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publications

Minnesota Medicine

Published monthly by the Minnesota Medical Association
July 2001/Volume 84

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A World of Pain Treatment Options

Multidisciplinary pain management centers offer a range of treatment options for patients living with chronic pain.

By John Fineberg

Tony White's job as the operations manager of a trucking company required that he sit for long periods of time. But the chronic pain in his lower back and hips, which developed over several years, was making it difficult to do his work. The 41-year-old Elk River man was in such constant pain that it even woke him up from his sleep. And what had once been pleasure for this veteran of 11 marathons—running—was fast becoming torture. "Some days, after only running half a mile," White says, "I'd turn around and walk home."

As anyone who has experienced ongoing pain can tell you, chronic pain can ruin what would otherwise be a wonderful life. In a worst-case scenario, the impact of chronic pain can be loss of a job, family, and self-worth; a downward spiral into total physical and psychological dysfunction; and even drug addiction.

In the past, a person like White would have had to live with pain simply because of the scarcity of effective medical treatments. Physicians often were unable to diagnose underlying conditions, and patients with persistent pain were frequently bounced from one practitioner to another. Feeling as if no one was focusing on them as an entire person, patients often became frustrated, disillusioned, and depressed. But today, with new treatment options, people have come to expect quick relief.

Initially, pain is a biological signal that something is wrong in the body. But when pain itself becomes the problem, treatment requires more than routine strategies. One increasingly common option for physicians is making a referral to a multidisciplinary pain clinic. Set in hospitals and clinics and staffed by anesthesiologists, neurologists,

physiologists, and other physicians who have specialized in pain management, these pain centers share a commitment to a coordinated approach to treatment and offer an array of therapies ranging from implantable drug pumps to herbal medicine and from fluoroscopically guided injections to biofeedback. While not always able to provide quick relief, these clinics are a resource for the primary care physician who is unable to help a patient with chronic, acute, and cancer pain.

Medical Advanced Pain Specialists (MAPS)

White was ultimately referred to Medical Advanced Pain Specialists (MAPS), a clinic-based pain medicine center pioneered by David Schultz, M.D., who developed his expertise in regional anesthesiology in the operating room at North Memorial Medical Center in Robbinsdale. Schultz's vision for MAPS was to establish a comprehensive outpatient pain treatment clinic that offered more than just injections. The practice, which opened in 1995, includes anesthesiologists, a physiatrist, a neurologist, nurses, physical therapists, a dentist, nurse practitioners, and an acupuncturist. The clinic's physicians are all board-certified in pain management.

Schultz is the medical director and owner of the facilities, which include clinics in Coon Rapids, Edina, and Chaska, and at North Memorial Medical Center. The clinics feature four components: interventions, including injections, implantable devices, nerve destruction, and other invasive techniques; rehabilitation services such as physical and pool therapy; alternative medicine such as acupuncture and biofeedback; and behavioral health.

The primary focus of the initial examination at MAPS is on the physical aspects of the patient's problem. "If we're successful at treating that," Schultz says, "sometimes the other behavior issues get better on their own." On the other hand, if the psychological component is serious enough, a four-week, multidisciplinary program, incorporating outpatient counseling, reconditioning, and relaxation techniques, might be offered as an option.

Mayo Pain Clinic

The Mayo Pain Clinic in Rochester is another multidisciplinary group, including anesthesiologists, neurologists, psychiatrists, psychologists, physiatrists, physical therapists, nurses, and even a dentist. "The breadth of care here is greater than what you'd find in a lot of free-standing pain clinics," says David Martin, M.D., Ph.D., an anesthesiologist with subspecialty training in pain management.

Like MAPS, the group offers a wide variety of pain relief options. Medications can be given orally, in patches, or in topical formulations. Therapeutic agents such as steroids can be injected into the epidural space and other areas. Neurolytic substances such as alcohol or phenol

can be injected to destroy nerves, programmable intrathecal pumps can be introduced to deliver drugs directly into the spinal fluid, and electrical stimulators can be implanted to modulate pain perception in the spinal cord. To some extent, the choice of treatment is made by trial and error. "If a therapy's not working, we discontinue it and find something else," Martin says.

Behavioral and psychological techniques may be incorporated to help patients achieve better coping skills and to structure rehabilitation programs. "Not only is it important to educate the patient about the underlying etiology of their pain," Martin says, "but also to teach them what they can do personally to help relieve it, so they feel a sense of control and don't become overly dependent on the doctor every time they have a pain."

While its primary mission is taking care of patients, the Mayo Pain Clinic excels in research and education. "We believe patient care is best done by conducting ongoing research to find out how to do a better job, then teaching the knowledge to spread the word to other clinicians." Martin has recently stepped down from his position as the chair of the clinic to focus his attention on researching the mechanisms that modulate neuropathic pain in hopes of paving the way for new pain control drugs and techniques.

Sister Kenny Chronic Pain Rehabilitation Center

The Sister Kenny Chronic Pain Rehabilitation Program also treats patients with chronic, acute, and cancer pain. But unlike pain clinics directed by anesthesiologists, this clinic focuses entirely on rehabilitation as well as providing consultation services. "It's high-touch versus high-tech," says Matt Monsein, M.D., the center's medical director and a family practice physician.

Unique to this pain center is its three-week residential program, offering inpatient treatments ranging from relaxation training and biofeedback to more cognitive approaches looking at the emotions that accompany a pain experience. Besides Monsein, the clinic staff is composed of a psychologist, clinical exercise physiologists, a physical therapist, a relaxation therapist, a vocational counselor, pain specialty nurses, a chemical dependency counselor, a licensed acupuncturist, a biofeedback therapist, and a therapeutic recreation specialist. The clinic has access to other personnel in the hospital, including spine specialists, Monsein says, "but we don't do any invasive interventions in our rehab clinic."

Instead, at Sister Kenny the focus is on minimizing the use of addictive medications, increasing physical activity, getting patients back to work, and helping them regain a relatively normal lifestyle. "We make it very clear to patients that we're not 'treating' their pain as much as we're trying to help them to more effectively 'manage' their chronic

pain. And,” he says with a smile, “if their pain happens to get better while they’re here, we don’t charge them extra.”

Monsein, who became interested in the bio-psychosocial aspects of health care and pain rehabilitation more than 20 years ago, is clearly skeptical of the more common invasive treatments for pain. He concedes that the practitioners at MAPS and Mayo are “very skilled and well-trained,” but also notes that most of Sister Kenny’s patients have already tried such therapies. “Either they haven’t helped or they’ve only worked temporarily.” Monsein admits that his views “might be skewed somewhat because we tend to see patients who don’t do well in other pain programs.”

Monsein is also concerned about the long-term use of large amounts of opioids for noncancer-related pain. “Some patients do well with this approach. But for others, it’s a complete disaster, with escalating medication use, chemical dependency, psychological dysfunction, social disruption—and, on rare occasions—intentional or unintentional overdose.”

One such patient with a medication problem was 52-year-old Marlene Bukstein of New Hope. When Bukstein first came to the clinic, she was in a wheel chair and was addicted to morphine, which she was taking for pain caused by peripheral neuropathy and other medical conditions. “I was like a street junkie,” she says. “Today I can walk, and I’m drug-free.” At Sister Kenny, she learned that she had a choice: “I can live with my pain in solitude and sitting down, or I can live with my pain and get up and do things.” The Sister Kenny staff attempt to help people move beyond feeling victimized and hopeless and helpless about their situation, says Monsein. While Bukstein is quick to point out that not everyone in her therapy group had such positive feelings, her results were, nonetheless, dramatic.

Medical Motivations, Economic Factors

“Although a lot of doctors throw up their hands and pull out their hair,” Schultz says, referring to the complex difficulties of dealing with pain patients, the competition for patients suffering from pain is growing. One attraction for anesthesiologists, physiatrists, neurologists, and interventional radiologists who enter the field is the medical challenges it poses.

Another attraction is the monetary remuneration. Martin notes that some people go into pain medicine because it’s lucrative. “With an increasing demand for pain control among patients, there are a lot of opportunities to meet that demand by practicing pain medicine,” he says. “Whenever demand exceeds the supply of practitioners, the price goes up.” Unlike physicians in private practice, where they are paid per procedure, physicians at Mayo work on a salary basis. “At the end of the day, whether I do a lot of invasive procedures or none at all, I still get the same paycheck. Whenever you have a profit incentive, there’s a

risk that decisions might be based on economic factors, rather than on what's best for the patient."

Monsein concurs that the field is lucrative. But he points his finger more at the pharmaceutical companies and the manufacturers of pumps and "high-tech gizmos" than at physicians.

In an environment where both physicians and their patients are looking for a quick and easy fix, Monsein observes that "it's easier to take a drug than to change one's life style." That puts the more conservative approach of Sister Kenny at a major financial disadvantage. Sister Kenny finds it difficult to compete with the marketing budgets of pharmaceutical companies and the larger, invasive-oriented clinics. Monsein calls rehabilitation centers "a struggling breed. Rehab is not well-reimbursed, whereas injections are."

Martin agrees: "Third-party payers tend to reimburse better for invasive procedures than they do for the more cognitive approach."

On the Horizon

Pain centers such as MAPS and Mayo have a reputation for being on the cutting edge of pain therapy. According to Schultz, "We provide services and devices that are high-tech and rapidly evolving." One of those cutting-edge techniques is the intradiscal electric thermal (IDET) procedure, which was performed on Tony White, who suffered from back and hip pain.

White's primary care physician had prescribed a six-week program of physical therapy. With no improvement, his physician referred him to a MAPS clinic. After four steroid injections into the disc failed to alleviate the pain, the IDET procedure was performed. The technique involves placing a wire into the disc and heating it, sealing a tear in the disk, and burning out the sensing nerve. "It takes 30 minutes in the clinic and you're walking out the door," Schultz says. Because of IDET, White was spared a much more invasive lumbar fusion surgery, which Schulz says can require many months of recovery and, in practice, sometimes doesn't work very well. "I look at it as more of a last resort than a first-line therapy."

White wore a back brace and limited his activities for six weeks. Then, after beginning physical therapy, he gradually began to feel better. "My recovery," he says, "was almost textbook. They told me to expect it to take up to six months to achieve everything I was going to get out of it. It took exactly six months, and now I'm running 100 percent pain-free. It's been wonderful." Now 42, he has begun participating in half marathons, and aims to run full marathons in the near future.

Schultz, Martin, and Monsein are all excited about the future of pain management. Even Monsein, who works exclusively in rehabilitation, sees potential in new medications. "Hopefully there will be better

drugs that can treat pain more selectively, without the adverse effects of narcotics, in terms of both tolerance and side effects.” He acknowledges that some of the new Cox-2 medications for treating inflammatory conditions cause fewer bleeding problems and could have a profound impact on the treatment of chronic pain. But he worries that, with new therapies being based on studies of the pain mechanisms of animals, “we forget that we’re not dealing with a rat or a cat; we’re dealing with a much more complex system.” MM

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