CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

ISSUE 1 VOLUME 3, WINTER 2010

The last edition of the CAPM newsletter (Issue 3, Volume 2) focused on our need to better communicate with each other.

A case study was presented noting the challenges of co-ordinating multi-disciplinary assessment and treatment services - as well as mutually accepted goals and objectives- especially when most of us are still working in a solo out-patient environment..
Several ideas were received . Your Editor has taken these recommendations, 'consolidated' the responses and has presented you with even more challenges!

As much as we are trying to better communicate between ourselves as health providers; it is essential to also better communicate with our patients…

Many of us, trained in the medical sciences, have not been introduced to social science or psychology theory. What we 'think, know, recommend as treatment ' for our patient may in fact not be well accepted - because the patient is at another stage in their understanding (or non-understanding) of their particular pain problem.

The lead article, written by Eldon Tunks with some additional comments by your Editor will discuss the 'Readiness to Change' literature. Good pain management expects that the patient is actively participating in their treatment regime- which hopefully does NOT include ONLY medication. Understanding the need to change/ modify/adjust their activity level and lifestyle in order to control the pain is difficult for the majority of patients.

It is a particular challenge to the patient who has been injured in a traumatic event- because they HAVE to change (their behaviour) almost immediately (in order to better control symptoms. The patient with an insidious onset of a pain problem MAY have the time to adjust their lifestyle accordingly.

Of course, there are no absolutes.and no guarantees. Thus the need for the multi-disciplinary treatment environment- allowing us to share our skills and resources to more effectively assist our patients.

Members are reminded to notify your Editor about 'updates in your professions' concerning pain management initiatives and courses. You may also want to consider reviewing a book or article or presenting your own article for publication in this newsletter

All the best for a HEALTHY and PRODUCTIVE 2010 !

Respectfully submitted,

Gloria Gilbert, PT, M.Sc.
Secretary CAPM
Fellow, CAPM
Member and Fellow AAPM

Inside this issue:

Update from the Executive

Happy New Year to all our members and supporters! We're in the middle of our membership renewals. We value your membership and support of CAPM and if you have not yet renewed, please take the time to do that now.

We welcome two corporate members who have generously supported our efforts. These are Purdue Pharma and Sanofi-Aventis both companies with a strong track record in promoting education and excellence in pain management. We look forward to continued progress of CAPM with the help of our corporate members.

CAPM Executive positions are held for two years. The first executive elections were held two years ago and we are now soliciting nominations from you for election or re-election of president, vice president, secretary, and four (4) members at large. Please give your careful attention and support to this election so that we will continue to have strong leadership and create the changes that are needed for professional identity and excellence in pain management in Canada.

The executive is working toward sponsoring a two-day course later in 2010 with the purpose of building skills in pain assessment and management, through problem-based presentations and clinical demonstrations. CAPM is committed to skill-building education that is multidisciplinary in scope, with topics that are central to advanced skills in pain assessment and management.

For the past year the executive has also been working on a plan for additional credentialing options. Beyond the recommended credentialing that is available through our partner the American Academy of Pain Management, our intention is to develop Advanced Credential options for specific skill areas. The first step in this development is the course late in 2010. This course will offer credits toward an eventual Advanced Credentialing.

With best wishes for 2010,

Yours sincerely,

Eldon Tunks MD FRCPC,
CAPM President
Diplomate of CAPM
Member and Diplomate of AAPM

Update from the Professions

1. The Pain Sciences Division of the Canadian Physiotherapy Association has launched a new website http://sites.google.com/site/canadianpainphysiodirectory/.

This website will direct both health providers and patients to physiotherapists across Canada who have a special interest in treating the 'patient with chronic pain'.

Your editor, a physiotherapist, has sent in an Update on CAPM to the Pain Sciences Davison quarterly newsletter. To date, several inquiries have been received from physiotherapy colleagues interested in the credentialing process.

2. Dr. Michael MacDonald, psychologist (MacDonald, Bryant psychologists in London) has authored an on-line book entitled Unbelievable Pain Control.com

Mike notes that although it is directed at lay readers, it may be of interest to health professionals as well.

For access click on www.UnbeliveablePainControl.com

Meeting Notices

1. Traumatic Brain Injury. The second annual meeting on Mild Traumatic Brain Injury: Challenges and Controversies in Treatment will be held on Friday February 5, 2009 in Toronto. It is described as a 'must-attend' event for health, insurance and legal professionals working with mTBI For further information contact Conference Services at 416-597-3422 Ext. 2693 or click on http://torontorehab.com/education/mildbraininjury2010.html

2. The 13th World Congress on Pain will be held in Montreal from August 29-September2, 2010. Check out www.iasp-pain.org/Montreal for poster/abstract submission as well as early bird registration details.

3. The American Academy of Pain Management will hold its 21st Annual Clinic Meeting in Las Vegas, Nevada on September 21-24, 2010. This is an exciting meeting – and location to meet your colleagues who are involved with 'Integrative Pain management'. Contact http://www.aapainmanage.org.

4. The Integrative Mental Health Conference (presented by the Arizona Centre for Integrative medicine) will be held from March 22-24, 2010 in Phoenix. Check out www.integrativemedicine.arizona.edu for updates and details.

5. The 7th annual Nutrition and Health Conference (State of the Science and Clinical Application) will be held from May 9-12, 2010 in Atlanta, Georgia. Check out www.NHConference.org for details.

October 2009- October 2010 has been declared as the Global Year Against Musculoskeletal Pain by the International Association for the Study of Pain. Check out information at: www.iasp-pain.org/GlobalYear/MSP

Case Study (Follow-up): Suggestions for Better Co-ordination of Services

The case study presented in the last newsletter (Fall 2009) discussed the challenges in providing appropriate treatment services when a lawyer referred a 'chronic pain' patient to an out patient physiotherapist (PT). The patient had been involved in a MVA several years previously and had not been able to return to /resume their pre-morbid activity level and function.

In order to develop an effective treatment program , the PT needed to 'develop a team' around her.

This scenario in fact should NEVER have developed in the first place. !!

However, as is often the case, when a patient takes time to 'recover from injuries'- the family physician is often relegated to a back seat –and the auto industry (or other insurer) often takes over.

It remains important for both patients and treating health professionals to ensure they understand that the insurance company cannot 'order' treatment programs or medical investigations. However, they often make the recovery process challenging by instituting a myriad of assessments, treatment recommendations and (often realistic) time-lines for recovery . This in fact only adds to the patients' worries and concerns and often delays recovery even more (check out www.UnbelieveablePainControl.com).

It is the family physician who knows the patient the best (before and after the event)- and who should be the primary health professional directing treatment.

Dr. Brian Kirsh, is the Medical Director of the Chronic Pain Management Unit at Hamilton Health Sciences. He has presented a comprehensive plan ensuring that the family physician remains the key co-ordinating health professional for all pain management programs. *(This of course should occur whether or not the patient has been involved in a personal injury claim.)*

Case Study Follow-up continued...

Brian notes the following:

- Family doctors review decision about investigations and analgesia therapy, make immediate referral to physiotherapy and consider psychological assessments in cases where emotional factors may be important
- That a diagnosis of 'probable chronic pain' (*your editor disagrees that chronic pain should be considered a diagnosis. It is a symptom of an underlying problem)* be made at 3 months after the injury.started). The patient should then be referred for a comprehensive assessment which include a pain management physician, psychologist, PT and OT at the minimum.
- The team decides on whether current treatment is sufficient or if additional treatment is needed.
- Individual or multiple unimodal therapies such as physio, psychology, driver rehab, OT etc is co-orientated by the family physician
- *(If functional goals cannot be achieved),* referral for interdisciplinary assessment and treatment be recommended with follow-up care and coordination of services by a community team.

One of the challenges not mentioned by Brian is the fact that family physicians in independent practice do not get paid to be the 'co-ordinating' health professional. They also do not usually have the time (and sometimes the experience) to co-ordinate multidisciplinary pain management teams.

However, within the auto insurance industry in all Provinces there is a vehicle to request remuneration for time spent on co-ordination of services (counselling?). Although it may be challenging to work though the paper-work , if more family physicians take back ownership of their patients health care needs the insurance industry will HAVE to change policies and procedures.

Family physicians must also make themselves knowledgeable about the current literature and management of the patient with chronic pain symptoms. Pharmaceutical companies sell medication but their research is important. Pain management organizations continues to develop information sites and newsletters that SHOULD be read by all primary health care professionals.

As is presented in this case scenario, it also remains incumbent on the family physician to be knowledgeable about the 'rehabilitation industry'. In Ontario, the Financial Services Commission of Ontario (www.fsco.gov.on.ca/) has clearly (?) delineated goods and services for which a patient is eligible.

Even if the family physician has 'referred the patient; to an appropriate rehabilitation professional or for assessment, the family physician can still remains the primary health care professional co-ordinating treatment and management.

Now we all just need time- !

Lead Article: Readiness to Change

By: Eldon Tunks, MD, FRCPC

Eldon provides a course on Readiness to Change annually to the Canadian Memorial Chiropractic College. He also presents this material to all the medical residents who study with him. It is not copyrighted.

Theories and research on 'Readiness to Change' is extensive. However, it is often not discussed/ transmitted to the health professional providing 'physical treatment' (physician, therapists, chiropractors etc).

It again reminds us all of the need for improved communication and co-ordination of health care services. It also reminds us that pain intensity scores may not be as important to measure change as a decrease in disability scores and an increase in a patient's ability to improve their functional tolerances.

Please review the article. Members may want to develop this theme further by superimposing a case study on the various STAGES…allowing us to better appreciate the need for integration of physical and psychological goals of treatment.

Lead Article continued...

STAGES OF CHANGE CAN BE CONCEPTUALIZED AS:

1. Not ready to accept that the problem can be helped by self-management.
2. First exposure to the idea of self-management.
3. Beginning to do something about self management (e.g. learn new skills)
4. Committed to continue skills development and relapse prevention.

1. ***" Not Ready for Self Management"***
    - the mental shock and dismay of the injury and shattered experience of self
    - anger, denial, depression or over-optimism
    - has not absorbed accurate information about injury, prognosis and change options
    - difficulty in transition from acute care environment (what I cannot do or others must do for me) to a rehabilitation environment (what I can do)
    - threats to disability and sense of control: bowel/bladder, sexuality, pain, physical helplessness

    What is Needed
    - provision of physical and emotional support, relief of distress, sensitivity to feelings and fears, respect for the person, re-assurance
    - information input, beginning to suggest a future orientation
    - during initial rehab assessments, to begin to give rehab a dace by developing a supportive therapeutic relationship

2. ***" Contemplating Self-Management"***
    - rehab team gives emotional support (and therapy now has a face)
    - patient begins to absorb what has happened
    - assessment process has an educational function regarding what may be possible
    - 'the patient may still feel like a passive participant'

    What is Needed
    - 'education', answering questions about what is possible, addressing fears, changing focus to what I **can** do
    - continuing to give rehab a face and develop relationships
    - addressing discomfort and anxieties, including pain
    - initial shock and emotional and physical distress is acknowledged
    - supportive climate with respect and positives regard is the beginning of the therapeutic relationship with professionals.

    Question for the health provider: Can this patient be 'engaged'? (i.e. are they ready to involve themselves in this process of change?)
    The following criteria are a good test of engagement:
    1. Patient aggress with therapist on 1 or more goals for functional change
    2. Motivation is demonstrated (willingness to do, learn or try something)
    3. The patient has adequate psychological mindedness (can adjust to mood, beliefs, worries, conflicts)
    4. The capacity to learn something from the therapist - 'capacity for insight'

3. ***"Beginning to act"***
    - increasing patient-therapist, peer and family relationships
    - developing skills and learning information about control (vital functions, body functions, sexuality, pain, comfort, mobility, routine)
    - motivation is increased by successful experiences and encouragement by staff and others
    - developing a sense of mastery
    - beginning to consider a future

Lead Article continued...

What is Needed

- educational input with a focus on understanding the injury and the mechanisms of problem resolution
- development of a roadmap for reasonable therapeutic goals and the mechanism of problem resolution
- therapists acting as coaches and tutors
- team's emphasis on manageable functional goals and active participation
- collaboration with patient in setting goals and measuring progress
- struggles with overcoming barriers) and need for dignity and individuality are respected
- emotional support and encouragement from team and others (be aware of intensity of patient-therapist bonds. Patient often feels that these relationships give them hope and change their lives. One must respond to this trust respectfully and knowledgeably).

GOALS

The three criteria for useful rehabilitation goals:

1. are they realistic? (can they be achieved?)
2. are they important? (will they impact on the roles and functions that will make a difference?)
3. are they adequately specific? (can they be measured enough to set quotas and chart progress?)

4. "***Commit to long-term action*"**
   - acquiring strategies and attitudes for long-term health maintenance and self-care
   - re-creating social support network that was disrupted by the injury/illness
   - re-designing independent living, with dignity and sense of control (bowel, bladder, pain, finances, house routine, modality, sexuality etc)
   - perspective on personal and family development and creativity- the dimensions of quality of life

Team gradually introduces long-term objectives

CANADIAN ACADEMY OF PAIN MANAGEMENT

1143 Wentworth Street West, Suite 202, Oshawa, ON L1J 8P7
Phone: 905-404-9545; Fax: 905-404-3727; office@eventsinsync.com; www.canadianapm.com

POSITIONS AVAILABLE MAY 2010

The following positions are available to CAPM members, nominated by other CAPM members for the term beginning in May 2010. If interested, please complete the nomination section and return by fax to **1-905-404-3727** or email ellen@eventsinsync.com by **FEBRUARY 15, 2010**

President: Subject to the authority of the Board, the President shall be charged with the general management, direction and supervision of the affairs and operations of the Corporation. He/she shall have such other powers and duties as the Board may prescribe. **Term May 2010 to May 2012.**

Vice-President: during the absence or disability of the President, his/her duties shall be performed and his/her powers shall be exercised by the Vice-President, or if there is more than one, by the Vice Presidents in order of seniority. A Vice-President shall have such other powers and duties as the Board or the President may prescribe. **Term May 2010 to May 2012**

Secretary: The secretary shall attend and be the Secretary of all meetings of members and Directors and shall enter or cause to be entered, in books kept for that purpose, minutes of all proceedings thereat; he/she shall give or cause to be given, as and when instructed, all notices to members, Directors and Honourary Directors; he/she shall be the custodian of all books, papers, records, documents and other instruments belonging to the Corporation except when some other Officer or agent has been appointed for that purpose; and he/she shall perform such other duties as the Board or the President may prescribe. Term May **2010 to May 2012.**

Members at Large (4): Shall perform such other duties as the Board or the President may prescribe. **Term May 2010 to May 2012.**

NOMINATION FORM

CAPM members are invited to either nominate or second a nomination of up to six (6) candidates in total.

I _____ would like to have my name stand for the position

of _____ described above for the term as outlined.

Nominated by: _____

Nominated by: _____

PLEASE INCLUDE A PARAGRAPH ON YOUR REASONS FOR SEEKING THE POSITION – Maximum 250 words