



# SPS NEWS

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## Applying Study Results in Your Practice; II: *P*-values and Statistical Significance.

Ike Eriator, MD, MPH.

Hypothesis testing in medical studies involves three steps. First the null and alternate hypotheses are specified. Then, the compatibility of the study results with the null hypothesis is determined. Then a decision whether to reject or not reject the null hypothesis is made. *P*-values are often used in published articles and they give an indication of the strength of evidence against the null hypothesis. The null hypothesis assumes that there is no effect, and so no differences between the groups being compared. The alternate hypothesis is the opposite and assumes there are differences between the groups. *P*-values give us the probability of obtaining a result as extreme as (or more extreme than) the one observed, if the null hypothesis was true (Dawson and Trapp, 2004). Put another way, by looking at such values, we get an indication of the probability that the findings observed could have occurred by chance alone. Knowing how to interpret *p*-values of studies is an indispensable tool in our armamentarium, especially in modern times when our clinical and administrative decisions are governed by evidence-based medicine. *P*-values are often misunderstood, misinterpreted and misused.

### **P-Values and Null Hypothesis;**

*P*-values really assumes that the null hypothesis is true, and measures the compatibility of the observed data with the null hypothesis. *P*-value is a continuous statistic and is expressed as a probability. Probability deals with the relative likelihood that a certain event will or will not occur, relative to some other event. *P*-values therefore range from 0.0 to 1.0. A small *p*-value indicates poor compatibility between the observed data and the null hypothesis. Thus, the alternative hypothesis will be a better explanation of the results than the null hypothesis. Conversely, a large *p*-value suggests a high degree of compatibility between the null hypothesis and the observed data. Therefore, the null hypothesis is a better explanation of the results. However, no *p*-value, no matter how small, excludes chance as a cause of the observed results, and no *p*-value, no matter how big, confirms chance. Put another way, since *p* is a probability function, no *p*-value, no matter how small excludes the null hypothesis, and no *p*-value, no matter how big confirms the null hypothesis. Remember that an event can still occur no matter how small the probability. We need to keep this in mind as we interpret *p*-values and apply them to our decision making.

As an example, consider our study involving the trial of anticonvulsants in diabetic neuropathic pain (see SPS News, May 2006, pages 3-4). We gave a certain anticonvulsant medication to forty patients with diabetic neuropathic pain (group A) and compared them with another forty similar patients who remained untreated with the medication and received only a placebo (group B). Supposing that our statistical test of the differences in effectiveness gives a large value of *p*, for instance 0.2, we can say that the data could occur often when the null hypothesis (which says that there is no difference in response between groups A and B) is really true. We are therefore unable to rule out the possibility that the null hypothesis is true. The anticonvulsant and placebo may be equally effective and any difference between the groups may be explained by chance variation. Supposing, on the other hand, the *p*-value comes out to be very small, for instance, 0.001, then it is far less likely that our data could have arisen by chance alone, and the null hypothesis is not likely to be a good explanation of the result. The alternate hypothesis is a better explanation. We assume that one treatment is superior to the other.

### **P -value of 0.05**

Imagine that your partner is tossing a coin and if it comes up as a head, you pay. If the coin keeps coming up heads, by the 4<sup>th</sup> or fifth throw, you are likely to complain that it was rigged. A *p*-value of 0.05 is 1 chance in 20, and is somewhere between the 4<sup>th</sup> and fifth throw. Although *p*-value is continuous, statisticians often use a cut off point of 0.05 in deciding whether to reject or accept the null hypothesis as the most likely explanation of the observed data. Results are considered statistically significant when the *p* value is less than or equal to 0.05. When the *p*-value is greater than 0.05, the result is considered not statistically significant. The latter suggest that the data failed to provide sufficient evidence for us to doubt the null hypothesis. Not statistically significant is akin to "not proved" or "inconclusive".

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## Mission Statement

The Southern Pain Society is a regional section of the American Pain Society and endorses and supports the mission and goals of the American Pain Society. The Southern Pain Society's missions are to serve people with pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community.

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SPS News is the official publication of the SPS, provided quarterly to its members. SPS may publish material dealing with controversial issues. The views expressed are those of the authors and may not reflect those of the SPS. No endorsement of those views should be inferred unless specifically identified as the official policy of the SPS. Submissions are welcomed. Publication is based on editorial judgment as to quality of material, timeliness, and potential interest to members.

# Editor's Desk

Ike Eriator, MD, MPH



Returning thanks is perhaps the most urgent of any duty. Often we take things for granted and do not take time to give credit to those most deserving. This may be because our everyday heroes challenge us in many more ways than saints. So we spend less time acknowledging the good work of the "saints". So, I will take this opportunity to say **thank you** to all of those who took time to contribute to the newsletter in 2007. It is your efforts

that have kept the Newsletter going. Many of you contributed full length articles. Others made suggestions and still others helped to review some materials. Some of you contributed to the regular columns. To all of you, I again, say, thank you. There are different ways to contribute, and each member should avail themselves of their special skills. There is a place for articles, comments, letters and news. Send a poem. None of us can do everything. But each of us can do something. And our commitment to our society requires that we do that which we are able to do. And there are lots of opportunities in our everyday professional life. The 17<sup>th</sup> century writer, John Dryden once said that of all the happiness that man can get, it is not in pleasure, but in rest from pain. Put another way by Thomas Jefferson – one of the founding fathers of American Independence- the art of life is the art of avoiding pain. He is a wise pilot that steers clear of the rocks and shoals with which he is beset. Sophocles, the Greek poet and dramatist advised that we should not count any mortal fortunate until he has departed this life free from pain. So as people involved with treating or controlling pain, we see pain patients regularly and there is always something we can learn from them -and share with others.

In this issue, we introduce the Pain Practice Corner (PPC). It will be a forum for learning and sharing. We bring you interviews of some pain practitioners and the nature of their practice. We find out things they wished they had known when they were starting out. Success or greatness is not necessarily where you started from, but how you improved on it. People ascend to great heights, mostly by a winding path. Maybe there is something we can learn from their professional past that will help change our current pain practice. We also find out what these practitioners see as the future of pain management. The greatest amongst us cannot see through brick walls, but unlike the rest of us, they do not build one. Read through the interview and let us know what you think.

Happy 2008 and we look forward to your literary contribution this year. Warm memories, best regards and happy reading....

# President's Message

Daniel M. Doleys, PhD

There are nearly 700,000 veterans of fighting in Iraq and Afghanistan. More than 90% of all wounded veterans report pain, As we hear and read more about pain in wounded veterans, we must remember how much we owe to veterans. We must not forget that the investigation of the relationship between subjective psychological states and objective drug responses began during World War II. In *Pain in Men Wounded in Battle*, Henry Breecher wrote, "Three-quarters of badly wounded men, although they have received no morphine for hours... have so little pain that they do not want pain relief medication, even though the questions raised remind them that such is available for the asking. This is a puzzling thing and perhaps justifies a little speculation." His systematic questioning of stress induced analgesia led to his advocacy of the use of placebo in all drug clinical trials. Through his advocacy, the prospective, double-blind, placebo-controlled clinical trial in pain management was born.

But this letter has little to do with pain, as such. All the same, I feel compelled to write it. I guess that is the prerogative of having a 'president's letter'. The event happened on a return flight from a week-end course in Dallas this past Saturday evening. I was fortunate enough to qualify for an upgrade to first class. A young soldier, given a first class seat, as all armed service personnel should, by the gate agent, sat next to me. There were plenty of other seats available; but after-the-fact, I realize he was suppose to sit where he did. As we talked I discovered that he was a paratrooper in the Army. He was from a small community in the Birmingham, Alabama area and joined the Army at the age of 17, right after graduating high school. James (as I shall refer to him), perhaps one of the most pleasant and courteous young men I have ever come across, has two children, 16 months and four years old. He was on the way home for eighteen days before returning to Afghanistan where he was serving his second tour of duty. He had also served in Iraq, where he lost three close buddies. Despite this he re-enlisted. When I asked "Why?" his answer was immediate and very clear, "I have a family to take care of and a country to protect". We briefly discussed the politics of it all, but this was a subtext and not what caught my attention. As James became aware that I was a psychologist, he volunteered having "PTSD". Loud, unexpected sounds, especially in the night, often elicited a conditioned emotional response. Flash-backs and night mares were not as bad as they once were. The three medicines he was taking provided some relief of his symptoms and allowed him to 'do his job'.

Once in the air, James relocated to a window seat; leaving me with all sorts of thoughts. Having a son about his age, I could not help but wonder 'what if?'. I was very humbled by his courage and commitment. I could only begin to image what

it would be like eighteen days from now when he would once again have to leave his young family and return to his unit. I thought then and still do, that all groups/offices should make an effort to 'adopt a soldier'. Regardless of ones feelings about the war(s), we must remain mindful that there are many "James's" putting their life on the line every day, and many young families having to find a way of coping with the ultimate fear. Letters of support and encouragement, extra gifts for the children at special times of year may be one way, however inadequate, of saying "Thank you".

Some-how that brief encounter with James has left its mark. I would guess the same has happened to many of you. If not, I hope it soon will. It has a way of putting the frustrations of our academic and clinical lives, i.e. difficulty meeting budgets, and deadlines, paying the bills, not to mention dealing with disgruntled patients, demanding insurance companies, reimbursement issues, government guidelines and regulations, in perspective. As we in SPS continue to plan for and ultimately enjoy, our annual meeting in New Orleans, we need to appreciate that such freedoms do not belong to everyone. We must remember how much to owe to veterans. James, my new friend, take care. Return safe. Our thoughts and prayers will be with you!

## Newsletter Submissions

All submissions to SPS News should be typewritten and double spaced with title and name of author(s). The article should be copy-ready. Please include biographical information.

### Submission Deadlines

Winter edition-November 1; Spring edition-February 1; Summer edition-May 1; Fall edition-August 1. Please submit your articles to [lpostal@southernpainsociety.org](mailto:lpostal@southernpainsociety.org) or to our editor [ieriator@anesthesia.umsmed.edu](mailto:ieriator@anesthesia.umsmed.edu)

# Help Your Patients “Duck and Run” from Pain Relief Quackery

Leanne R. Cianfrini, PhD

At the recent SPS annual meeting in Nashville, I noticed a distinct focus on highlighting evidence-based treatments for pain. In his presentation, Dr. Ike Eriator gave helpful suggestions to attendees about how to critically evaluate research methods and statistical results published in the pain literature to best guide true evidence-based clinical practice.

When I returned to work on Monday after the meeting, a patient of mine with low back pain stuck a brochure in my hand for herbal pills that were “guaranteed” to “eliminate” his chronic pain and he asked me for my opinion. He, of course, had already tried conventional methods of spinal fusion, epidural blocks and injections, a multidisciplinary pain management program, and most of the available opioids and non-opioid pain medications with only moderate relief. He was, unfortunately, still searching for a “cure.”

At his request, I did some online sleuthing about this particular herbal remedy to discover that the pills were not FDA-approved, the physician endorsing the pills was not affiliated with any “leading research university” as claimed in the brochure, and individuals who had sent in their \$39.95 for a month’s supply had been bitterly disappointed and had returned the medicine in hopes of recouping their money. I explained to the patient that the pills were mostly comprised of vitamin C and he would be better served by either making some dietary changes or purchasing less expensive vitamin supplements. He listened carefully, nodded at my comments that defined his pain as chronic and not exactly “curable” by a secret miracle pill, and...he sent away for them anyway.

As pain professionals, we are taught that randomized controlled trials are the gold standard of research design. We are reminded to critically evaluate the literature. We strive to be mindful of how we frame potential treatment outcomes when communicating with our patients. We have a duty to consider and promote evidence-based treatments. As a pain psychologist, I spend much of my time helping patients adjust to more realistic expectations for their treatment outcomes and to take responsibility for their own health care. Our patients: 1) do not spend time reading research journal articles about medical outcomes and are rarely taught how to critically examine proposed pain treatments; 2) often base their health care decisions on information obtained solely on physician recommendation or on easily accessible sources such as chat room advice or TV commercials; 3) are barraged by offers of miracle pills, herbal remedies, essential oil sprays, magnets, pillows, special water, etc, in direct mail marketing, magazine advertisements, or infomercials; and 4) are simply desperate for better pain relief. Such patients are

more than willing to spend their money for the promise of overnight pain elimination.

I am not alluding here to legitimate holistic medicine techniques that are backed by scientific study (e.g., acupuncture). I refer instead to flat-out fraudulent or misleading product advertisement. Health care marketers have become quite sophisticated in their techniques. Patients who fall victim to exaggerated claims of pain relief from a product are not only exposing themselves to being cheated out of money, but they may experience negative side effects from non-FDA approved substances, may be impacting the efficacy or safety of their physician-prescribed medication regimen, may be steered away from useful evidence-based treatments, and may suffer the emotional disappointment and hopelessness brought on by yet another “failed” treatment.

So, it is vital that you help to educate the public about the dangers of unregulated health products. Encourage your patients to be wary, to be good consumers of health care, to make educated and informed decisions. Advertisers for these products often use the same phrases and gimmicks to gain consumers' attention and trust. Your patients can protect themselves by learning some of their techniques. Below is a list of some “red-flag” claims often seen in marketing for products that are not authentic or evidence-based:

- **One product does it all:** Beware of claims that one little pill can treat inflammation, headache pain, bone health, high blood pressure, insomnia, and obesity at all once.
- **Personal testimonies:** These are difficult to prove and are the weakest form of scientific validity. They may be case examples that have been passed on from person to person or simply made up.
- **Quick fixes:** Be wary of promises for quick relief, especially if the condition is chronic and serious. Advertisers use ambiguous language (e.g., “can cure in days”) to make it easier to finagle their way out of any legal action that may result.
- **“Natural”:** This term implies that a product is safer than conventional treatments or has no side effects. However, “natural” does not necessarily equate to safety. Even some plants (e.g., poisonous mushrooms) can kill when ingested. Besides, any product--synthetic or natural--potent enough to work like a drug is going to be potent enough to cause side effects.
- **New-found treatment:** Claims that suggest “innovation,” “miracle cure,” “new discovery,” or “magical” are highly suspect. If a product was actually a *cure* for pain, it would be widely reported in the media and regularly prescribed by health professionals. Such a product would not be hidden in an obscure magazine ad, late-night infomercial, or web-

site promotion where the marketers are of unknown, questionable or nonscientific backgrounds.

- **Satisfaction guaranteed:** A money-back guarantee with no questions asked? Good luck getting your money back.
- **Meaningless medical jargon:** Fanciful terms that sound impressive generally cover up a lack of scientific proof.
- **Endorsement from a doctor from “A Leading University”:** What “leading university”? Why wasn’t it named? If the doctor did appropriate scientific research on the remedy within a legitimate research program, it would be published in a reputable scientific journal. Physician endorsement can sound impressive, but the credentials of the physician are often obscured.
- **Act now!:** Advertisements that urge the patient to act quickly to grab a good deal force the patient to purchase in haste before they can properly research and expose the claims.

The patient should always ask himself: "Does it sound too good to be true?" If it does, it probably isn't true. The #1 thing for patients to remember is: Don't let desperation cloud your judgment. My patients are not always willing to accept the fate of chronic pain without a struggle. I remind them not to stray from scientific health care in a desperate attempt to find a solution. Scientific health care may indeed include supplements or holistic healing if appropriate. I encourage them to discuss questions about an advertised “cure” with their physicians.

To check a product out further, FDA health fraud coordinators also suggest that patients heed the following advice:

- Talk to family members and friends. Legitimate medical practitioners should not discourage you from discussing medical treatments with others. Be suspicious of treatments offered by people who tell you to avoid talking to others because "it's a secret treatment or cure."
- Check with the Better Business Bureau or local attorneys general's offices to see whether other consumers have lodged complaints about the product or the product's marketer.
- Check with the appropriate health professional group. Many of these groups have local chapters that can provide you with various resource materials about your disease. (*Authors note:* For example, the American College of Rheumatology has a patient education section that includes a good fact sheet to help patients evaluate claims about herbal and natu-

ral remedies: <http://www.rheumatology.org/public/factsheets/herbal.asp>)

- Contact the FDA office closest to you. Look for the number and address in the blue pages of the phone book under U.S. Government, Health and Human Services, or go to [www.fda.gov/ora/fed\\_state/dfs\\_r\\_activities/dfs\\_r\\_pas.html](http://www.fda.gov/ora/fed_state/dfs_r_activities/dfs_r_pas.html) on the FDA Website. FDA can tell you whether the agency has taken action against the product or its marketer. Your call also may alert FDA to a potentially illegal product and prevent others from falling victim to health fraud.

*\* If you would like these tips in a patient-friendly handout*

## Welcome to our New Members!

**Geralyn Datz, PhD** practices pain management and behavioral medicine in Hattiesburg, MS. Dr. Datz has indicated an interest in acute, chronic, pediatric and cancer pain. She would be interested to work on the program and e communications committees for SPS.

**Elliot J. Rampulla MD** practices pain management in Tuscaloosa, AL. He is interested in chronic and cancer pain and would like to work on the membership, by-laws, professional education and newsletter committees for SPS.

**Michael H. Greenwald, MD** practices pediatric pain medicine in Atlanta, GA. Dr. Greenwald is interested in acute, chronic, pediatric and cancer pain.

**Christopher Roberts, MD** Practices chronic pain management in Jacksonville, FL. He is interested in the membership and program committees for SPS.

**Kathleen M. Eaton, MD** is a PM&R spine specialist from Pinehurst, NC. She would like to work on the professional education committee.

**Regina D. Austin, PhD**, a clinical psychologist from Johnson City, TN and is interested in chronic pain.

**David Nelson, MD** is in general practice and pain management in Savannah Georgia.

**Steven Schott, DO** practices physical medicine in Tampa, Florida. He is interested in the membership committee.

**Continued from Page 1** With a chance of more than 5 times in 100, there is just too great a likelihood that it was due to chance. There is nothing unique to 0.05 as a cut off point. There is probably not much difference between a set of data whose p-value is 0.055 and another whose p-value is 0.045. But we would consider the latter statistically significant, and the former, we would consider statistically insignificant. This use of an arbitrary cut off point in deciding whether or not to reject the null hypothesis is the chief limitation of significance testing, as this may be an oversimplification of the complex biological process being studied (Aschengrau and Seage, 2003). Since we are taking an arbitrary cut off point, we run the risk of incorrectly rejecting or not rejecting the null hypothesis. For instance, the significance level of 0.05 carries a 5 percent chance of falsely rejecting the null hypothesis, when in fact, the null hypothesis is true (see types I and II errors in the SPS News, May, 2006, pages 3-4). This is similar to what is ordinarily described as a “fluke” (Greenhalgh, 2001). Using a 1 percent significance level is less risky, but the price for being more conservative is paid in terms of Type II error.

Another inherent limitation in using the p-values is that they simultaneously reflect the sample size and the effect size (or differences in effects or magnitude of association). When we make decisions based on the p-value of a study, the relative contribution of the sample size and the measure of association is unclear. In the anticonvulsant study, the p-value may be large because the sample size is too small or the difference in effects between the anticonvulsant and placebo is small. If either the sample size or the effect size is very large, the p-value will be much smaller. Consider the situation where the effect of a medication is not much different from placebo, but the study used a very large sample of patients. In such a study, the p-value will be small and may be below the cut off of 0.05 and the study will be considered statistically significant. However, for the clinician, a drug that produces only a little difference from a placebo may not be worth administering to patient, irrespective of what the p-value is. Consider another situation. Supposing in a study, the patients on one treatment have five times less pain than the patients on another treatment, you will expect to find a significant difference. But if the sample size is small, the p-value will be large, and may not reach the cut off level. Such a small study may fail to detect a difference that is real. The astute clinician will consider using the drug that made such a huge difference, even if the p level did not reach the statistically significant cut off point – until bigger studies are done.

#### **Statistical versus clinical significance;**

Significance has come to mean everything or nothing (Colton, 1974). It is ironic that many clinicians often think that the p-value of a set of data should determine their action. Many people today, wrongly, see the achievement of statistically significant results as a success and statistically insignificant results as a failure. You often hear colleagues describing studies with significant results as “positive” and those with non-significant results as “negative”. P-values are only a part of the evaluation of the validity of the data (Altman, 1991). Large sample sizes may result in statistically significant differences, even if the treatment differences are minimal and not clinically important (Friis and Sellers, 1999). Statistical significant results does not

mean that bias or confounders have been ruled out as a reasonable explanation of the observed data. Thus the statistical significance may be invalid. Thus, statistical significance does not mean clinical significance. Neither does a statistically significant result mean that there is a causal association.

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## **The Pain Practice Corner**

**(PPC)** Lori Marshall, MD and Ike Eriator, MD, MPH.

The Pain Practice Corner is geared towards providing you with information about pain specialists and their practice. History is remarkable for its ability to repeat itself. There is a lot we can learn based on what some practitioners had passed through in the past and how they look forward to the future. History sometimes becomes more remarkable when it presents with an example that we cannot easily reproduced. Some of the guests for this column will fall into both classes.

Our first guest is **Benjamin Johnson, MD, MBA**. Dr. Johnson is the immediate past president of the Southern Pain Society. He organized the recent SPS conference in Nashville, which was very successful. He was at the Vanderbilt University Medical center, where he directed the Pain program and pain clinic for several years before moving into private practice. He is fondly remembered by many of the pain fellows and residents who trained under him. He has very busy phone lines, because he still gets calls from many of them. Dr. Johnson is known for his decorum, understanding and empathy. We reached him in Nashville, Tennessee.

*SPS Interviewer: What does your practice consist of?*

**Dr. Johnson:** My practice is a group practice consisting of 9 neurosurgeons, a staff of physical therapists, nurses, a nurse practitioner, and two pain specialists. As pain specialists, our primary responsibility is to care for the non-surgical patients that are referred to the neurosurgery practice. We

also provide pain management consultation for post-surgical pain syndromes.

*SPS Interviewer: Tell us a little about your typical work day.*

Dr. Johnson: My typical workday consists of performing interventional procedures, and seeing a few patient consults – either inpatient or outpatient.

*SPS Interviewer: How long have you been doing this?*

Dr. Johnson: I have been involved in this current practice setting for about three years. Previously I was in an academic pain practice at Vanderbilt University for over 15 years.

*SPS Interviewer: Has your practice changed over time?*

Dr. Johnson: I used to have a comprehensive academic pain control center complete with research activity and post-graduate fellows. Now I'm in a private practice setting with a primary focus on interventional procedures. I enjoy doing the procedures myself, but I miss the challenge of influencing young physicians in a comprehensive pain medicine practice. I also miss not having a dedicated behavioral specialist in our practice.

*SPS Interviewer: Tell us a few things you love about your practice;*

Dr. Johnson: I love the challenge of working with the complex post-surgical patients that form a large part of our practice. I work with a group of excellent neurosurgeons that listen to our concerns and lend their expertise on request.

*SPS Interviewer: Are there things you wish you had known when you were starting out?*

Dr. Johnson: No, because I had the advantage of having an excellent mentor (Dr. Winston Parris) from the very beginning of my pain practice experience.

*SPS Interviewer: If you had to do it all over again, what would you change about your practice?*

Dr. Johnson: I would try to maintain a fully comprehensive pain practice. I would also make it a policy that I would not see a patient who refused to see our behavioral consultant.

*SPS Interviewer: What are the other things that you feel matter in life, and how do you find time for them?*

Dr. Johnson: My family: I always try to make time for them, and keep my work at work. Golf: I often play just a few holes in the late afternoon, and practice a lot on the weekends; Spirituality: I have always remained active in my church. Giving back: I have been involved in volunteer medi-

cal missions, and have made seven overseas trips. I also volunteer for church-sponsored healthcare activities.

*SPS Interviewer: How long have been associated with the Southern Pain Society?*

Dr. Johnson: About 16 years

*SPS Interviewer: What do you love about the Southern pain society?*

Dr. Johnson: The annual meetings have always been of high quality and a low cost activity. Secondly, the people who are active in the SPS have been an excellent resource. In addition, the SPS has a legacy of leaders who have been influential in the development of our specialty.

*SPS Interviewer: What do you feel is the biggest problem in pain care today?*

Dr. Johnson: We don't seem to care enough about our specialty to get politically involved in meaningful numbers. The politicians need to hear from us, and we need to add our influence to their decision-making process.

*SPS Interviewer: What do you see as the potential solution(s)?*

Dr. Johnson: We must become politically active in order to save our specialty.

*SPS Interviewer: Where do you see pain as a specialty going in the next 5-10 years?*

Dr. Johnson: Practicing pain medicine will become increasingly challenging due to healthcare economic and political pressure. We must continue to work harder to legitimize our specialty, since we have so many adversaries and competitors.

*SPS Interviewer: Any general advice you give to your patients?*

Dr. Johnson: They must become more active in their own disease management. They must become more active politically about their healthcare needs. They must be willing to pay the price (lifestyle changes, etc.) for improving their pain condition.

*SPS Interviewer: What advice do you give to pain professionals like you that are just starting out?*

Dr. Johnson: I advise them to take some business courses in order to speed up their learning curve for business issues within their practice, because their margin for error is diminishing rapidly. I would also strongly advise them to get involved in organized medicine, so that they can become a part of the process of making their voices heard for the good of pain medicine in particular, and medicine as a whole.



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## See you in N'Awlins!

Todd Sitzman, MD, MPH    Program Chair

It is once again for our thoughts to turn to our Annual Meeting. We would like to take this opportunity to invite you to the Southern Pain Society's 2008 Annual Meeting at Harrah's Hotel in New Orleans, LA September 26—28, 2008. We are co-sponsoring this meeting with the Mississippi Pain Society to make this a first-rate educational experience. This year's theme is "**Essentials of Pain Medicine**" and will appeal to clinicians interested in obtaining an overview of pain medicine fundamentals, including diagnosis and treatment of common pain disorders. A wide range of educational opportunities will be provided, including clinically focused lectures and case presentations with renowned experts. Additionally, the latest products and services on the pain medicine market will be showcased in the exhibit hall.

This meeting offers an unparalleled opportunity to network with your fellow pain medicine practitioners in a relaxing atmosphere. Please join your colleagues in New Orleans for a wonderful experience, and a weekend get-away opportunity with family friends in a setting known for world renowned entertainment, great food and a little fun.