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Building an Energetic Integrative Community: Working For and With Our Members

By DEBRA NELSON-HOGAN, DIRECTOR OF EDUCATION AND EDITOR OF *THE PAIN PRACTITIONER*
and LENNIE DUENSING, MEd, EXECUTIVE DIRECTOR OF THE ACADEMY AND EDITOR-IN-CHIEF



Twenty-three years ago, the American Academy of Pain Management (Academy) began building a foundation—a membership base—that was truly inclusive and represented clinicians from a wide variety of disciplines. The founders recognized that because of the

complexity of chronic pain, patients would not get “better” with single modality treatments (e.g., pills or shots) and that optimal care required multiple interventions and treatment by a multidisciplinary/interdisciplinary team. This is what has always set our organization apart from the other professional pain organizations and has given us our strength, agility, and ability to grow as new understandings about pain emerge.

In 2009, the Academy took a step forward when it shifted from an interdisciplinary to a patient-centered Integrative Pain Management (IPM) approach—a model of care that relies on both compassion and knowledge. An IPM approach aims to not only relieve pain, but to restore overall health, wellbeing, and wholeness. It is a model that is safe, effective, ethical, and that challenges the very way that pain has been practiced in this country for more than two decades. In essence, it does this by actually “flipping” the paradigm of care for people with pain. Modalities, such as improved nutrition, exercise/movement, and stress reduction that are considered to be “adjunctive” to treatment with conventional interventions (e.g., interventional procedures and medications), now become central components of care, while medications and interventional procedures become the “adjunctive” treatments that are employed when necessary to achieve pain management goals.

As the evidence to support the use of an IPM approach increases, members and attendees at the Annual Clinical Meeting are requesting more education on how to successfully incorporate integrative modalities. For example,

several presentations at the 2010 meeting discussed the latest research on mindfulness-based meditation for both people with pain and the health care providers who take care of them. Meditation was among the top 10 requested programs for the 2011 meeting, along with acupuncture, manual therapy, and successfully incorporating CAM into practice. Test data also show gaps in clinician competence around nonpharmacologic approaches to managing chronic pain; the two posttest questions most frequently answered incorrectly on our recent fibromyalgia monograph related to the evidence for exercise.

In a recent paper on nonspecific treatment effects (1), Robert Jamison, PhD, of Brigham and Women’s Hospital and Harvard Medical School, notes that “despite technical advances in many different types of pain treatment, the outcome literature suggests that only a minority of patients with chronic noncancer pain show measureable benefit from any of the treatments commonly given for this condition” and that much of outcome variance “has to do with the unique aspects of the human brain and the individual’s need to interpret pain.” Dr. Jamison stresses the importance of patient-centered care that involves compassion, empathy, effective communication, and patient education to maximize nonspecific treatment effects. This is the foundation of an IPM model.

These concepts were supported by the Department of Defense in a May 2010 task force report issued by the Office of The Army Surgeon General, entitled *Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families*. Two important statements made in this document are:

Pain medicine should be managed by integrated care teams which employ a biopsychosocial model of care. The standard of care should have objectives to decrease overreliance on medication driven solutions and create an interdisciplinary approach that encourages collaboration among providers from differing specialties.

The perception of many patients and providers is that pain management specialists fall within one of two categories: intervention-centered (e.g., needles) or medication centered (e.g., pills). Neither of these unitary approaches to pain management completely meets the needs of patients, who often present complicated causes and reasons for their pain. Therefore, a comprehensive and integrated approach to pain management across several medical specialties is required.

The complete document can be found online at http://www.armymedicine.army.mil/reports/Pain_Management_Task_Force.pdf

Changing Not Only What We Do, But How We Do It

Through this transition, we who work at the Academy are also discovering that shifting the paradigm of pain care to an IPM model is also transforming the organization itself—and this includes the way we engage, work with, and work for our members. In other words, we understand that changing how pain is managed requires us to build an energetic integrative community that works collaboratively with us to deliver the best possible programs and products. We would like to have your input and let us know how you would like to participate. ■

REFERENCE

1. Jamison RN. Nonspecific treatment effects in pain medicine. *Pain: Clinical Updates*. 2011;XIX(2):1-7.

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