competency in pain assessment and management, yet there are no uniform standards to determine when a pain specialist should be consulted. Pain specialists may be neurologists, anesthesiologists, physiatrists, etc. Neurologists' unique skills in the evaluation of pain as a process of the nervous system, functional assessments, and expertise in the management of psychoactive medications are essential to proper pain management. Unfortunately, there is little support for Pain Medicine, that is, the evaluation and medical management of chronic painful conditions. Economic reimbursements do not favor cognitive evaluation but incentivize highly technical interventions. The short term management of pain with a procedural approach leaves many patients to continue suffering. Sociopolitical factors significantly interfere with the medical management of pain, especially inhibiting the long term prescribing of opioid analgesics despite

consensus that some patients require and benefit from such treatment. Uneven access to medical care in our society particularly discriminates against certain groups of patients with chronic painful conditions. It seems that to date, neurologists in general do not consider themselves to be pain medicine experts despite their unique qualifications and potentially important contributions to this clinical area. Currently there are 185 physicians certified in neurology and pain medicine. There are four physicians certified in child neurology and pain medicine. The ABPN no longer has CAQs in Pain Management. Pain Medicine initial certification from the ABA is 3,901. Pain Medicine recertified diplomats total 1,499, but only 1,454 are valid as of 01/01/2009 – 45 have future dated certificates.

#### *Palliative Care*

As of 2008, the ABMS has recognized the new specialty of Hospice and Palliative Medicine and the first subspecialty certification examinations were given. Palliative Medicine is broadly conceived as supportive care of seriously ill patients and their families. Neurologists treat many patients with serious, life-limiting illnesses and as such they have responsibility to provide pain and symptom management; psychosocial support for the patient/family; and assist with complex medical decision analyses and advance care planning (the elements of palliative care). Neurologists have special expertise in prognosticating functional recovery of the nervous system and in the diagnosis of brain death, which is especially important in the acute care setting. General neurologists should be familiar with the options for end of life care including hospice.

### **B. Research**

#### *Pain Medicine*

Pain research is largely driven by the clinical need for more effective medical interventions, particularly to find nonopioid medications. Pharmaceutical industry supports this. Pain research at the NIH is scattered across different institutes despite intermittent consensus documents outlining a coordinated approach within the NIH. The clinical pain medicine evidence base is lacking in some important areas, despite the enormous accumulation of knowledge regarding human pain in the last few decades.

#### *Palliative Care*

Palliative care research covers a broad range of topics including physical symptom management, psychosocial aspects, communication, advance care planning, costs, delivery systems, and defining a “good death.” There is no central industry drive or focus within NIH for this important endeavor. Data are accumulating that show the positive effects of hospital-based palliative care teams on clinical outcomes and costs of care.

### **C. Education**

#### *Pain Medicine*

Education in pain medicine is not standard in medical school curricula, although much progress has been made. At best, medical education includes didactic in fundamentals early in medical school and continues throughout clinical training. Pain Medicine fellowships exist, but these are largely interventional fellowships that produce clinicians who are well trained to perform procedures. There are 94 pain medicine fellowships according to the ACGME; eight of these readily accept neurologists. As best as can be determined, only three accredited programs are housed within the department of neurology at the 94 institutions.

### *Palliative Care*

The ACGME is currently evaluating the first group of proposals for Palliative Medicine fellowship programs in the US. It is anticipated that ACGME approved programs will begin training fellows in July 2009.

## **D. Medical Economics Issues**

### *Pain Medicine*

As discussed above, like other cognitive skills, pain medicine practice is poorly reimbursed. The time involved in evaluating and medically treating patients particularly with controlled substances is not paid. There are no specific reimbursement codes for the various aspects of this specialty medical care.

### *Palliative Care*

Similarly, Palliative Medicine is not an entity within reimbursement codes. The ICD-9 Palliative Care “V” code is not associated with payment scheme. Currently, there is an effort to establish a set of reimbursement codes for clinical palliative care activities. The Medicare hospice benefit provides a fixed per diem rate for the hospice agency, which in turn provides compensation for the entire hospice team, including hospice physicians.

## **E. Legislative Issues**

### *Pain Medicine*

There is a dangerous trend to legislate this area of medical practice, due to the political pressures to address issues of drug abuse. Mass confusion regarding what we know and do not know about pain medicine and addiction begs for intelligent guidance from our specialty to avoid bad legislation that would impede medical care.

### *Palliative Care*

Historically, there have been many efforts to legislate end of life care; the use of opioids in this setting has also been targeted to support a particular political agenda. Some states have passed legislation pertaining to clinical end of life issues, in part responding to public perception that doctors manage end of life poorly. AAN has position statements that are relevant to this area.

## **IV. SWOT ANALYSIS OF THE SUBSPECIALTY**

- A. Current Strengths in each of the 5 areas (patient care, research, education, economics, legislative)
  - 1. Patient Care
    - a. The recent establishment of board credentials for this subspecialty lends strength to the concept that this is a subspecialty for neurologists, rather than anesthesiologists alone. For many years, the latter group’s physicians have been considered “the pain management doctors” in America.
    - b. The Decade of the Brain helped to create an atmosphere of pain research. The subspecialty has benefited from this greatly in our understanding of the pathophysiology, and the potential treatment alternatives within the area of pain have been greatly expanded. Thus, translational care has improved significantly in

the past decade. Unfortunately the current Decade of Pain research and management has not achieved the same recognition from Neurological societies.

2. Research  
There has been an explosion of basic neuroscience research on pain. Unfortunately, few neurologists participate and the field has been widely criticized for inadequate ties to actual clinical need. Most basic science pain researchers would agree that more input from clinical neurologists would help pain research advance more rapidly.
3. Education  
Several patient advocacy groups are encouraging education in the area of pain disorders. Very few are offered around the country, and most of these are regional unless they are affiliated with one of the national or international pain organizations.
4. Economics
  - a. An overarching issue for neurologists is that procedures are reimbursed at a higher rate than the cognitive procedures at which neurologists excel. However, many neurologists in pain management do few procedures.
  - b. Physicians who are involved in the care of hospice patients are reimbursed at 100% of Medicare part B allowances.
5. Legislation
  - a. Largely due to the efforts of grass-roots patient advocacy groups, Congress recently passed two relevant bills. The first dealt with making pain services more available for our active duty military personnel and for veterans. The second was designed to encourage the NIH to create special programs to improve multi-disciplinary pain research, and that same legislation encouraged additional funding of pain research through the NIH.
  - b. Two states now require pain CME credits prior to re-licensure of any physician. Other states are now also considering the same requirement.

**B. Weaknesses in the 5 areas (patient care, research, education, economics, legislative)**

1. Patient Care
  - a. Even though there has been some increase in the number of neurologists who are interested in managing patients with chronic pain disorders, it is still true that most neurologists have little desire to handle chronic, non-headache pain disorders unless they are related to a diagnosis of a specific peripheral neuropathy. When patient care demands the use of opioids or chronic follow up, such patients are referred to “pain management specialists”, who are usually anesthesiologists.
  - b. Unfortunately, those same “pain management physicians” are seldom as well trained as the neurologists in the use of agents that we typically consider beneficial in the treatment of neuropathic disorders. There seems to be little interest in our residency programs producing physicians who are interested in the arena of pain management.
2. Research

- a. Though much research has been accomplished in the past decade, the large majority has been performed by PhD's at the biomedical level or by clinicians other than neurologists.
  - b. Though the NIH has made some efforts to improve funding for pain disorders, the funding continues to be insufficient for the needs of the specialty or the needs of the patients with disorders of chronic pain.
  - c. Much of the research that is being done has been accomplished primarily for certain diseases, such as headache, complex regional pain syndrome, diabetic peripheral neuropathy, spinal cord pain, or vulvodynia. Many of the funds for these research areas have been granted by organizations other than the National Institutes of Health.
3. Education
- a. Most American medical schools do not provide any training in pain management, other than discussion of analgesics within their pharmacology courses.
  - b. The large majority of neurology residencies in the United States do not provide training in pain management. It is just assumed that neurology residents will learn pain management "by osmosis" or by bedside teaching. Unfortunately, this means that our present residents are taught by faculty members who themselves have not been taught pain management.
  - c. The Pain and Palliative Care Section and the American Academy of Neurology have not taken a lead in establishing treatment guidelines for pain disorders. The genesis of such documents is likely to arise from other societies, such as the American Pain Society or the International Association for the Study of Pain.
4. Economics
- a. The members of this section face no unusual weaknesses or challenges regarding reimbursement issues that are not typical to the average general neurologist.
  - b. Generally, neurologists who specialize in pain medicine do not work in the same office as anesthesiologists who specialize in pain medicine. The two specialties approach patients from such different perspectives that their practices mix poorly. Since many employers prefer the higher reimbursements that accompany procedures, neurologists may face discrimination in hiring or retention.
5. Legislation
- The Pain and Palliative Care section and the American Academy of Neurology have had little impact on legislation. Again, the impact which has occurred has arisen from either patient advocacy groups (the American Pain Foundation) or through other professional organizations (the American Pain Society).

**C. Opportunities for growth in each area (patient care, research, education, economics, legislative)**

- 1. Patient Care
  - a. Physicians and residents need additional training in the area of pain management and palliation. The American Academy of Neurology could lead in this effort by offering more pain management and palliative care topics at its annual meeting and at its regional meetings.



- b. The members of this Section encourage the concept that physician re-licensure could require a certain number of CME credits in the arena of pain management prior to granting a new license.
  - c. Those neurologists who do practice pain management and palliative care should create opportunities for themselves to teach the management of pain disorders and palliation in their localities.
  - d. The neurologists involved in the treatment of pain disorders and palliative care should create opportunities to work with the grass roots organizations for patient advocacy.
2. Research
- a. The American Academy of Neurology has the opportunity to work with other professional pain organizations or palliative care organizations to encourage the National Institutes of Health to provide funding for research in pain and palliation.
  - b. The AAN Foundation could set aside specific funding for research fellowships in the area of pain management.
  - c. The AAN should strongly consider establishing an award for research on neuropathic pain. This relatively small investment would visibly demonstrate the centrality and legitimacy of neuropathic pain in neurology.
3. Education
- a. The Pain and Palliative Care Section should work within the Academy to help create or support pain management fellowships. These fellowships should be willing to admit neurology graduates to the fellowship programs. Today, most pain fellowships will only admit graduates of anesthesiology or psychiatry training programs.
  - b. Members of this Section should create opportunities to lecture to hospital staffs, patient support groups, patient advocacy groups, and to local and regional medical conferences on the topics of pain and palliative care.
  - c. The Academy should work with the national accrediting agencies from medical schools to encourage specific modules for education within the disorders of pain management and palliative care.
4. Economics
- The members of this section face no unusual weaknesses or challenges that are not typical to the average general neurologist. Reimbursement for procedures is still favored over cognitive care.
5. Legislative
- a. The executive committee of the Pain and Palliative Care Section should encourage the Section members to be active in the support of legislation both at the state and national level that would foster either improved research or improved care for our patients.
  - b. The members of the Pain and Palliative Care Section should be active patient advocates, as demonstrated by willingness to contact legislators either at the state or national level, and express their opinions regarding a variety of issues or the legislation regarding patients with chronic pain disorders. Aggressive support from the Academy would be immensely beneficial.

**D. Threats to achieving goals in each area (patient care, research, education, economics, legislative)**

1. Patient Care

The single major threat remains that most pain management specialists are trained only to be interventionalists. There are very few physicians taking an active role in the broader scope of all aspects of pain management, including disease diagnosis and classification, and gathering evidence of relative benefits of different therapies.

2. Research

- a. Reduced funding for research in pain disorders is a constant threat.
- b. If the Academy does not take some interest in the area of non-headache pain disorders, then all efforts to improve research will fall upon the shoulders of other professional organizations.

3. Education

- a. Though the Pain and Palliative Care Section members can encourage their local medical schools to develop programs in pain and palliative care, the backing of our national organization would be more advantageous in improving pain education at medical schools.
- b. The same is true in neurology residency programs, as there is a dearth of training in pain management for our neurology residents.
- c. Without additional regional training, the non-pain management physician will continue to either under treat or mistreat patients who have chronic pain disorders. The Academy needs to actively develop training programs for neurologists.
- d. The Medicare moratorium on additional ACGME sanctioned training positions will be a significant impediment to the development of additional fellowships in pain management or palliative care.

4. Economics

The members of this Section appreciate the work by the Academy in maintaining the funding that we have from Medicare and other payers. However, the economics of pain management continues to be threatened by the continuing tendency to reimburse procedures at a higher rate than is cognitive work.

5. Legislative

- a. The members of the Pain and Palliative Care Section encourage the leadership of the Academy to work with other professional societies, at the organizational level, to encourage appropriate legislative maneuvers. The strength of the Academy would lend much credibility to such efforts.
- b. The Academy should encourage the various patient advocacy groups in their efforts to pursue legislation for certain patient groups, such as war veterans, members of the military, or the more obscure disorders of chronic pain.

**E. Current status of AAN input to each area (patient care, research, education, economics, legislative)**

1. Patient Care

The American Academy of Neurology has had little input in the area of patient care in the specialties of pain and palliation. The one obvious exception is the AAN Practice Parameters, several of which have recently dealt with relevant topics (PHN, painful neuropathies, TN). These efforts should be expanded where feasible (e.g. central pain, pain from spinal cord injury).

2. Research  
This Section is unaware of efforts of the American Academy of Neurology in the area of non-headache pain research.
3. Education  
The Academy has offered a few educational programs in non-headache pain management and palliative care at its annual meetings, but none at the biannual regional meetings.
4. Economics  
The Academy has had little input in the area of economics within the specialties of pain management and palliative care. The Section has benefited from the Academy's efforts overall to improve reimbursements, but these two sub-specialty areas need additional support. Our specialties are cognitive rather than procedural for most neurologists, so the specialties that do mostly procedures are favored by the third party payers.
5. Legislative  
The Academy is not a leader in legislative areas directly impacting pain management and palliative care. Other professional organizations are much more active in this area, including a number of grass-roots advocacy groups.

## **V. SPECIFIC VISION, GOALS AND OBJECTIVES FOR THE SUBSPECIALTY/SECTION**

### **A. Short Term (over 5 years)**

1. Specific defined goals and targets
  - a. There is no need to aggressively seek increased membership of the section at this time. Rather, there is a definite need to increase participation from inactive section members. Our goal is to increase participation at the section meetings at the annual AAN meetings to 20% of membership.
  - b. The executive committee will choose a chair of the education committee who has the desire and time to actively assist members of the section to submit educational proposals for annual meetings. These should involve not only academicians but also private practitioners.
  - c. Identify ten members of the Section who are willing to encourage the institutions at which they work or from which they graduated to change their admission requirements for pain medicine fellowships so that qualified neurologists can be accepted to their programs. Academy assistance would be most valuable.
  - d. Identify five members of the Section who are willing to encourage the institutions at which they work or from which they graduated to develop palliative care fellowships that accept neurologists in their programs. Academy assistance would be most valuable.

- e. The Section will identify twenty members who will develop regional educational sessions regarding pain management and palliative care. It is encouraged that each educational program draws upon the expertise of the members of the Pain and Palliative Care Section. Each of the training programs should include topics pertinent to pain management and palliative care.
  - f. The Section will work closely with the AAN to establish and fund an award for neuropathic pain research.
2. Operational strategies to achieve goals
- a. Improve communication between the Sections' executive committee and its membership.
  - b. The educational chairman of the executive committee will contact a larger number of the Section's members to increase the submissions for educational programs not only for the annual meeting but for the regional meetings. The educational chairman will also encourage the directors of the regional meetings to accept pain topics for their programs.
  - c. The members of the executive committee will work with the academicians within this Section to identify ten institutions at which pain fellowships already exist, but which have not been receptive to admitting neurologists to those fellowships. The committee will address the need to change admitting requirements so that neurologists can be enrolled. Assistance from the Academy would be invaluable.
  - d. The members of the executive committee will work with the academicians within this Section to identify five institutions at which palliative care fellowships could be created. The executive committee will assist in the initial organizational efforts to expedite the development of a palliative care fellowship at those institutions. Assistance from the Academy would be invaluable.
  - e. The executive committee will identify twenty academic physicians and twenty private practice practitioners within the same locale to create educational programs for pain and palliative care.
3. Specific action items for each goal
- a. Through the increased use of newsletters, increased access to the list serve, and increased phone calls for surveys, the executive committee will determine what changes need to be made in the design of the Section's annual meeting so that more of the private practitioners within the Section will attend the annual Section meeting.
  - b. The executive committee will assist the educational chairman in soliciting educational proposals (for the AAN's annual meetings) from members of the Section. The education chairman will be required to identify specific neurologists and specific research programs so that submissions could be made for educational topics, research topics, integrated neuroscience programs, etc. The educational chairman must do this at a time frame appropriate for meeting the deadlines for submission. The educational chairman should review each of these proposals prior to submission to assure academic rigor before the proposals are submitted to either the task force for the other assessment committees.
  - c. The executive committee will work with the AAN liaison to provide documentation to the institutions, and will encourage face to face meetings between the leaders of those institutions and the members of the executive committee, to encourage the admission of neurologists to the pain fellowship at the institution.
  - d. The executive committee will work with the AAN liaison to provide documentation to the institutions, and will encourage face to face meetings between the leaders of

those institutions and the members of the executive committee, to encourage the admission of neurologists to the palliative care fellowship at the selected institution.

- e. The chair-elect of the Pain and Palliative Care Section will take the leadership role in developing the regional programs. The chair-elect will work specifically with each academic physician and private practitioner identified so that the educational program will meet appropriate standards for academic rigor, and the chair-elect will assist in the selecting of members of the Section to the teachers at these regional educational programs.
4. Role of AAN in achieving goals  
The American Academy of Neurology liaison will be most helpful in all of these efforts, whether through communication or the accumulation of data and documentation. Since the education chairman of the executive committee will make a determined effort to improve academic rigor of proposals submitted for educational programs, the Section requests that the Academy leadership be more receptive to presenting pain topics for its educational programs. Specifically, we urge the Academy leadership to require that one course at each regional meeting be devoted to pain management.

Additionally, the AAN should engage the leadership of the other professional societies relevant to this section, encouraging collaboration.

5. Benefit to AAN and sub-specialty in achieving goals
  - a. If the Academy is supportive of these efforts, it can become a leader in the arenas of patient advocacy, regional education, and national education of its members on the topics of pain management and palliative care.
  - b. The Academy would be recognized as a force in the establishment of pain and palliative care fellowships for neurologists. The strength of the Academy would greatly benefit this effort, especially in joining forces with other pain management and palliative care professional societies.
  - c. If the regional educational programs are developed, the Academy would be recognized as the leader in pain education and palliative care education, rather than relinquishing this role to other professional organizations. It seems logical to the members of the executive committee that the academy could greatly impact the areas of pain management and palliative care if it worked at an organizational level with the other professional societies.
6. How will sub-specialty assess and address success/failure for each goal/ area?
  - a. The goals are defined simply enough so that success or failure would be easily decided simply on numerical data.
  - b. The benefit to the American Academy of Neurology can only be established over the long term.
  - c. The benefit to the private practitioner, with regards to improved education, can only be measured by the practitioner's improved comfort level in managing the patients with chronic pain disorders or with palliative care needs.

B. Long Term (over the next 5-10 years)

1. Specific defined goals and targets
  - a. Long-term goals are ambitious and depend on help and buy-in of our mother organization, the AAN.

- b. Practice: Parallel to the epidural position paper in Neurology, there is a dire need for much more education at the patient level, PCP level, and legislator level regarding the evidence base of pain management. Currently, the American love affair with technology is driving interventional procedures, which patients expect and payers reimburse, while the evidence clearly demonstrates that in the long term, the bland rehabilitative approach is far superior to most interventions for chronic pain. This approach is fading because it is not reimbursed. We have a major opportunity, as neurologists who are relatively neutral in the field of pain management, to educate the public, lawmakers, payers, and physicians, and change the course of medical treatment for chronic pain, saving billions of dollars for payers, patients, and government. However, this will take courage to stand up to entrenched practices and paradigms, and the misalignment of incentives. Physicians and hospitals are reimbursed much more for interventional approaches, and health insurers have no stake at the present time in preventing disability.
- c. Economics: Reverse the trend of 3<sup>rd</sup> party payment for unproven devices/interventions and denial for evidence-based low-technology rehabilitative approach.
- d. Legislation: Education of legislators as outlined under b above.
- e. Education:
  - i. Participate in ACGME pain fellowship accreditation and certification process. At this time, ACGME mandates that all pain fellows be trained by pain-certified neurologists (regardless of who administers the program). Neurology as a field should be intimately involved with all the planning and conceptualization behind pain fellowship training.
  - ii. Because of our relatively neutral incentive structure, we have an opportunity to become the leaders in primary care education and the development of the future of pain management, community based pain management.
  - iii. Strengthen links between Pain and Palliative Care. The AAN Ethics and Humanities committee in its 1996 position statement emphasized the urgency that neurologists understand and apply these principles of palliative care in the management of their patients.

There is a clear need for the development of educational opportunities in palliative care of patients with severe life-limiting neurological diseases. Also, little attention has been focused on the needs of patients actually dying of chronic neurological diseases. (Carver AC, et al. Neurology 1999; 53:284-293. End-of-life care. A survey of US neurologists' attitudes, behavior and knowledge). Recent publications have provided vital professional education in palliative care for neurologists (Payne R, et al. Continuum, Vol 11, Dec 2005, Pain and Palliative Care).

Palliative care has been defined by the World Health Organization as the total active care of patients whose disease is not responsive to curative treatment. Control of pain and other symptoms, and of psychological, social and spiritual problems experienced by patients with life-limiting disease are of critical importance to optimizing quality of life. The AAN Pain and Palliative Care

Section has the unique opportunity to provide educational opportunities for neurologists.

Long term goals of the Section should include: 1) the presentation of high quality courses and workshops at the annual AAN meetings which focus on key elements of pain and symptom management, while responding to the unique needs of patients with end-stage neurological diseases. It should be emphasized that high quality palliative care invariably incorporates key principles of clinical ethics as well as pain management; 2) there are clear opportunities for the Pain and Palliative Care Section to collaborate with the Ethics, Geriatrics, Neuromuscular, and Sleep disorders sections to develop high quality educational programs at the annual meeting; 3) the Pain and Palliative Care Section may also be provided the opportunity to recommend questions and content areas for the board examination administered by the American Board of Psychiatry and Neurology.

f. Research:

- i. Increase neurology participation in pain research and increase the number of young neurologists interested in a research fellowship. Were the Academy to promote pain as a “hot topic” and feature some major pain researchers, it is likely that quite a few resident level neurologists might develop research interests in pain.
- ii. Develop a Neurology Pain Section Patient Registry for Research in specific diagnoses that we can impact such as complex regional pain, small fiber neuropathy, etc.

2. Operational strategies to achieve goals

- a. Work closely with AAN leadership to share vision and plans for growth, and determine optimal strategy to achieve our goal as a “truth-broker”.
- b. Identify Section members willing to write position papers on the evidence-base for specific medical therapies, interventional approaches (e.g. spinal cord stimulation, sympathetic blocks, implanted pumps) and rehabilitative approaches (e.g. simple exercise, physical therapy, cognitive behavioral therapy, and intensive pain management programs) for neurological pain disorders.
- c. Identify appropriate persons to discuss the reasoning behind these insurance decisions at CMS and major private payers such as CIGNA, Blue Cross, United, etc.
- d. Earmark resources for disseminating evidence based medicine in lay terms for legislators.
- e. Begin a conversation with the appropriate ACGME representative and broach the question of who sits on the ACGME accreditation and certification committee for Pain Management.
- f. Identify members of the Section willing to develop website information and materials regarding chronic pain management, appropriate for the primary care physician. We would be glad to make the 4PCP program available to the Academy for more widespread utilization.
- g. Raise development funds sufficient to fund 1-2 fellowships in pain research.
- h. Develop a de-identified patient registry database; begin to consider the development of Section based therapeutic trials available to these patients.

3. Specific action items for each goal

- a. Identify the right people in AAN to begin a series of thought generating meetings.
  - b. Identify a series of interventional topics that will constitute the basis for position papers in the next 5-10 years, identify knowledgeable members to author these papers inviting members of other disciplines to participate (e.g. anesthesia, psychology, PM&R etc).
  - c. Arrange a meeting with the appropriate person at CMS to initiate dialogue.
  - d. Identify interested legislators who could help with information dissemination and ultimately legislation.
  - e. Work with the AAN representative to the ACGME to increase our input to the fellowship.
4. Role of AAN in achieving goals  
The broader goal of adjusting what amounts to public “mis-education” is a daunting task. If the AAN agrees that this is a worthwhile goal, the Section will need advice, help, and resources to achieve some gains, and this will truly need to be a partnership between the Section and the Academy.
5. Benefit to AAN and sub-specialty in achieving goals
- a. Ultimately thousands of patients with chronic pain (prevalence of chronic pain is 15% of the population, much more than diabetes – 6% or congestive heart failure – 3%) will benefit from improved outcomes. Society will benefit by reduced medical costs and recovering billions more in worker productivity and quality life satisfaction.
  - b. The Academy was established to benefit patients with neurologic disorders and would be fulfilling its self-defined role.
  - c. As neurologists with little disincentives in any direction, the AAN will be viewed as a “truth-broker”, strengthening its image in standing for patients and against financially driven approaches. As we end 2008 with several industries and services tainted by corruption and profit-motive, a strong stance against pain would be refreshing and place the Academy in a stronger position in all of its efforts.
  - d. From an academic perspective, it is our duty to provide the truth to the public.
6. How will sub-specialty assess and address success/failure for each goal/ area?
- a. Larger numbers of patients with chronic pain will experience improved outcomes and greater benefit, being able to return to useful functions such as work or home-making.
  - b. Increasing numbers of young neurologists will declare an interest in clinical or research arenas of chronic pain.
  - c. The American Academy of Neurology would be viewed as the unbiased “go-to” source for information regarding pain management.
  - d. The American Academy of Neurology will lead other specialties through collaboration, in establishing optimal care paradigms.
  - e. The rehabilitative approach to chronic pain will be reimbursed by payers once again.

## VI. SUMMARY

The Pain & Palliative Care Section has had a stable membership of 220 for the past few years. Private practitioners within the Section tend to be inactive. The Executive Committee members have always been academicians. The Section was created in 1995 to increase the number of pain



management and palliative care educational programs offered at the Academy's annual meetings. The present Executive Committee acknowledges that goal is unmet. We think it prudent now to expand our vision and realign our goals.

**THE P&PC EXECUTIVE COMMITTEE OFFERS THESE GOALS TO THE ACADEMY:**

1. Offer pain management and palliative care educational programs regionally to general neurologists and other health care providers. These will be hosted and taught by members of the P&PC.
2. Work eagerly with the Academy to establish an award to recognize contributions to neuropathic pain research. It seems fitting that such an award should be established to honor Dr. Mitchell Max.
3. Serve as a vocal advocate for the patients in need of our special services. Evidence now available is adequate for our Section to actively work with patient advocacy groups, other professional societies, third party payers, and legislators to improve patient care, reduce spending on unnecessary treatments, and increase reimbursement.
4. Work with the Academy to increase the number of pain management and palliative care fellowships willing to accept neurologists for training.

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