AMERICAN SOCIETY OF PAIN EDUCATORS

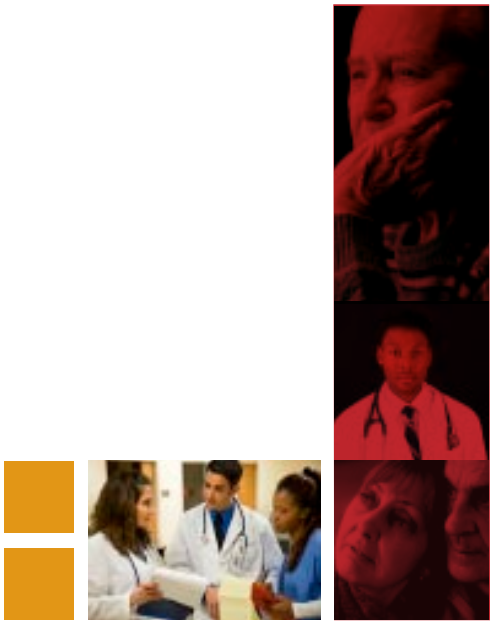
PAIN VIEW

www.paineducators.org

SUMMER 2006

Vol.2 N°.2

THIS ISSUE



2006 PAIN AWARENESS MONTH

September 1–30

Vision and Commitment:

30 Days of Pain Education Throughout September

THE AMERICAN SOCIETY OF PAIN EDUCATORS (ASPE) will launch a daily calendar of educational events for practitioners, focused on advancing better pain management outcomes during Pain Awareness Month, throughout September.

"We are providing a broad educational agenda to address the challenges of underdiagnosis and undertreatment of pain in the U.S.," says B. Eliot Cole, MD, MPA, ASPE executive director. "Noting that half of all visits to primary care (CONTINUED ON PAGE 4)

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PAINVIEW

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www.paineducators.org

Executive Director Message

September is National Pain Awareness Month, Sickle Cell Disease Month and National Alcohol and Drug Addiction Recovery Month. As members of the ASPE, you'll want to champion pain education. Pain educators can demonstrate through action what you do every day in your practice: answer questions, provide updates, and respond to inquiries from the media, your patients, and other healthcare professionals.

How best to do this, and continue to deliver clinical services to your patients? The ASPE is preparing a daily educational opportunity for your professional development during September. In addition, we continue to present regional updates on the implications of polypharmacy and the underlying mechanisms of pain as part of our ongoing commitment as a provider of pain education. You'll find a list of upcoming training programs at the member website www.paineducators.org.

The 2007 Pain Educators Forum will be held in Las Vegas as part of a larger initiative—Pain Week. Mark your calendar for September 6–9. Preregister by calling 888–ASPE–REG (277–3734) or visiting the website. Anyone interested in credentialing will want to master the 2005 curriculum (28 hours of material) at http://aventine.breezecentral.com/core/event/registration.html so you can advance to Level 2 content at the 2007 Forum.

Work continues on the credentialing examination. Want to help write exam questions? Be a "beta" test candidate? We want the credentialing process to reflect the scope of work done by our members. Please contact us at ri@paineducators.org, if you are interested in participating.

I really do want to hear what we are doing right as well as what we need to do to exceed your expectations. Send your comments, questions and any input to me at drcole@paineducators.org.

B. Eliot Cole

FEATURED CONTRIBUTORS

Penney Cowan recounts her journey to gain pain relief and offers suggestions for managing others who face a life of chronic pain. She is executive director of the American Chronic Pain Association.

President of The Humor Project, **Joel Goodman, EdD**, encourages pain educators to insert humor daily, personally and professionally, as a means to achieve better patient outcomes.

A professor at the University of Maryland, School of Pharmacy, **M. Lynn McPherson, PharmD,** puts a practical pain education spin on topical news items to keep you current.

Beginning this month, **Jeffrey Tarnoff**, our Director of Operations, (aka IT concierge), shares his insights regarding PowerPoint shortcuts and other computer-related challenges.

Lonnie Zeltzer, MD, professor of pediatrics, and director of the Pediatric Pain Program at UCLA, discusses the value of using a full-range of strategies to promote optimal pain management.

The ASPE Grows Stronger and More Effective with each New Member

The ASPE extends a warm welcome to all of our new members who have joined since the last issue of *PainView* was published. Congratulations—you are on your way to becoming noted and noticeable resources in pain management. We look forward to serving you well in your professional pursuits as pain educators. Please remember to avail yourself of all ASPE member benefits, which are updated regularly and can be viewed and reviewed at www.paineducators.org.

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> **"We want healthcare professionals to ask about pain, we want patients to tell us about their pain, and together we want to improve healthcare outcomes."**
>
> B. Eliot Cole, MD, MPA
> Executive Director,
> American Society of Pain Educators

(COVER STORY CONTINUED)

physicians are pain-related, we must provide information and tools to support the frontline practitioners who treat the majority of people in pain: clinicians, nurses and nurse practitioners, physician assistants and pharmacists," urges Dr. Cole.

This directed focus during Pain Awareness Month stems from two critical observations: the inadequacy of pain education offered during academic and clinical training, and the serious need for evidence-based pain management education for healthcare professionals treating the growing population of aging adults and the elderly.

"The ASPE urges pain educators to improve pain management through education in response to the increasing number of aging baby boomers who will not relinquish their busy, active lifestyles," says Dr. Cole. "Active aging adults expect appropriate treatment and support from their healthcare providers, and we should fulfill this expectation. As caregivers, we need to ask about and pay attention to our patients' pain." The ASPE will help you learn to be appropriately responsive.

Interested clinicians may register for a free informational resource guide and learn more about specific Pain Awareness Month events by calling (888) ASPE–REG or going to www.painawarenessmonth.org.

Events include live webcasts and web-based conferences on the following pain-related topics:

2006 PAIN AWARENESS MONTH
September 1–30

- **The state of pain management in America**
- **Arthritis**
- **Medication compliance**
- **Foot care**
- **Fibromyalgia**
- **Headache**
- **Low back pain**
- **Neuropathies**
- **Depression**
- **Sickle cell anemia**
- **Palliative and end-of-life care**
- **Polypharmacy: use of multiple medications**
- **Post-operative recovery**

Preview of First-ever Pain Week 2007

The ASPE is spearheading Pain Week 2007—a national conference to be held during Pain Awareness Month in September 2007—to present relevant, real-world pain education for the frontline practitioner. The conference will convene at the Red Rock Casino, Resort and Spa in Las Vegas, Nevada, on September 6–9, 2007, in concurrence with the ASPE Pain Educators Forum. The mix of plenary and breakout sessions will provide patient and practice management strategies appropriate for the primary care setting.

The purpose of Pain Week is to have multiple organizations come together with the ASPE to further pain education for all practitioners: physicians, nurse practitioners and nurses, pharmacists and physician assistants. "Organizations are encouraged to participate through joint partnerships of select sessions or by running specific educational tracks; each organization can play a part in improving the lives of people with pain through education," says Dr. Cole.

Organizations and corporations interested in partnership or sponsorship opportunities during 2006 Pain Awareness Month and 2007 Pain Week are encouraged to contact Steve Porada at sp@paineducators.org.

Chronic Pain Turns Patient into Advocate

by **Penny Cowan**

My pain started just like it does for many others—out of the blue. After the birth of my second child, an excruciating headache developed. Busy attending to a newborn and toddler, I ignored the pain until it moved to my neck and then spread bodywide, reducing my ability to function. I went to my doctor expecting to undergo some tests, get diagnosed and treated.

I spent the next 6 years in a compromised functional state, in an endless search for pain relief. Since I lived in Pittsburgh, I assumed I had had the best care possible. When I was referred to the Pain Management Center at The Cleveland Clinic, I went out of immense guilt that my disabling pain was destroying my family. I had lost who I was; the pain defined me. There, I was diagnosed with fibromyalgia. I had become so totally deconditioned that I couldn't lift a cup or get up from a chair without searing pain. After all, I had been told repeatedly that "if it hurts, don't do it" and that I should "learn to live with the pain," but I was never told how to do it!

I've now had 22 years of self-care in managing my pain. I want pain educators to enlighten other pain practitioners, patients, their families, and caregivers about the real possibility of helping patients live well despite their chronic pain.

Many pain sufferers will have spent countless years "doctor shopping" in search of relief, and trying to find a knowledgeable and empathetic ear. When they finally get to you, they will be defensive. We shouldn't have to prove we are in pain. Practitioners tend to rely on concrete data in assessing pain, but there is no clinical benchmark; rather, focus on the person's functionality. By using a quality of life scale, clinicians can more closely identify with the patient's experience.

Finally, practitioners can best serve their patients by addressing any limits to therapy and exploring therapeutic alternatives. Surgery, for example, may or may not help.

TEACHING TIPS

- Promote the real possibility that patients can live well despite chronic pain.
- Change the message from "learn to live with the pain" to "here's how to gain control over your pain!"
- Catch people before they become too disabled.
- Explain that effective pain management is a continuous process, requiring adjustments to medications and exploring non-pharmacologic therapies.

Here are some other strategies:

Validate the patient's experience and the pain. Begin with a good conversation: frank and direct. It's ok to say:

"You may always have to live with some pain."

"There no known cure."

"Your condition may not be 'fixable', but can be effectively managed."

Encourage the patient to become assertive about managing her pain. Explain that controlling pain is a continuous process. Therapies may help for a brief time, and then no longer provide relief, requiring adjustments and changes.

Create a pain management plan that transforms the patient from a disabled patient to an able-bodied person. Suggest resources that will promote improved quality of life.

Your patients' outcomes will improve as their daily functioning increases and their sense of suffering decreases. In effect, I, the person in pain, am ultimately responsible for maintaining my own wellness, with assistance from my healthcare team and family. Reach out and help!

Chronic Pain and Too Little Sleep: Part II

The Treatment Conundrum: New Insights

People who suffer from pain and sleeplessness are seeking help in increasing numbers. Typical symptoms include insomnia, fatigue, chronic pain and depression. Often, the depression can be attributed to inadequate sleep and/or pain, which may or may not be the case, necessitating consideration.

"When trying to tackle the concomitant treatment of pain and sleep, the inclination has been to reduce pain first in order to promote sleep," says Lynette A. Menefee, PhD, assistant professor of anesthesiology at the Jefferson Pain Center, Jefferson Medical College, in Philadelphia, PA. "However, pain medications (eg, opioids, analgesics) should not be increased automatically in response to complaints of poor sleep since the specific medication and the timing of administration can adversely affect sleep, negating the value of therapy." Stimulant-based pain medications taken in the evening will relieve the pain,[1] but may simultaneously disrupt sleep; the net effect is an increased sensitivity to daytime pain.[2]

"Recent evidence demonstrates that patients experience greater pain during the day following a night in which subjects slept poorly," says Timothy Roehrs, PhD, Sleep Disorders and Research Center, Henry Ford Health System, in Detroit, MI. "Our findings support the confounding effects of sleep in healthy individuals, and suggest that pain sensitivity is underestimated." A net loss of 4 hours of sleep produced hyperalgesia (an extreme sensitivity to pain), and the consequences of sleep loss are cumulative such that 1–2 hours of sleep lost over several nights would have the same detrimental effect on pain as one bad night of sleep.[3] Furthermore, it may be that specific disruption of rapid eye movement (REM) sleep has the greatest impact on next-day hyperalgesia, according to Dr. Roehrs.

TEACHING TIPS

- The biodirectionality of pain and sleep necessitates simultaneous treatment of both conditions.
- Prescriber beware: pain medications may alter sleep, adding to a preexisting sleep deficit.
- Since inadequate sleep enhances daytime pain sensitivity, treating disturbed sleep can reduce daytime hyperalgesia.
- Reserve opioids (and caffeine-containing medications), which are REM suppressors, for daytime pain, and rely on nonstimulant agents before bedtime.

"By prescribing opioids for pain relief, you may alter the body's natural analgesic system during sleep," says Dr. Roehrs. "To offset this possibility, clinicians might consider using a nonstimulant-type pain medication, such as gabapentin or tricyclic antidepressants, at night to promote sleep, and reserve opioid-type drugs to manage daytime pain." By inference, Dr. Roehrs hopes that by improving sleep, the need for pain medication at night can be reduced.

Given this new data, pain educators can respond to the bidirectional relationship of pain and sleep by promoting restorative sleep as a clinical intervention to reduce pain.[4] Benzodiazepines and nonbenzodiazepines are viable options to promote sleep, provided the recommendations of the NIH State-of-the-Science Conference on the Manifestations and Management of Chronic Insomnia in Adults are followed.[5]

"Next, sleep-promoting medication will be given prophylactically to pre-surgical patients to determine whether sound sleep prior to surgery minimizes post-procedural pain, which may enhance restorative sleep, thereby decreasing the need for extended pain medication," says Dr. Roehrs, who is currently leading just such a study.

"Given concerns about drug-drug

interactions, pain educators can promote a therapeutic strategy for patients who are suffering simultaneously from chronic pain and insomnia," says Dr. Menefee, "that assures the best outcomes for both conditions."

References:

1 Menefee LA, Cohen, M, Anderson WR, Doghramji K, Frank ED, Lee H. Sleep disturbance and nonmalignant pain: a comprehensive review of the literature. *Pain Med*. 2000;1:156–172.

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3 Roehrs T, Hyde M, Blaisdell B, Greenwald M, Roth T. Sleep loss and REM sleep lossare hyperalgesic. *Sleep*. 2006;29(2):145–151.

4 Roehrs T, Roth T. Sleep and pain: interaction of two vital functions. *Semin Neurol*.2005;25(1):106–16.

5 Buscemi N, Vandermeer B, Friesen C, Bialy L, Tubman M, Ospina M, Klassen TP, Witmans M. *Manifestations and Management of Chronic Insomnia in Adults. Evidence Report/Technology Assessment No. 125*. AHRQ Publication No. 05–E021–2. Rockville, MD: Agency for Healthcare Research and Quality. June 2005.

With Appreciation

THE AMERICAN SOCIETY OF PAIN EDUCATORS WOULD LIKE TO ACKNOWLEDGE THE FOLLOWING SPONSORS AND SUPPORTERS FOR THEIR GENEROUS SUPPORT OF OUR ONGOING EFFORTS.

WE ARE EXTREMELY APPRECIATIVE OF OUR SPONSORS' WILLINGNESS TO PROMOTE THE ASPE MISSION TO TRAIN HEALTHCARE PROFESSIONALS TO BECOME RECOGNIZED RESOURCES IN AND EDUCATORS OF EFFECTIVE PAIN MANAGEMENT TO THEIR CLINICAL PEERS, PATIENTS, AND CAREGIVERS.

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www.tna-support.org

Pain Research in the News

by **M. Lynn McPherson, PharmD**

Better Education Curtails Substance Abuse

Illicit use and abuse of controlled pain medications are common concerns for pain practitioners. Strategies to detect and discourage medication abuse are an important and prudent part of any pain practice. Manchikanti and colleagues recently evaluated the impact of implementing antiabuse strategies in their multi-disciplinary, interventional pain practice.[1,2]

In the first study, patients were educated about the importance of adhering to their prescribed medication plan; clinicians established a program of medication vigilance, including history-taking, periodic evaluation of appropriate intake of medications, random urine drug testing, opioid agreements, and pill counts. In addition, participants gave consent to a chart audit, and to collection of prescribing/dispensing information from the patient's community pharmacy, referring physician, and other physicians involved in the patient's care.[1] Medication abuse was defined as the patient's receipt of a controlled substance from any source other than the prescribing physician. Results showed that controlled substance abuse occurred among 9% of participants versus 17.8% reported in earlier research.

In the second study, patients underwent urine drug testing to screen for cocaine, marijuana, or amphetamines.[2] There was a statistically significant decrease in illicit medication use (16% for participants versus 22% from previous data).

It is vital that pain educators reinforce the role of patients as partners in their own care, making it our obligation to explain that patient monitoring is one valuable strategy to discourage and divert patients from medication abuse. These strategies are employed to protect the patient, the prescriber and the practice. Explicit patient education regarding these elements of the care plan is essential to allay patient fears, and to outline expectations in the partnership that is pivotal to providing effective pain management.

TEACHING TIPS

- Foster a patient-practitioner partnership—a pivotal tool in effective pain management.
- Promote patient monitoring as a valuable strategy for proper medication use.
- Explicit patient education regarding a self-care plan is essential to allay patient fears, and to outline treatment expectations.
- Promote patient risk assessment for acetaminophen toxicity and proper dosing.

References

1. Manchikanti L, Manchukonda R, Damron KS, et al. Does adherence monitoring reduce controlled substance abuse in chronic pain patients? *Pain Physician*. 2006;9:57–60.
2. Manchikanti L, Manchukonda R, Pampati V, et al. Does random urine drug testing reduce illicit drug use in chronic pain patients receiving opioids? *Pain Physician*. 2006; 9:123–129.3

Addressing Risk of Daily Acetaminophen Use

Acetaminophen is a workhorse analgesic in our bag of tricks, thanks to a long-standing history of effectiveness and an acceptable safety margin when taken as directed. Recent research suggests that taken daily, acetaminophen may raise serum alanine aminotransferase (ALT). Watkins et al,1 considered the incidence and magnitude of ALT elevation in healthy subjects divided among 4 active treatment groups: 3 groups received various opioid/acetaminophen combination tablets and 1 group received acetaminophen alone; all participants received 4 grams of acetaminophen daily.

Only one of 39 participants receiving placebo experienced ALT elevation

greater than double the upper limit of normal versus 53% of treatment recipients. Twenty-five percent of participants receiving acetaminophen experienced an increase in ALT in excess of 5 times the upper limit, as did 49% of those receiving combination treatment. The magnitude and temporal patterns of ALT elevations were similar in all active treatment arms, including the acetaminophen-only group.

This clinical trial illustrates that 4 grams of acetaminophen per day (with or without opioid) in healthy adults is associated with ALT elevation. Pain educators may want to recommend that patient risk for acetaminophen toxicity such as previous acetaminophen therapy, hepatic dysfunction, alcohol use, or use of other hepatotoxic medications be considered before initiating acetaminophen therapy. Patients should be educated to avoid exceeding the recommended dosing for acetaminophen, so as to minimize modifiable risk factors.

References

1 Watkins PB, Kaplowitz N, Slattery JT, et al. Aminotransferase elevations in healthy adults receiving 4 grams of acetaminophen daily: a randomized controlled trial. *JAMA*. 2006;296(1):87–93.

Benefits of Membership in the American Society of Pain Educators

The fastest growing pain organization in the US today, the American Society of Pain Educators (ASPE) is a 501(c)(3) non-profit professional organization dedicated solely to training healthcare professionals to become specialized resources for pain management in their clinical settings. As the only organization dedicated to preparing certified pain educators (CPEs), the ASPE provides the skills and knowledge necessary for healthcare professionals to educate their peers and patients, together with families and caregivers, on ways to relieve pain by the safest means possible.

Since the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires pain management education in all of its accredited institutions, the ASPE goal is to eventually have a CPE in every JCAHO-accredited facility.

Specific member benefits include:

- Print copy of *PainView* – the official newsletter of the ASPE
- Online version of *PainView*
- Personal paineducators.com e-mail address
- Custom ASPE-member business cards – to let clients, patients, and colleagues know that you belong to the ASPE and that you are a Pain Educator
- Discounted registration to the Pain Educators Forum and other regional meetings
- Access to the ASPE Membership Directory
- Email alerts for newly published articles on pain-related topics
- Professional development as a clinical health educator
- Networking support
- Negotiated member discounts on travel, entertainment and more
- Access to Pain Educators Mentor program
- Access to Pain Educators Advisor program
- Access to the ASPE members-only site
- Pain Awareness Month educational resources
- Online Pain Awareness Month educational resources

For more information, please visit the ASPE website at www.paineducators.org. If you have questions about membership, you may contact Redza Ibrahim at: ri@paineducators.org.

Distraction Lessens the Pain, At Any Age

Chronic pain is both physical and psychological. Clinicians must recognized that the mind is very powerful, which can work against or for the person in pain.

"Unless we show patients how to master, cope with, or turn off the pain, the more the pain will take over and inhabit their lives," says Lonnie Zeltzer, MD, professor of pediatrics at the UCLA David Geffen School of Medicine. People who suffer from chronic pain begin to anticipate it, worrying that they won't be able to cope. This sets off a vicious cycle—the pain gets magnified by the physiological arousal with increased epinephrine and sympathetic tone, which heighten the pain sensation. "Breaking this cycle is best managed with a combination of pharmacologic and behavioral strategies, although psychological strategies alone can work," says Dr. Zeltzer.

"The goal is to present options that redirect the focus away from the pain so that the patient can set up new, less toxic pathways than the pain neuromatrices that got started," explains Dr. Zeltzer. This is where pain medicine needs to go, now," she says. The newest pain therapy is a Virtual Reality computer game that plays on distraction as a means to reduce the pain sensation. While playing the devise distracts, it is also promoting a sense of mastery and building a sense of competence. Different than the static distraction of television watching, the interactive aspect of virtual gaming is more captivating.

TEACHING TIPS

- Always consider the emotional impact of pain when assessing a person in pain.
- Unless patients are taught ways to master or cope with the pain, the more their pain will diminish their lives.
- Present options that redirect the focus away from the pain to promote new, less toxic pain sensitivity pathways.
- Anything that diverts attention can turn the pain sensitivity and physical arousal to something positive, and/or self-esteem enhancing.

Having an arsenal of tools available to address the perception of pain head-on is essential for pain educators. (See Table 1). Yoga for example rebalances a dysregulated sensory nervous system, but also provides the person with a self-help method for dealing with the pain by putting the patient in control. Feeling out of control magnifies the pain sensation.

There are data from functional MRIs that validate altered pain perception following therapies such as cognitive imagery and biofeedback.

"The more engaged a person, the more likely attention will be diverted away from her pain," says Dr. Zeltzer. "The more absorbing the activity, the greater the reduction in pain sensation possible." The games are nice but the goal should be to create a setting that allows the person to escape from the pain by becoming immersed in a fantasy or that is totally captivating. "That's why hypnosis and biofeedback work; I've used these tools to have children imagine adventures," says Dr. Zeltzer

"Anything that holds a person's attention, and gets the mind off the pain, can turn the pain sensitivity and physical arousal to something positive, and/or self-esteem enhancing," says Dr. Zeltzer. "Certainly, the work in the virtual reality field is new and catchy, but there are many ways to reduce pain perception, and that's where options such as cognitive behavioral therapy, breathing, imagery and relaxation are effective in physically and biologically altering the metabolic activity in pain perception areas of the brain."

The pain rehabilitation model is an important part of the desensitization process. When patients realize their own ability to alter their pain through physical activity, they are able to move beyond the fear to explore lifestyle changes that support positive functionality, according to Dr. Zeltzer.

The physiological impact of pain,

specifically the anxiety, stress, worry, and fear, which turn up the volume on pain, should always be considered when assessing a patient for pain. The pain sufferer has the ability to reduce pain without analgesia, simply by lessening her anxiety level. There are many ways to calm the mind such as yoga, biofeedback, breathing, progressive muscle relaxation, meditation and hypnosis that biologically reduce pain signals.

Pain educators can help patients directly, or by referring them to specialists who train people in pain to use a variety of strategies for relaxing their muscles, their emotional state, and their body.

The last caveat—whenever a person is in a lot of pain from conditions such as irritable bowel syndrome, fibromyalgia, migraines, arthritis; visceral pain (eg, interstitial cystitis); or, even abdominal pain (eg, stomachache), there is often an additional myofascial, musculoskeletal component that can be lessened by redirecting the patient's attention through physical activity. "Movement, even if it hurts early on, will feel better as the person does more," says Dr. Zeltzer. "This is good pain, as opposed to the bad pain anticipated by fear or worry."

Resource: Zeltzer LK, Schlank CB. *Conquering Your Child's Chronic Pain: A Pediatrician's Guide for Reclaiming a Normal Childhood.* 2005. New York: HarperCollins Publishers.

Table 1 Integrative Pain Management Therapies

- Acupuncture
- Art therapy
- Biofeedback
- Breathing exercises
- Cognitive imagery
- Craniosacral therapy
- Hypnotherapy
- Massage therapy
- Progressive muscle relaxation
- Physical therapy
- Psychotherapy (eg, behavioral)
- Qigong
- Reiki energy therapy
- Virtual reality video games
- Yoga (ie, Iyengar)

ASPE
PAIN EDUCATION TOOL

In our ongoing commitment to provide members with practical patient-care tools, and to facilitate their use, we are making these items available on the member website, www.paineducators.org. The newest tool is a Monthly Pain Diary. Please let us know if your find it useful. Are there other ways we can support your ability to become a more effective pain educator?

Humor Instills a Humanizing Element to Pain Care

by **Joel Goodman, EdD**

In my first column, I proposed inserting humor into your pain practice. Beyond delivering clinically competent medical care, humor—which induces laughter—can differentiate pain educators from peers, by instilling a humanizing element in pain care.

Bernie Siegel, MD, a former surgeon, devotes his efforts to a lofty goal of moving medical training from the delivery of clinical information to true medical education, in which we become one healing team. Humor can and should be a tool in every physician's black bag. Why not, when humor has been shown to improve patient behavior and treatment compliance as well as drug effectiveness?

Clinicians have a profound influence on patient care simply from the authority that comes with the role and, therefore, practitioners should recognize the value that humor presents, according to William F. Fry, Jr., MD, emeritus professor at Stanford University School of Medicine.

Consider that a humor shot in the arm can make it easier to maintain a healthy perspective in dealing with the bureaucracy of our insurance-driven, time-constrained world.

One self-help tool, with double value, is to develop a Humor First Aid Kit, which pain educators can use themselves and suggest to colleagues and patients. The idea is to amass items, such as cartoon strips, props (ie, smiley face ball, mask), signs, bumper stickers, buttons, books, audio tapes, and video clips that tickle your funny bone, make you laugh, or bring a smile to your face. The idea is to encourage patients to amass positive stimuli that can provide a break from the pain.

TEACHING TIPS

- Move from a practice focused on the delivery of clinical information to true medical education, in which we become one healing team
- Actively engage in a dose of humor, daily
- Improve patient behavior and treatment compliance as well as drug effectiveness with laughter
- Build a Humor First Aid Kit and teach others to do the same

The evidence points to the health benefits of humor, especially when it's a regular part of a person's life. Here are a few more ways to introduce more humor into your life as well to share others.

- **Take in regular doses of funny films, joke books, and comedians.** For example, a favorite Seinfeld or Simpsons episode, Lily Tomlin as the operator in the 1970s hit, Rowan and Martin's Laugh-in: "one ringy, dingy".
- **Browse through the humor section of a bookstore or library.**
- **Read the cartoons in newspapers and magazines, or schedule a daily cartoon visit to a comic site on the internet.** Post favorites on the refrigerator, desk blotter, bulletin board, or in your wallet, and change them regularly.
- **Expose yourself to different styles of humor.** (ie, political, slapstick)
- **Keep a humor journal.** Catch and record amusing remarks, clever puns, unintentional verbal slips; note clever bumper stickers, license plates, witticisms, and funny events.
- Visit www.humorproject.com for more ideas.

Humor can be powerful medicine, and laughter can be contagious. It's reassuring in these days of chronic diseases and painful, costly medical procedures that laughter is inexpensive and priceless. And, the only side effects are pleasurable. The more you tune in to the funniness in this world, the better it will look.

American Academy of Family Physicians Addresses Pain Management

INTERVIEW: **Norman B. Kahn, MD**

The American Academy of Family Physicians (AAFP) is one of the largest national medical organizations, representing more than 94,000 family physicians, family medicine residents, and medical students. Its mission is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity.

"We recognize what ASPE recognizes pain is underdiagnosed and undertreated despite the availability of numerous treatment options," says Norman B. Kahn Jr., MD, vice president for science and education at the American Academy of Family Physicians. "Clearly, this is a terrible commentary on our society, but it is a reality that must be faced by both physicians and their patients. There are many reasons for this, not the least of which is a litigious environment that breeds fear among physicians such that not writing prescriptions for pain medications overrides the potential value to patients.

"The AAFP recognizes that clinicians are more apt to downplay the seriousness of chronic pain as a potentially fatal, medical disease," says Dr. Kahn. "In response, we have stepped up educational efforts to reach out to family physicians by developing programs geared to improve the assessment and treatment of pain." By promoting a sense of competency among physicians in addressing pain management, they will gain confidence in properly prescribing pain medications.

PERSPECTIVE

- By promoting a sense of competency in addressing pain management, physicians will gain confidence in properly prescribing pain medications.
- Since clinicians are more apt to downplay the seriousness of chronic pain as a potentially fatal medical disease, the AAFP has stepped up educational efforts to reach out to family physicians

To that end, the AAFP has begun developing programs on pain management. For instance, pain topics were incorporated into the 2006 annual scientific meeting and will be similarly covered at the 2007 AAFP annual meeting through lectures, seminars, and workshops. The upcoming annual meeting will coincide with the launch of the yearlong clinical focus, which will feature chronic illness, including the challenges of chronic pain. In add-ition, the AAFP sponsors several national courses in adult medicine and geriatrics that include pain management, and an online, continuing medical education video program, *Managing Pain: Dispelling the Myths* that is available at http://www.aafp.org/online/en/home/cme/self-study/videocme/managingpain.html

"This is a start," says Dr. Kahn. "We are certainly open to doing more pain education and would be happy to expand our efforts with the help of the ASPE. Because our specialty is so broad, family physicians are always in demand, making travel difficult. Given their limits on time, the most effective means of educating AAFP members would be to develop a lecture series that brings the information to their doorstep. The AAFP would welcome more programs that educate family physicians about pain management through outreach local and regional chapters. Another option would be to publish a series of CME bulletins on pain management for common pain conditions, and for targeted patient populations, which has proven to be a successful educational vehicle," suggests Dr. Kahn.

Becoming a more technically sophisticated pain educator

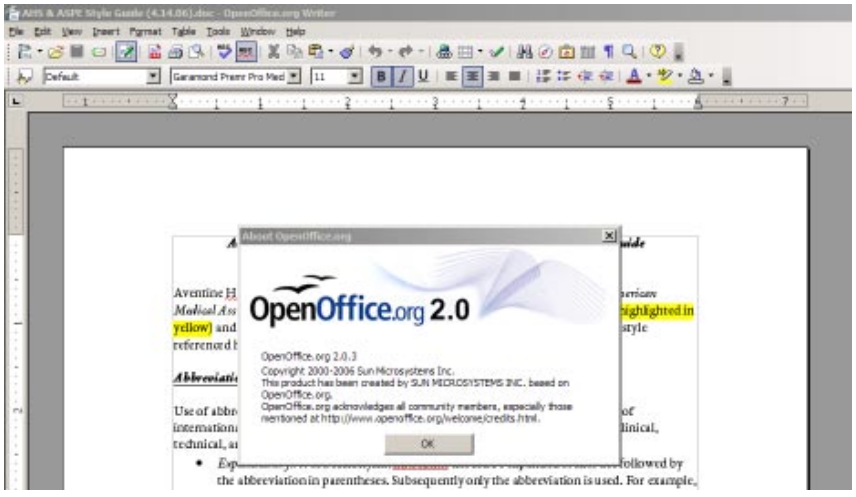
by **Jeffrey Tarnoff**

Pain Educators often face technical hurdles—whether it involves creating a stellar PowerPoint presentation for a conference or trying to setup a patient education website. In this new PainView column, answers to members' technical questions will be provided to enhance the technological savvy of all ASPE members.

Q. I've been asked to develop a presentation for an upcoming conference; however, I work in a private practice and we don't have Microsoft Office. Are there any less expensive programs similar to PowerPoint that I could use? ~Robin, Toledo, OH

A. Dear Robin, how about a free solution? You can download the latest version of the OpenOffice.org software suite at www.openoffice.org. (They have versions that will work on Mac OS, Windows, and Linux.) Included with the software suite are the aptly named Write, Impress, Calc, and Base, which are their versions of Microsoft Word, PowerPoint, Excel, and Access, respectively. Previous versions of this suite have been somewhat clunky and unbearably slow, but version 2.0 has changed all that.

While the software varies slightly from PowerPoint, if you've used the Microsoft version, you should have no trouble transitioning to Impress. One thing to keep in mind, however, is that by default, OpenOffice.org saves files in a different format than Microsoft Office. If you'll be sharing the documents you create; make certain to save them in the Microsoft Office format.



Q. I recently attended grand rounds, and when someone asked a question, the presenter was able to immediately jump back to the slide in question. How is that done? ~Jake, New York, NY

A. Dear Jake, one not-well-known feature of PowerPoint is its many keyboard shortcuts, which can be employed during creation of slides and a slideshow. Two of my favorite features are: skipping to a desired slide and blanking the screen to either white or black. To travel immediately to any slide, just type the slide number on the keyboard and hit the enter key (note: you won't see any numbers on the screen when you're typing). If you'd like to remove the slide and blank the screen to either white or black, just press the w or b key. To bring the slide back, just tap the key again.

You can find a helpful listing of all the PowerPoint keyboard shortcuts at http://office.microsoft.com/en-us/assistance/HP051955191033.aspx.

Shortcuts while preparing your PowerPoint presentation

CTRL + N
Create a new presentation

CTR + K
Insert a hyperlink

F7
Check spelling

CTRL + Z
Undo an action

CTRL + Y
Redo or repeat an action

ALT + F4
Quit PowerPoint

CTRL + M
Insert a new slide

CTRL + D
Copy selected slide

CTRL + O
Open a presentation

CTRL + W
Close a presentation

CTRL + P
Print a presentation

CTRL + S
Save a presentation

F5
Start your slideshow

Shortcuts during PowerPoint slideshop

B or PERIOD
Display a black screen, or return to the slideshow from a black screen

W or COMMA
Display white screen, or return to the slideshow from a white screen

ESC, CTRL + BREAK, or HYPHEN
End a slide show

CTRL + H
Hide the pointer and navigation button

CTRL + P
Redisplay a hidden pointer and/or change the pointer to a pen

CTRL + A
Redisplay a hidden pointer and/or change the pointer to an arrow

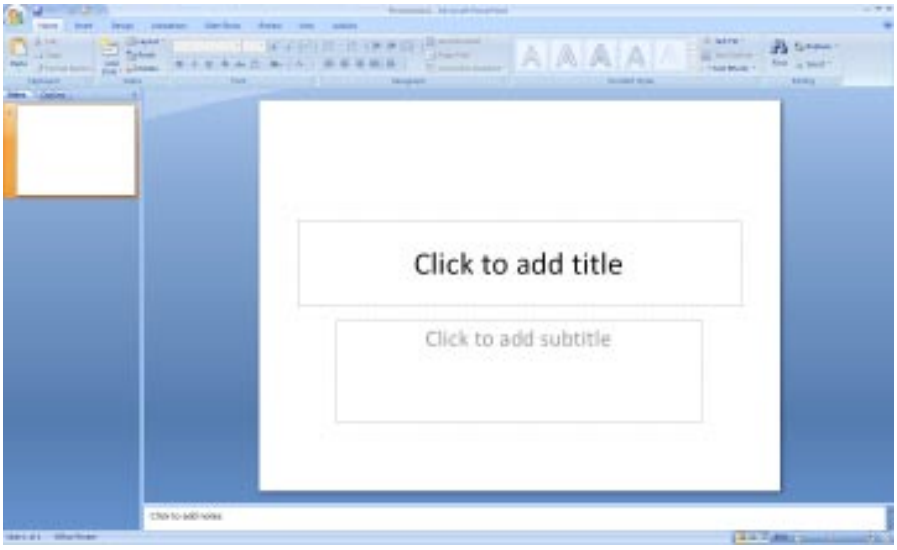
Q. I have been reading a lot about the new beta version of Microsoft Office, and was wondering how I can find a copy. Is there anything special I need to know before trying it out? ~Wanda, Medway, MA

A. Dear Wanda, sounds like you are onto cutting edge technologically! Microsoft recently released Beta 2 of their Microsoft Office 2007 (only for Windows), and it's available for preview at http://office.microsoft.com. You have two options for test driving the software: 1) you can use an online version, which allows you to play with the software without having to install anything on your computer, or 2) you can download the trial software and actually use it. Microsoft is charging $1.50 for the privilege of testing their software. At that price, it's still quite a steal, as you'll be able to use the software free of charge until early 2007.

If you plan to install the software on your computer, you'll have the option of keeping your current versions of the Office applications or removing them all together (the one exception to this is Outlook 2007, which cannot be installed if you want to keep a previous version of Outlook). Once you launch the applications, you'll immediately notice the new interface, which utilizes what Microsoft terms "ribbons." Most of the menus have disappeared, and the context-sensitive ribbons put the features you need for the task at hand front and center. This takes some time to get accustomed to, but I think you'll begin to enjoy the new interface.

Keep in mind that Office 2007 uses a new proprietary file format, so if you save any newly created files, you may want to save them in Office 2003 format so that you won't have any trouble if you elect to stop using the beta or send files to colleagues. You can also download a free compatibility pack from Microsoft that will allow Office 2003 to open documents created in Office 2007.

Feel free to submit your technical questions, be submitted to me at support@paineducators.org. While we can't promise every one of your questions will be addressed, I'll do my best to respond. I look forward to hearing from you.

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