

# Organization of Chronic Pain Services

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Since the initial organization of pain centers carried out in the 1960s by J. J. Bonica in the United States, S. Lipton in the United Kingdom, and a few other specialists in Western countries, the enormous necessity of this type of health service has become clear, along with the difficulty of its comprehensive organizational approach in order to be effective for the diagnosis and therapy of this patient population.<sup>1,4</sup>

The foundation in 1974 of the International Association for the Study of Pain (IASP) strengthened the development of pain facilities in the United States and around the world. Consequently, in response to the proliferation of pain centers during the last 2 decades, various medical associations have defined and classified the types of such facilities.<sup>5,7</sup>

According to the scope of the therapeutic approach, pain centers can be classified into three models:

1. Pain centers following the medical model, in which pain is treated as a symptom of a disease to be diagnosed
2. Pain centers working with the behavioral model, in which pain behavior and associated impaired function are considered as important as the underlying pathophysiology
3. Pain centers with a predominant focus on the cognitive-behavioral model, in which patients are considered to develop aberrant convictions in regard to their functional capacities and prognoses<sup>8</sup>

Today, particularly in Europe and Australasia, chronic pain conditions are treated by a combination of intervention and the behavioral-rehabilitation model, as reports of the efficacy of cognitive-behavioral programs for the treatment of chronic pain conditions have shown variable outcomes in comparison with the selection criteria of interventional approaches, which are better defined.<sup>9,13</sup>

In the United States, all three models have been established during the past three decades, although recent changes introduced in managed healthcare have modified in many cases the approach of preexisting pain facilities.

This chapter will cover the following topics:

- Pain treatment facilities
- Pain medicine as a new specialty
- Administrative issues

Appendixes with related recommendations can be found at the end of the chapter.

## Pain Treatment Facilities

Pain treatment facilities were established to treat chronic, refractory pain related to conventional medical, surgical, and rehabilitative modalities. Multidisciplinary pain centers were developed to treat specifically a group of patients mainly suffering from chronic back pain that did not improve with conventional treatment, causing them to remain disabled. These patients showed, in addition to the existence of chronic pain, behavioral and psychosocial impairment that required the intervention of a multidisciplinary team approach that would deal with the patient's problem simultaneously.

Regardless of the therapeutic approach, the lack of regulation of pain centers and the various clinical structures that used the term indiscriminately forced the American Society of Anesthesiology (ASA) and the IASP to classify the different pain facilities according to their professional composition, modalities of treatment, organization, pain conditions being treated, clinical or basic research, and teaching potential.

Thus, the ASA classifies pain centers into four types<sup>6</sup>:

1. Major comprehensive pain centers
2. Comprehensive pain centers
3. Modality-oriented pain clinics
4. Syndrome-oriented pain clinics

Overall, it is important to note that the function and organization of these pain centers rely greatly on the training, beliefs, expertise, and specialty of the director; the composition of the staff; and the type of institution.<sup>1</sup>

The variation in staff makeup and available therapeutic modalities has caused both physicians and the public to have misinformation about differences among the pain syndromes and the types of pain centers or clinics.

Another step in the process of defining chronic pain services was reached by the Commission on Accreditation of Rehabilitation Facilities (CARF) with the establishment of a certification process for pain clinics for one type of treatment model (i.e., chronic pain management programs).<sup>14</sup>

Because of this lack of definition, the IASP<sup>15</sup> established guidelines and characteristics for four types of pain treatment facilities (Table 5-1, Appendix 5-1).

This classification makes a clear distinction between the multidisciplinary pain centers and clinics (MPC) and those facilities without multidisciplinary orientation. The only difference between the multidisciplinary pain centers and multidisciplinary pain clinics is that the former have to develop research and teaching activities. Nevertheless, both types of centers must provide inpatient and outpatient treatment, and the teams must contain diversified staff members, including more than one physician specialty and a psychologist or psychiatrist.

**TABLE 5-1** \* INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN CLASSIFICATION OF PAIN FACILITIES

*Modality-oriented clinic*

Provides specific type of treatment (e.g., nerve blocks, transcutaneous nerve stimulation, acupuncture, biofeedback) May have one or more Healthcare disciplines Does not provide an integrated, comprehensive approachn *Pain clinic* Focuses on the diagnosis and management of patients with chronic pain or may specialize in specific diagnoses or pain related to a specific region of the body Does not provide comprehensive assessment or treatment Institution offering appropriate consultative and therapeutic services would qualify but never an isolated solo practitioner.

*Multidisciplinary pain clinic*

Specializes in the multidisciplinary diagnosis and management of patients with chronic pain or may specialize in specific diagnoses or pain related to a specific region of the body Staffed by physicians of different specialties and other healthcare providers Differs from a multidisciplinary pain center only because it does

not include research and teaching *Multidisciplinary pain center* Organization of healthcare professionals and basic scientists that includes research, teaching, and patient care in acute and chronic pain

Typically a component of a medical school or a teaching hospital Clinical programs supervised by an appropriately trained and licensed director Staffed by a minimum of physician, psychologist, occupational therapist, physical therapist, and registered nurse Services provide integrated care based on interdisciplinary assessment and management Offers both inpatient and outpatient programs

Adapted from Loeser JD: Desirable characteristics for pain treatment facilities: Report of the IASP taskforce. In Bond MR, Charlton JE, Woof CJ (eds): Pain Research and Clinical Management, vol. 4. 1991, pp. 411-415.

## Pain Medicine: A New Specialty

Scientific inquiry into the anatomy and physiology of pain perception increased, and with the discovery of opiate receptors in animal and human tissues, the actions of peptides on endogenous opioid receptors, the development of new therapies for the alleviation of pain, and the classification and description of chronic pain syndromes, some essential pieces were added that support modern pain therapy.<sup>16,18</sup>

The emerging specialty of pain medicine has been increasingly recognized over the last 2 decades by medical organizations, regulatory agencies, and third-party payers. This specialty is formed by a distinct and unique body of knowledge and a defined clinical application that supports a clinical practice. Moreover, pain medicine has fostered growth of scholarly knowledge and research and fills a recognized gap in health professional training (Table 5-2).

In its official policy statement, the American Academy of Pain Medicine (AAPM) defines pain medicine as follows:

The specialty of pain medicine is concerned with the prevention, evaluation, diagnosis, treatment, and rehabilitation of painful disorders. Such disorders may have pain and associated symptoms arising from a discrete cause, such as postoperative pain or pain associated with a malignancy, or may be syndromes in which pain constitutes the primary problem, such as neuropathic pains or headaches. The diagnosis of painful syndromes relies on interpretation of historical data; review of previous laboratory, imaging, and electro-diagnostic studies; behavioral, social, occupational, and avocational assessment; interview and examination by the pain specialist; and may require specialized diagnostic procedures, including central and peripheral neural blockade or monitored drug infusions. The special needs of the pediatric and geriatric populations are considered when formulating a comprehensive treatment plan for these patients.

The pain physician serves as a consultant to other physicians, but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitative services, performing pain-relieving procedures, counseling of patients and families, (directing a) multidisciplinary team, (coordinating) care with other healthcare providers, and (providing) consultative services to public and private agencies pursuant to optimal healthcare delivery to the patient suffering from a painful disorder. The pain physician may work in a variety of settings and is competent to treat the entire range of painful disorders encountered in the delivery of quality healthcare.

However, the official establishment of pain medicine as a medical specialty needs a process of accreditation that could be obtained, as in other specialties, through any of several, well-defined medical boards. Until now, in the United States only one medical association—the American Board of Pain Medicine

**TABLE 5-2 \* PAIN MEDICINE: OPERATIONAL CRITERIA**

A distinct and unique body of knowledge as evidenced by texts and journals; clinical applicability sufficient to support a clinical practice

Ability to generate scholarly knowledge and support research Ability to meet numerical standards for training programs, trainees, and practicing diplomats De facto recognition as clear subject area by governmental bodies  
(e.g., NIH, NCI, AHCPR) and nongovernmental organizations  
(e.g., WHO, IASP, AAPM, APS, WIP) Fills a recognized gap in health professional training

Adapted from Carr DB, Aronoff GM: The future of pain management. In Aronoff GM (ed): Evaluation and Treatment of Chronic Pain, 3rd ed. Baltimore, Williams & Wilkins, 1998.

AAPM, American Academy of Pain Medicine; AHCPR, Agency for Health Care Policy; APS, acute pain service; IASP, International Association for the Study of Pain; NCI, National Cancer Institute; NIH, National Institutes of Health; WIP, World Institute of Pain, WHO, World Health Organization.

(ABPM), recognized by the American Medical Association—offers training and accreditation in pain medicine through rigorous procedures. The ABPM has been granted full recognition in California by the American Board of Medical Specialties.

In Europe, the situation differs because there is no medical association that links the numerous countries through the territory, and the lack of homogeneous legislation represents a practical barrier for the recognition of any new medical specialty. Only a few exceptions to this situation exist, such as in Turkey, where there has been official recognition of treatment of pain as a medical specialty since 1993, with specific resources for training, research, education, and clinical practice throughout the country.

In the rest of the world, academic regulatory obstacles and paucity of resources limit the process of accreditation and the recognition of this specialty.

In an effort to strengthen a world initiative in the process of education and training of physicians interested or involved in pain medicine, the World Institute of Pain (WIP), an international association of pain centers founded in 1994, defines different goals that meet a common interest for pain physicians:

1. Educate and train personnel of member pain centers, including local hands-on training, international seminars, and exchange of clinicians.
2. Update pain centers with state of the art pain Information, including a newsletter, scientific seminars, interlinked telecommunications, and publication of a journal and books.
3. Develop common protocols for efficacy and outcome studies.
4. Communicate administrative and patient-related matters on a regular basis by way of a newsletter, a telephone hookup, a world directory of pain centers (region by region), and video conferencing (including patient consultation).

5. Categorize and credential pain centers by mail correspondence, local information, and the industry's medical representatives.
6. Develop an examination process for pain centers to test trainees and provide information about the examination process.
7. Encourage interested industrial parties to provide information on pain medicine to each region of the world; bring local pain physicians into contact with industry for education about new techniques and training in their use; and formulate a fellowship training program.

Despite the fact that pain clinicians are treating chronic pain on a daily basis, education on pain is absent at the various levels of the medical career, whether at medical schools or at postgraduate levels. Formal education and training are essential so that fellowship programs can be set up to precede the establishment of full residency programs in pain medicine. Residency programs should include specific training in the different areas involved in the field, including surgical training for interventional procedures and education in the important fields related to management of chronic pain and cancer pain, such as psychology, oncology, and symptomatic relief.

Many issues and questions remain to be answered or resolved by the scientific community. These include but are not limited to such areas as the epidemiologic figures on chronic pain, whether associated with disability or not; the existence of pain in degenerative syndromes and in advanced incurable diseases; the predisposing factors for suffering pain; the neuro-matrix of pain transmission and modulation; the role of the autonomic nervous system in the neurophysiology of pain; the development of more selective drugs for central and peripheral nervous system action; the role of affectivity and the psychological processes that are involved in the perception of pain and suffering; the development of more selective and minimally invasive techniques for pain control; the improvement in understanding the maturation and aging of the nervous system; and the measurement, assessment, and validation of pain.

Finally, some attention is due to the administrative issues burdening the clinical practice of pain medicine, because many difficulties have appeared that complement the above-mentioned situations.

## Administrative Issues

The increasing public demand on healthcare services is rapidly changing the shape and characteristics of pain facilities, much as in other medical specialties in which providers of healthcare services are at the crossroads between pressure exerted by consumers and the managed care rules.<sup>19</sup>

Patients have acquired an enormous amount of information through the media; specifically, the Internet is becoming the most popular means of information gathering. In addition, the public has a growing skepticism about the traditional sources of medical information. Chronic pain patients are a very vulnerable population with a large percentage of malpractice victims. Many of them in desperation look for relief by trying pseudoscientific approaches, typically by self-referral.

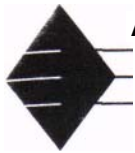
In that scenario, demystification of medicine through health education that provides accurate information to patients and families is a principal goal of the pain physician. The lack of understanding by the patient of the diagnostic evaluation, treatment modalities, and prognosis contributes to confusion among patients and health providers.

Healthcare systems have finite resources; that is, the innovations in pain management are viewed quite favorably by insurers and policy makers who see potential cost savings in a patient's rapid return to normal function after surgery or in home care rather than hospital care for a patient with a chronic or terminal illness.<sup>20</sup>

Several Western countries, including the United Kingdom, Canada, and Australia, require economic justification for approval of any new drug, and there is an increasing trend to apply these criteria to clinical trials by means of cost analyses through diverse perspectives. Extrapolating this concept to the area of pain management, studies should be developed in terms of cost-benefit analysis of therapies and their cost-effectiveness and cost of use, in which benefit is defined in terms of quality of life.<sup>21-22</sup>

However, findings that can be applied to many medical disciplines in regard to managed care seem to be distorted in the environment of patients with chronic and complex illnesses. These persons often require advanced comprehensive care services, well beyond what the primary care physician can generally provide. Such patients often require well-trained sub-specialists or referral to complex comprehensive systems of care. The cost of such services is often far beyond the customary cost, and only by assuming the challenge of normalization and accreditation of health services can pain medicine survive.<sup>23-24</sup>

Pain physicians must be aware that there is a need for moving away from treatment algorithms to a strategy based on levels of care.



## Desirable Characteristics of Pain Treatment Facilities<sup>15</sup>

### DEFINITION OF TERMS

The following terms are defined briefly in this section; a more complete description of the characteristics of each type of facility appears in subsequent portions of this chapter.

1. **Pain Treatment Facility.** This generic term is used to describe all forms of pain treatment facilities without regard to personnel involved or types of patients served. Pain unit is a synonym for pain treatment facility.
2. **Multidisciplinary Pain Center.** This organization of healthcare professionals and basic scientists includes research, teaching, and patient care related to acute and chronic pain. This type of center is the largest and most complex of the pain treatment facilities and ideally would exist as a component of a medical school or teaching hospital. Clinical programs must be supervised by an appropriately trained and licensed clinical director. A wide array of healthcare specialists is required, such as physicians, psychologists, nurses, physical therapists, occupational therapists, vocational counselors, social workers, and other specialized healthcare providers. The range of disciplines required of healthcare providers is a function of the varieties of patients seen and the healthcare resources of the community. The members of the treatment team must communicate with each other on a regular basis, both about specific patients and about overall development. Healthcare services in a multidisciplinary pain clinic must be integrated and based upon multidisciplinary assessment and management of the patient. Inpatient and outpatient programs are offered in such a facility.
3. **Multidisciplinary Pain Clinic.** This healthcare delivery facility is staffed by physicians of different specialties and other nonphysician healthcare providers who specialize in the diagnosis and management of patients with chronic pain. This type of facility differs from a multidisciplinary pain center only because it does not include research and teaching activities in its regular programs. A multidisciplinary pain clinic may have diagnostic and treatment facilities to serve outpatients, inpatients, or both groups.
4. **Pain Clinic.** This clinic is a healthcare delivery facility that focuses on the diagnosis and management of patients with chronic pain. A pain clinic may specialize in specific diagnoses or in pains related to a specific region of the body. A pain clinic may be large or small, but it should never be a label for a solo practitioner. A single physician functioning within a complex healthcare institution that offers appropriate consultative and therapeutic services could qualify as a pain clinic if chronic pain patients were suitably assessed and managed. The absence of interdisciplinary assessment and management distinguishes this type of facility from a multidisciplinary pain center or clinic. Pain clinics can, and should be encouraged to, carry out research, but it is not a required characteristic of this type of facility.
5. **Modality-Oriented Clinic.** This healthcare facility offers a specific type of treatment and does not provide comprehensive assessment or management. Examples include nerve block clinic, transcutaneous nerve stimulation clinic, acupuncture clinic, and biofeedback clinic. Such a facility may have one or more healthcare providers with different professional training; because of its limited treatment options and the lack of an integrated, comprehensive approach, it does not qualify for the term "multidisciplinary."

### DESIRABLE CHARACTERISTICS OF A MULTIDISCIPLINARY PAIN CENTER

1. A multidisciplinary pain center (MPC) should have on its staff a variety of healthcare providers capable of assessing and treating physical, psychosocial, medical, vocational, and social aspects of chronic pain. These therapists work with occupational therapists, vocational counselors, social workers, and any other type of

- healthcare professional who can make a contribution to patient diagnosis or treatment.
2. At least three medical specialties should be represented on the staff of a multidisciplinary pain center. If one of the physicians is not a psychiatrist, physicians from two specialties and a clinical psychologist are the minimum required. An MPC must be able to assess and treat both the physical and the psychosocial aspects of a patient's complaints. The need for other types of healthcare providers should be determined on the basis of the population served by the MPC.
  3. The healthcare professionals should communicate with each other on a regular basis both about individual patients and about the programs offered in the pain treatment facility.
  4. There should be a director or coordinator of the MPC. He or she need not *be* a physician, but if not, there should be a director of medical services who is responsible for monitoring the medical services provided.
  5. The MPC should offer diagnostic and therapeutic services that include medication management, referral for appropriate medical consultation, review of prior medical records and diagnostic tests, physical examination, psychological assessment and treatment, physical therapy, vocational assessment and counseling, and other services as appropriate.
  6. The MPC should have a designated space for its activities. The MPC should include facilities for inpatient and outpatient services.
  7. The MPC should maintain records on its patients so as to be able to assess individual treatment outcomes and to evaluate overall program effectiveness.
  8. The MPC should have adequate support staff to carry out its activities.
  9. Healthcare providers active in an MPC should have appropriate knowledge of both the basic sciences and clinical practices relevant to chronic pain patients.
  10. The MPC should have a medically trained professional available to deal with patient referrals and emergencies.
  11. All healthcare providers in an MPC should be appropriately licensed in the country or state in which they practice.
  12. The MPC should be able to deal with a wide variety of chronic pain patients, including those with pain resulting from cancer and other diseases.
  13. An MPC should establish protocols for patient management and assess their efficacy periodically.

14. An MPC should see an adequate number and variety of patients for its professional staff to maintain their skills in diagnosis and treatment.
15. Members of an MPC should carry out research on chronic pain. This does not mean that everyone should be doing both research and patient care. Some function only in one arena, but the institution should have ongoing research activities.
16. The MPC should be active in educational programs for a wide variety of healthcare providers, including undergraduate, graduate, and postdoctoral levels.
17. The MPC should be part of or closely affiliated with a major health sciences educational or research institution.

#### DESIRABLE CHARACTERISTICS OF A MULTIDISCIPLINARY PAIN CLINIC

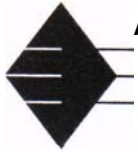
The distinction between an MPC and a multidisciplinary pain clinic is that the former has research and teaching components that need not be present in the latter. Hence, items 15, 16, and 17 in the foregoing list are not required for a multidisciplinary pain clinic. All other items should be present.

#### DESIRABLE CHARACTERISTICS OF A PAIN CLINIC

1. A pain clinic should have access to and regular interaction with at least three types of medical specialties or healthcare providers. If one of the physicians is not a psychiatrist, a clinical psychologist is essential.
2. The healthcare providers should communicate with each other on a regular basis both about individual patients and about programs offered in the pain treatment facility.
3. There should be a director or coordinator of the pain clinic. If he or she is not a physician, there should be a director of medical services who is responsible for the monitoring of medical services provided to the patients.
4. The pain clinic should offer both diagnostic and therapeutic services.
5. The pain clinic should have designated space for its activities.
6. The pain clinic should maintain records on its patients so as to be able to assess individual treatment outcomes and to evaluate overall program effectiveness.

7. The pain clinic should have adequate support staff to carry out its activities.
8. Healthcare providers working in a pain clinic should have appropriate knowledge of both the basic sciences and clinical practices relevant to pain patients.

9. The pain clinic should have trained professionals available to deal with ferráis and emergencies.
10. All healthcare providers in a pain clinic should be appropriately licensed in the country or state in which they practice.



## Joint Commission on Accreditation of Healthcare Organizations Standards for Pain Management<sup>21, 22</sup>

The new standards for pain assessment and management of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) apply to ambulatory care facilities, healthcare networks, behavioral healthcare facilities, home care, hospitals, long-term care organizations, long-term care pharmacies, and managed behavioral healthcare organizations.

These standards recognize pain as a condition that requires specific assessment and management and is finally recognized inside the main frame of patient rights with consequent organizational responsibilities.

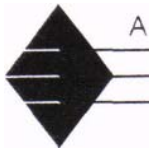
In summary, the standards point out the various aspects of pain care with which the healthcare organizations must comply:

- Explicit recognition of the right of patients to appropriate assessment and management of pain.
- Screening for the existence of pain and assessment of the nature and intensity of pain in all patients.
- Recording the results of the assessment in a way

that facilitates regular reassessment and follow-up.

- Determining and ensuring staff competency in pain assessment and management, and addressing pain assessment and management in the orientation of all new staff.
- Establishing policies and procedures that support the appropriate prescription or ordering of effective pain medications.
- Educating patients and their families about effective pain management.
- Addressing patient needs for symptom management in the discharge planning process.
- Maintaining a pain control performance improvement plan.

These new standards have started to be scored for compliance in 2001, and many key professional organizations and accredited healthcare organizations will discuss their experiences in managing pain in order to finalize the guidelines.



## Standards for Physician Fellowship in Pain Management<sup>23</sup>

1. **Definition.** A physician fellowship in pain management is a specialized postgraduate program of study in assessing and managing patients with chronic pain of all types and understanding the sciences basic to the practice of pain management.

2. **Duration.** A fellowship in pain management should require a minimum of 1 year of full-time clinical training. Additional research training may be desirable, depending on the fellow's career goals, but should not erode the clinical training period.

3. **Prerequisites for Fellowship in Pain Management.** To be eligible for a fellowship in pain management, the candidate must be board-eligible or board-certified in one of the recognized specialties of medicine; furthermore, the specialty area must involve experience with patient care. The fellow must be a graduate of an approved school of medicine. The fellow must provide at least three letters of a reference and a curriculum vitae when applying for a fellowship position. The fellow must be licensed to practice medicine by the appropriate governmental agencies.

4. **Resources.** The fellowship must occur within a medical institution capable of providing a suitable educational environment. At least three recognized patient care specialty areas must be offered at the same institution. The institution must have a medical library with appropriate resources for this level of training. The clinical pain treatment program or its parent institution must be accredited by the appropriate governmental agencies. The pain treatment facility must have suitable space allocated for its clinical and educational activities. It must have a sufficient volume and variety of patients to provide the fellow or fellows with adequate educational opportunities. The pain treatment facility must see at least 100 new patients per year per fellow; there must be at least 500 patient visits per year per fellow. Pain treatment facilities that specialize in one region of the body or one type of disease are by themselves not adequate as a training resource.

5. **Director.** There must be a designated director of the pain management fellowship. The director shall be a physician who participates in the diagnosis and treatment of patients within the pain management facility offering the fellowship in pain management. The director of the fellowship need not be the administrative or medical chief of the pain treatment facility, but

the fellowship director and administrative and medical chiefs, if they are not the same, must demonstrate the ability to interact in such a way as to be conducive to the education of fellows. The director shall be responsible for the design and implementation of the fellowship; he or she shall be responsible for certifying that a fellow has successfully completed his or her training period and has mastered the requisite knowledge, skills, and attitudes. The director must be a member of the International Association for the Study of Pain (IASP) and a national chapter. It is desirable that the director have extensive experience in the management of patients with the complaint of pain; it is also desirable that he or she have educational and administrative experience above and beyond the fellowship in pain management. The director shall be responsible for maintaining an up-to-date file on each fellow, documenting his or her educational progress and any deficiencies.

6. **Faculty.** There shall be at least three members of the pain treatment facility staff who are designated as faculty in addition to the director. Faculty members shall be appropriately certified in a patient care specialty. If one of the faculty is not a psychiatrist, an additional faculty member must be a licensed clinical psychologist who has expertise in pain management. Faculty members shall also be members of the IASP and a national chapter. Faculty members of a fellowship in pain management shall represent at least three healthcare delivery specialties. Other types of healthcare providers in addition to physicians and psychologists may also be members of the faculty. Faculty members must spend a major part of their professional time working within the pain treatment facility.

### CLINICAL TRAINING SUBJECTS

Although not every fellow will be fully trained in every area listed here, every fellow should at least have had some exposure to patients whose care involves all these areas.

- I. Medical diagnosis and therapy
- A. History and physical examination
- B. Measurement of pain

- C. Physical therapies
- D. Vocational and rehabilitation assessment and management
- E. Participation in multidisciplinary assessment and treatment
- F. Anesthesiologic procedures (when appropriate for the fellow's prior training)
- G. Surgical procedures (when appropriate for the fellow's training)
- H. Other procedures appropriate to the fellow's prior specialty training
- I. Psychological diagnosis and therapy
- A. Use of diagnostic tests
- B. Collection of data from interview and standard forms
- C. Comprehensive assessment
- D. Treatment options
  1. Individual, group, and family psychotherapy
  2. Cognitive-behavioral therapies
  3. Biofeedback and relaxation techniques
  4. Hypnotherapy
- III. Pharmacotherapy
  - A. Analgesics
    1. Nonopioids
    2. Opioids
    3. Adjunctive drugs
  - B. Antidepressants
  - C. Sedative-hypnotics
  - D. Benzodiazepines
  - E. Others
- IV. Specific types of painful conditions to be included in the fellow's educational program
  - A. Pain associated with cancer, including issues of death and dying, palliative care, and hospice care
  - B. Postoperative and post-trauma pain
  - C. Pain associated with nervous system injuries
  - D. Pain associated with chronic disease
  - E. Pain of unknown causation
  - F. Pain in children \*
  - G. Pain in the elderly
- V. Regional pain syndrome to be included in the fellow's educational program
  - A. Headache
  - B. Facial pain syndromes
  - C. Neck and upper back pain
  - D. Low-back pain
  - E. Extremity pain syndromes
  - F. Pelvic and perineal pain

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