HISTORY OF PAIN

The Story of the Texas Pain Society: Formation and Function of a Regional Pain Society

P. Prithvi Raj, MD*; C. Stratton Hill Jr, MD†; Gabor Racz, MD‡; James Heavner, DVM, PhD§,¶; Martin Grabois, MD**; Lynn Neill, MD††; William Willis Jr, MD, PhD‡‡; C. M. Schade, MD, PhD§§; Ralph Rashbaum, MD¶¶; Aaron Calodney, MD***; Allen W. Burton, MD†††; Judson Somerville, MD‡‡‡

*Departments of Anesthesiology and Pain Medicine, Texas Tech University Health Sciences Center, Lubbock, Texas; †The University of Texas M. D. Anderson Cancer Center, Houston, Texas; ‡Department of Anesthesiology, Texas Tech University Health Sciences Center, Lubbock, Texas; §Departments of Anesthesiology and Physiology, Texas Tech University Health Sciences Center, Lubbock, Texas; ¶Anesthesia Research, Texas Tech University Health Sciences Center, Lubbock, Texas; **Department of Physical Medicine and Rehabilitation, Baylor College of Medicine, Houston, Texas; ††El Paso, Texas; ‡‡Department of Anatomy and Neurosciences, The University of Texas Medical Branch, Galveston, Texas; §§Center for Pain Control, Garland, Texas; ¶¶Texas Back Institute, Plano, Texas; ***Axis Spine Care, Tyler, Texas; †††Houston Pain Associates, Houston, Texas; ‡‡‡Pain Management Clinic, Laredo, Texas, U.S.A.

■ **Abstract:** The idea of forming a Texas Pain Society came to the Founders in 1987 due to disparity and deficiencies in the practice of pain management in the United States and, in particular, the State of Texas. The Founders considered very carefully the implication of forming such a society. They diligently mapped out the mission and goals of the Texas Pain Society in those early formative years. This report is the history of Texas Pain Society as the activities unfolded from 1989 to 2011.

The reader may question why there is a need to tell such a story. We believe strongly that, with disparities of standards of practice in pain medicine and poor recognition of advances in pain management, this scenario is quite common in many states and countries. The practitioners of pain management in these regions certainly must have considered getting together and forming a consensus on the standards of practice in their communities. This historical report of the Texas Pain Society provides the relevant information necessary and the efforts to be made for a society's mission to achieve its goals and have an ongoing impact in its own region. We hope that we have shed some light on a process for the formation of a regional pain society such as ours. ■

Key words: pain management in Texas, society formation, regional pain societies, history of pain

Address correspondence and reprint requests to: P. Prithvi Raj, MD, 1097 Cameron Glen, Cincinnati, OH 45245, U.S.A. E-mail: prithviraj@fuse.net.
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INTRODUCTION

Since the establishment of the International Association for the Study of Pain in 1973, the management of pain has been a significant concern for all practicing physicians. Remarkable advances have occurred with the knowledge of pain mechanisms and the course of pain syndromes. Yet this knowledge from efforts of the International Association for the Study of Pain has not transferred to the clinicians who routinely manage such patients. The reasons for this disparity between researchers and clinicians are many, including that: (1) Globally, pain is not considered a specialty by regulatory bodies, except in rare instances; (2) Pain treatments are mostly inadequate for chronic, persistent pain syndromes; (3) Physicians have disparate education and training with regards to pain management among different disciplines; (4) Government and regulatory agencies do not have laws on their books that reflect the up-to-date status of pain management; (5) Referral physicians are not usually aware of the modalities of pain management the pain physician may offer the patient; and (6) Significantly, the epidemiology of pain is poorly known.

No reliable and consistent epidemiological data in any national or international literature indicate the incidence of pain and its impact on society in terms of health and economic status. These deficiencies in current pain management need to be addressed to provide the best care for pain patients in the future. Pain physicians in Texas recognized these problems and created the Texas Pain Society (TPS) to find solutions to the above concerns for patients and stakeholders in Texas.

THE NEED TO FORM A SOCIETY AND EVOLUTION OF THE IDEA

In Texas, although clinicians of various disciplines were interested in pain and its treatment, no formal "pain clinics" or clinical training programs designed exclusively for the study and treatment of pain existed, except in some academic centers. It became evident that, if pain management were to be improved, educating physicians and training them adequately, specifically for intractable pain, would be necessary.

In 1987, Prithvi Raj (The University of Texas [UT] Houston Medical School) Gabor Racz, and James Heavner (Texas Tech University Health Sciences Center [TTUHSC]) discussed the possibility of forming an organization of physicians in Texas to advance the cause of improving and standardizing pain management. At this time, Stratton Hill had successfully gotten the Intractable Pain Treatment Act (IPTA) passed through the Texas Legislature. That served as an impetus that accelerated this initiative to form a state society. Even prior to the IPTA act, since 1987, multiple discussions had been held in conjunction with June Seminars at TTUHSC. Gradually the decision evolved to form the TPS.

THE FIRST MEETING

On December 16, 1989, approximately 6 months after passage of the Texas IPTA, an organizational meeting to form the TPS was held at The UT Medical School/ Hermann Hospital in Houston. The following were in attendance: Drs. Raj, Racz, Heavner, Hill, Grabois, Neill, Talmage, Willis, Gerger, Carl Noe, and Calodney. At this initial meeting, officers were elected; and each of the founder members donated $1,000 to cover the expenses of incorporation and other legal matters. Racz was elected the first president, for 2 years. Initial activities were strategized and planned for that first year, including adoption of by-laws, obtainment of tax-exempt status with the Internal Revenue Service, and establishment of a society bank account (Figure 1). The organizers realized that simply having a self-appointed organization of physicians practicing the nascent specialty of pain medicine would not be sufficient to allow them to lay claim to be the authoritative voice of pain medicine for the state. The Texas Medical Association (TMA) was the official organization recognized by the Texas Legislature, and other state and nongovernment organizations, as the principal authoritative voice for all medicine for the state. Consequently, recognition by the

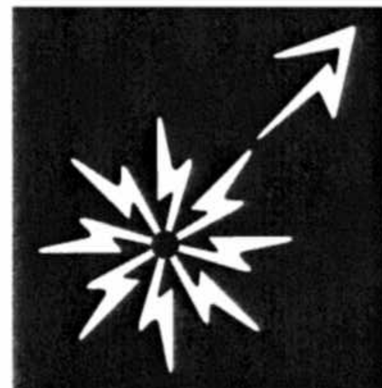

Figure 1. Logo of the Texas Pain Society.

TMA through its Council of Medical Specialties was essential for a medical specialty to speak authoritatively for its specialty. One of the Council's requirements was a sufficient number of physicians practicing that specialty.

MISSION STATEMENT AND GOALS

In that first meeting the founders discussed and approved the mission and goals of the society, agreeing on matters related to providing the best possible health care to pain patients in Texas suffering from chronic, painful conditions. Furthermore, it was agreed for the TPS to provide a structure for educating physicians, legislators, and other stakeholders about the best practice of pain medicine in the state. Finally, and significantly, the TPS needed to become the voice of the pain patient and the pain physician. This was to be accomplished with the help of published materials to be provided to members.

To accomplish this, goals were set up to provide an official address for the TPS, obtain tax-exempt charitable status, organize a membership drive and create promotional avenues for educating Texas physicians in pain management.

The TPS started up quite simply to see if it could inform a Texas physician as to what a pain physician could do and the appropriate kind of patient he/she could refer to a pain center. The goal was to promote the specialized nature of a pain physician and what he/she could uniquely provide if a patient was referred. The TPS also wanted to see that proper recognition was given to pain physicians by the regulatory and reimbursement agencies. Other goals of the TPS were to have multidisciplinary and equitable geographic representation among TPS board members and to encourage the involvement of women physicians.

FORMATIVE YEARS

The TPS needed a base, as there were no additional resources available at that time. Racz was the professor and chairman of Anesthesiology at TTUHSC and independently had established the annual TTUHSC Pain Symposium, which had been going for some years. The key organizers of the program were various faculty members but, most importantly, Jim Heavner. It was logical for his symposium to change the scientific sessions and add an extra period on Sunday morning (the last day) of the annual symposium. This would eventually also become an official part of the TPS annual meeting. This change was successful in attracting physicians from Texas and other states to attend the TPS general meeting.

During the early years the TPS was approached by different organizations, including the Southern Pain Society, the American Academy of Pain Medicine and the American Society of Interventional Pain Physicians, to form an alliance. Ultimately, the TPS and the American Society of Interventional Pain Physicians entered into a memorandum of understanding to cooperate from time to time on issues of mutual interest.

It is important to describe the personal reflections of the founders at this time. Unfortunately, not all were able to comment; but the following were expressed by significant founder members.

IMPACT OF FOUNDERS AND PRESIDENTS

The impact of Founders in the formation of the Texas Pain Society cannot be overestimated (Appendix A: Recollections—online supplementary material). The initial idea of forming a Society by Prithvi Raj was unique and different in that period in 1989. His efforts to sell this idea to his colleagues such as Gabor Racz, James Heavner and Stratton Hill had a high impact on enthusiasm and consensus building early on to form a Society. Gabor Racz was instrumental in allowing the Texas Society of Anesthesiologists (TSA) to endorse the formation of the TPS to be a component Society of the Texas Medical Association (TMA). James Heavner structured the Society correctly and provided legal and administrative processes to be developed in that early stage, which has stood it in good stead, even today. Stratton Hill's contribution is legendary in legislative successes on behalf of TPS. His efforts have significantly improved the standard of practice of pain management in Texas. Other Founders were very dedicated to develop this Society by participating in educational endeavors and working in academic centers to promote this Society.

The TPS had a series of very good presidents and board members. Cris Schade developed skills and interest in organizational medicine and was elected and re-elected to be one of our delegates to the TMA. Ralph Rashbaum, Aaron Calodney, Allen Burton and countless others contributed in many ways, as we expanded in terms of an executive office, mini-courses, newsletter, input into the medical system and structure, growth in corporate support, and serious leadership in

Table 1. Past Presidents

Individual	Term
Gabor B. Racz, MD	1990–1992
C. Stratton Hill Jr., MD	1992–1994
C. Stratton Hill Jr., MD	1994–1996
Sharon Weinstein, MD	1996–1997
P. Prithvi Raj, MD	1997–1998*
	1998–2000
C. M. Schade, MD, PhD	2000–2002
Samuel J. Hassenbusch, MD, PhD	2002–2004
Ralph Rashbaum, MD	2004–2006
Aaron Calodney, MD	2006–2008
Allen W. Burton, MD	2008–2010
Judson Somerville, MD, DABPH, FIPP	2010–present

*Vice president that served as president.

many directions. We have an influx of many young members and a bright foundation for future involvement and growth. Sam Hassenbusch was a true leader for the TPS. He had a vision of the TPS working closely with the American Academy of Pain Medicine (of which he was also president) and Texas Association of Neurological Surgeons (of which he was also president). He was a unifier and had a great vision of collaboration and common ground that was inclusive and patient focused. He spent much time and energy on the American Medical Association Resource-Based Relative Value Scale group, arguing for higher reimbursement for pain specialists (Table 1).

The details about the Founders and the President's achievements as described by their oral history are found in the online Appendix of this article (Appendix A).

ACHIEVEMENTS

In 10 years, the TPS achieved delegate status with the TMA (Appendix B: online supplementary material), secured a seat on the Carrier Advisory Committee (Appendix C: online supplementary material), established a significant leadership role in the Legislature, changed the Triplicate Prescription Program, instituted the Chronic IPTA and Texas Medical Board (TMB) Rules for treatment of chronic pain, and significantly influenced the rules at the Texas Workers' Compensation Commission for preserving and improving access to pain medicine in Texas.[1] At the same time, we preserved our status as a state organization by not becoming a chapter of a national organization.

Education

Collaboration with the TMB. Directing educational efforts to TMB members seemed to be the next logical target for solving the disparity of education and training in pain physicians. Pain practice potentially could be changed by the TMB[2] because the Texas Legislature had granted it rule-making authority. Having the TPS educate members of the TMB about modern pain treatment and subsequently adopt rules embracing such treatment would make modern pain treatment the new standard of practice. Members of the TPS Board made several personal presentations to the TMB. The TPS was then asked to draft proposed rule changes and additions to the Texas Medical Practice Act (MPA). Ambiguous phrases were defined, and other changes were made. The TMB made some modifications to the drafted proposal and, after a consensus was reached, officially adopted the rules in 1995.

Recognition of the Pain Physicians in Texas. Drs. Stratton Hill and Schade also worked with the American Board of Pain Medicine by testifying before the TMB on advertising rules for advertising board certification in pain medicine. Not only was board certification by an American Board of Medical Specialties' board recognized, but also through our efforts supporting the American Board of Pain Medicine, its board certification was also recognized at that time and could be used in advertising in Texas.

Collaboration with the Texas Society of Anesthesiologists. The TPS has also renewed its commitment and collaboration with the TSA, giving a block of pain lectures at the TSA meetings for 2008, 2009, and 2010, with good attendance and excellent networking with TSA leadership.

TPS Annual Meeting. Aaron Calodney had a vision for a free-standing TPS annual meeting. At the same time, it was felt to be important that this would be an additional educational offering, not to detract from the established Lubbock Pain Symposium, Tex-Med sessions, regional lectures, or TSA lecture offerings. The first TPS annual meeting was in October 2009. The meeting was an amazing success in terms of attendance and value to the pain community. The second annual TPS meeting was even more successful than the first. The TPS provides many high-quality educational offerings and now has an annual educational calendar.

The TPS was able to further its mission of education by not only continuing the biannual newsletter, *The Texas Pain Bulletin*, but also adding fax broadcasts to

its members, which then led to e-mail blasts to members. This has added significantly to the value of being a TPS member. In 2001, membership benefits were changed to include a subscription to *Pain Practice*.

Tex-Med Annual Pain Sessions. Texas Pain Society Board members achieved approval by the TMA for Tex-Med Annual Concurrent Pain Sessions. The theme of the presentations was chronic opioid therapy, the dos and don'ts. These were very popular break-out sessions; the attendance at that session was ranked either #1 or #2 of all the breakout sessions at Tex-Med for several years.

Legislative Activities

The Texas IPTA. Re-educating physicians about the pharmacology of opioid prescribing was necessary. That would be a daunting and long-term goal requiring significant resources. Equally daunting was physicians' fear of regulatory and legal consequences of a change in prescribing, especially expanding indications and increasing dosages. Perhaps the most daunting challenge of all, however, was changing the prevalent negative cultural image opioids have in our society. Their image as drugs of abuse was so strongly ingrained that recommending any increase in usage would be tantamount to a betrayal. For success, it would be necessary to approach all these issues simultaneously. The strategy was to first address the fear of regulatory and legal sanctions against opioid prescribing.

At the beginning of the 71st Session of the Texas Legislature in January 1989, Stratton Hill discussed with Bill Hobby, lieutenant governor, the plight of pain treatment in Texas and the United States. With a little persuasion, he supported introducing legislation that would better define opioid use in the treatment of intractable pain and offer some protection for physicians who adopted new treatment recommendations. The legislation was drafted with the cooperation of the TMA. As Stratton Hill and his colleagues examined the then existing MPA, much to their surprise, they could not find any mention that opioids had a legitimate medical purpose. The only references to opioid use were in the context of their abuse. Physicians were warned to avoid prescribing opioids to known abusers or anyone whom they should have known was a drug abuser. Certainly, one objective of TPS colleagues was to amend the act and legitimize the medical use of opioids. Basically, the IPTA, as drafted, contained four provisions: (1) opioids had a legitimate medical purpose, (2) a physician could prescribe opioids for a patient diagnosed with intractable pain (intractable pain was defined in the statute), (3) no group or organization (clinic or hospital staffs) could interfere with a physician who prescribed opioids for a patient diagnosed with intractable pain, and (4) the TMB could not discipline a physician who prescribed opioids for a patient with intractable pain. Of course, provision four did not deny the TMB its duty to require the physician to practice medicine within the accepted Standard of Practice. Language in the existing statute prohibiting prescribing opioids to known "drug addicts," or individuals a physician should have known were "drug addicts," was retained. As we shall subsequently see, this language presented future difficulty for adequate pain treatment. The Act was to be known as the IPTA.

Lieutenant-Governor Hobby, the presiding officer of the Senate, arranged for State Senator Chet Brooks, dean of the Senate, to sponsor the legislation in the Senate. With this combination of political power, the legislation passed the Senate in record time with no opposition. On the House of Representatives side of the legislature, it was a different story. In 1989 the conspicuous medical concern in Texas, as well as the entire United States, was the emergence of the devastating HIV/AIDS epidemic. Scant knowledge about this disease and its initial devastating impact on our society caused grave public health concerns about containing its spread. The fact that most individuals initially affected by the outbreak were homosexual males, a certain segment of society, attached implications of moral failure on the part of those contracting the disease. Some members of the Texas House of Representatives also embraced this notion, including the Chairman of the Public Health Committee (chairman), where hearings about HIV/AIDS and IPTA legislation were held concerning the structure of proposed legislation. Unfortunately for the prospects of passage of the IPTA, the representative chosen to sponsor the IPTA in the House was a family physician on the Public Health Committee (Committee) who was instrumental in crafting the major HIV/AIDS legislation that did not contain provisions relating to an individual's moral failure that the Chairman of the Public Health Committee wanted in the legislation. Sadly, the Chairman took umbrage against the family physician and blocked any subsequent legislation he was sponsoring, including the IPTA, from coming out of the

Committee. Attempts at pressuring the Chairman to relent were unsuccessful, and the IPTA failed to emerge from the Committee and come to a vote in the House of Representatives during the Regular Session of the 71st Legislature. There was no substantive opposition to the merits of the legislation.

Fortunately, all was not lost. Governor Bill Clements subsequently called a Special Session of the 71st Legislature to consider failed legislation regarding Workman's Compensation. Special Sessions customarily last for 1 month and can deal only with matters the Governor designates. The only matter designated for this session was Workman's Compensation. Legislators had failed to make progress on this issue during the Regular Session, and this proved to be the case during the Special Session. Sensing another impasse, and rather than having a completely futile session, Governor Clements acquiesced to Lt.-Governor Hobby's request to admit the IPTA for legislative consideration. On this attempt, all critical legislators, including the Speaker of the House of Representatives, who had the power to move legislation out of a committee, were positioned to see to it that the IPTA was not obstructed by political vindictiveness. The IPTA was passed in July 1989 and became effective on September 1, 1989.

The Texas IPTA was the first such act passed by any state legislature in the United States. Under the guidance of Harvey Rose MD, and State Senator Leroy Green, the Legislature of the State of California had passed similar legislation in 1988; but it was vetoed by Governor Pete Wilson because of its complexity and cost. A revised bill, similar to the Texas legislation, was introduced in 1990 in the California Legislature and passed, making California the second state to pass such legislation. Through the ensuing years most states have adopted legislation regarding pain treatment.

Abolishment of Multiple-Copy Prescription (Triplicate) Program. Another impediment to appropriate prescribing of opioids was Texas' Multiple-Copy Prescription (Triplicate) Program.[3] Texas was one of six states that required Schedule II prescriptions be written on a state-issued prescription form that created three copies. The original copy and a carbon copy were given to the patient to present to the pharmacist, who sent the original copy to the Narcotics Division of the Texas Department of Public Safety (NDDPS); the pharmacist maintained the carbon copy on file for 2 years after filling. The third copy remained with the prescribing physician, who was required to keep it on file for 2 years. Having a copy of a prescription sent to the state police had a chilling effect on physicians' use of these prescriptions. Studies both in Texas and other states using multiple-copy prescription forms demonstrated that physicians prescribed Nonscheduled analgesic drugs in lieu of Schedule II drugs, despite a clear indication for a Schedule II drug, to avoid using a triplicate-prescription form. This practice, requiring use of any state-issued prescription form, contributed to, and continues to contribute significantly to, the inadequate treatment of pain. Physicians prescribing oral opioids were initially scrutinized for opioid prescribing, but physicians using interventional techniques in which opioids are administered have since come under scrutiny.

The TPS determined that the triplicate-prescription program was a serious impediment to adequate pain treatment and began a campaign to replace it with a single prescription form and electronic monitoring of Schedule II drugs. In the summer of 1996, a law student from the University of Houston Law School was hired with funds provided by a grant to work with the TMA, the NDDPS, legislators, and pharmacy organizations to devise a strategy to get legislative support to change Schedule II prescribing. Multiple meetings were held with these organizations and agencies and, after reaching consensus, legislation was drafted.

Coincidentally with these developments was the realization that the revised MPA did not allow the use of opioids for treating pain in drug addicts under any circumstances. As a compromise for getting support for the initial IPTA and subsequent adoption of rules adopted by the TMB, legislators and TMB members insisted that language prohibiting prescribing opioids to known drug abusers or individuals the physician should have known were drug abusers remain in both documents. No one opposed this language because AIDS was unknown and, especially, its spread in intravenous drug users by contaminated needles could not be predicted. Similarly, the development of severe painful complications of AIDS, such as systemic herpes zoster and painful peripheral neuropathy, could not have been anticipated. An amendment to the IPTA to provide for prescribing strong opioids to addicts who developed painful medical conditions after contracting AIDS was added to the agenda to present to the legislature.

Happily, the TPS efforts were successful; and the Legislature passed legislation to phase out the triplicate

prescription, adopt an electronic prescription-monitoring system, and amend the IPTA. These changes were to occur over an agreed-upon time, taking into account the time the NDDPS needed to put into place the equipment and tamper-proof prescription forms required for efficient operation. Approximately 1 year was considered a reasonable time for these changes to occur. Unfortunately, the NDDPS was unable to meet the time table; and in the 1999 session of the legislature introduced legislation to remove any time line for implementing changes to the triplicate-prescription program. This was done without the knowledge of the TPS. Only after the TPS realized that a seemingly inordinate amount of time had passed with no action taken on the prescription program did it realize that nothing was happening. The TPS exerted pressure on the NDDPS through various state officials, and the triplicate-prescription program was finally replaced by a single-copy, state-issued "official" prescription form for Schedule II drugs. This action occurred approximately 10 years after the original legislation was introduced and passed by the Legislature. The legislation regarding authority to prescribe opioids to addicts who subsequently developed painful medical conditions after contracting AIDS did become law in a timely manner.

Texas' Sunset Law, the MPA, and the TPS. All agencies of the state are subject to review every 12 years by a "Sunset Commission" (Commission) authorized by the Legislature to evaluate the efficiency of the agency's operations and determine the necessity of its continued existence.[4] The Commission comprises an equal number of members from both houses of the Legislature and a prescribed number of lay members appointed by the governor. Chairmanship of the Commission alternates between the House and Senate. After a thorough evaluation, the Commission recommends action concerning the agency to the Legislature. If an agency is not actively "re-created" by the Legislature at the end of the 12-year term, it is automatically "sunsetted," ie, ceases to exist. It cannot continue to operate under its previous authorization past the 12-year period if the Legislature does not actively authorize its continuance. The TMB is subject to this review. The process involves reviewing the original act creating the agency, amendments to the act, and rules it adopts, along with measurements of its accomplishments.

The TPS became interested in this process because the MPA outlines the disciplinary procedures for physicians who are charged with violating its provisions. With new information regarding dosing of opioids and permutations in the Standard of Practice for treating pain, an increasing number of Texas physicians treating pain were accused of violating the MPA. Upon review of the disciplinary procedures, it was found that the entire process beginning with the initial charge, the various hearings, the findings of fact, and the ultimate sanctions were fraught with stealth, ambiguities, and arbitrariness. The combination of uncertainty about the current Standard of Practice for pain treatment and the flaws in the disciplinary process itself made physicians reluctant to treat pain adequately when opioids were indicated. The Sunset process was considered an opportunity to make changes in the disciplinary process to make it more transparent and fair to physicians who were attempting to practice pain treatment applying modern information about the requirements for achieving adequate relief of chronic pain.

The TPS had the opportunity to participate in this sunset process involving the TMB and the MPA in 1991 and 2003. In 1991, we were unaware of the existence of the Sunset Commission and relied on a state senator to represent our interests in making changes in the MPA. Toward the end of the legislative session, we made inquiries about the contents of the revised MPA and were distressed to learn that none of our recommendations for change was contained in the new MPA.

We were more sophisticated 12 years later for the 2003 legislative session and began working with the Commission beginning in the fall of 2002. Grant money was used to hire a senior law student from The UT Law School in Austin to help analyze the existing disciplinary procedures in the MPA and Rules made by the TMB. The results of this analysis produced a 66-page document that was presented to and discussed with the Commission's staff. Members of the TPS also advocated for the recommendations contained in the document before open hearings of the Commission itself. Of course, the Commission was free to use or not use any recommendations the document contained. Predictably, the Commission recommended that the TMB be continued. The final legislative bill contained many recommendations that the TPS had proposed. It is difficult to determine whether the new MPA has made a significant difference in physicians' approach to pain treatment. Many external changes in federal law enforcement agencies have occurred since the passage of the latest MPA,

which have exerted a dampening effect on the use of opioids for pain treatment.

Drs. Stratton Hill and Schade worked tirelessly with the Texas Legislature and the TMA to end the triplicate-prescription program and move it to the official prescription program, ie, single script. In addition, Drs. Hill and Schade provided testimony at the Texas Workers' Compensation Commission on the Spine Treatment Guidelines, Medical Fee Guidelines, Pain Treatment Guidelines and multiple other rules that, in effect, promoted access to pain medicine for injured workers.

Representation in the TMA House of Delegates. In 1999, then-President Raj announced that the TMA had approved representation in its House of Delegates for the TPS. Dr. Schade was nominated as the first delegate to the TMA, starting service in 2000, and has proudly represented the TPS continuously up to the present time. In Raj's words, "This has given the TPS a state-wide voice in pain management." And, in fact, the TPS is now recognized as the "go-to" organization by the TMA when it comes to any legislative or regulatory items that impact the delivery of pain medicine in Texas.

Election to Medicare Carrier Advisory Committee. Gabor Racz, MD, was the first pain medicine representative to serve on the Medicare Carrier Advisory Committee with the assistance of TPS. His nomination was unique in that it was the first time in the history of the Carrier Advisory Committee in Texas that the voice of pain medicine was at the table.

ADMINISTRATIVE SUPPORT FOR THE TPS ACHIEVEMENTS

Many issues that swirled around during the mid-2000s included rewriting of Rule 170, establishing like-specialty peer-review for TMB (Texas State Board of Medical Examiners at that time) complaints, and writing and vetting an acceptable informed-consent agreement with the TMB in collaboration with our counsel, Victoria Soto, JD, and Donald Patrick, TMB executive director. The ongoing collaboration with Dr. Patrick has evolved, with the president talking to him many times, primarily to educate about pain-management issues.

In 2006, Connie introduced the Board to Krista Crockett, who would be executive director during Allen Burton's tenure. She was critical to any success attained. She has a tremendous grasp of complex legislative issues and is very gifted at consensus building in a meaningful way. Her ability to network with the TMA and various legislators has been key to our successes. Along with Dr. Schade, these two (Crockett and Stratton Hill) have propelled the TPS into being a significant force in the legislative realm. Without her vital presence in pushing the Board of Directors, ensuring task follow-through, overall organizing, and (vital) networking (and that of her predecessor, Connie), the TPS would not be the success it is today.

We were fortunate to have Victoria Soto join the TPS as our legal counsel in 2007. She has many years' experience at the TMB, is quite well versed on pain medicine medico-legal issues, and has helped our society tremendously with issues involving the TMB, opioid agreements, urine drug screening, lobbying, and many, many related issues. The TPS had established its first office in the Soto legal suite in Austin, and it was quite nice. The TPS office has become a good rallying point for Austin for business, legislative and regulatory meetings, such as the "First Tuesdays" programs, and others.

ANNUAL MEETING

The TPS Board now has an official, structured annual meeting and an annual general membership meeting in Lubbock during the June TTUHSC program. The Board also has retreats and teleconferences for strategic planning as required.

PRESENT STATUS OF THE TPS

The TPS is the largest state pain society and most legislatively active. Indeed, most of the TPS Board of Directors and past presidents have had significant involvement with most national and international pain societies. Recently, the Carolinas pain society was started, basically adopting the TPS bylaws, structure and strategy. Also, last year, the California Society of Interventional Pain Physicians invited the executive director to speak to their group on legislative affairs.

Another successful endeavor was establishing regional lectures and legislative clinic tours. These projects both take an enormous amount of organizational work to ensure a good-quality program and value for all attendees. The executive director goes on the road regularly to host at least 10 or more of these sessions around the state, improving the visibility and respect

for pain medicine. Numerous local chapters of the TPS have been established, with their own leadership and lecture series. Current local chapters include Austin; El Paso; Dallas/Fort Worth Metroplex; and, recently, Houston. These chapters infuse new members and provide a forum for TPS leadership to give feedback to members directly about ongoing issues.

As the stature and influence of the TPS grew, we were noticed by national organizations. The TPS received offers from the Southern Pain Society, the American Academy of Pain Medicine, and the American Society of Interventional Pain Physicians to become a chapter of these national organizations. After much discussion by board members, it was unanimously decided that the primary purpose of the TPS was to represent the patients of Texas and, to remain focused on Texas issues and Texas physicians; we should not become a chapter of any national organization. Out of this discussion rose the concept of a "Memorandum of Understanding" to coordinate and cooperate in the promotion of the goals of our organization. A Memorandum of Understanding was signed with the American Society of Interventional Pain Physicians in December, 2001.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Appendix A. Recollections.

Appendix B. TMA letter of January 4, 2000, notifying the TPS of its delegate status.

Appendix C. TPS letter of May 28, 2000, requesting that Gabor Racz, MD, be added to the Carrier Advisory Committee.

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