Editorials

A land half won: pain and the modern world

Pain medicine needs to be clear about what can and cannot be achieved

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Much has been done by the International Association for the Study of Pain, its members and its national chapters over the past two decades to improve the recognition and treatment of chronic pain. The World Health Organization has similarly mounted a sustained international campaign for cancer pain relief, and palliative care has improved and grown almost everywhere. However, despite real progress, especially in awareness, big challenges remain.

Research has revealed some of the multiple mechanisms at play in causing pain, and multimodal therapeutics tend to reflect this complex neurobiology.[1] There is strong emphasis on neuroplasticity, particularly central sensitisation, with the growing realisation that central changes generate pain long after peripheral nociceptive stimuli have waned or disappeared altogether (hence the name change from "chronic" to "persistent" pain). A holistic approach to care — the so-called biopsychosocial model — has been widely and enthusiastically adopted for all forms of pain management.[2]

Modern pain specialists tend to be polarised into centralists and peripheralists: those who concentrate their efforts on the brain and central nervous system, and those who try to block and modify peripheral structures and processes. Both approaches have validity. To some degree, all pathophysiology can be seen as altered survival mechanisms and almost always involves inflammation.[3] It appears that, in the modern world where lives are long and psychological stresses abound, primitive mechanisms to protect us in acute injury play havoc with our ageing bodies and nervous systems. Better blockade of inflammatory pathways must still be a Holy Grail of medical research.

For many years, pain and palliative care specialists saw their main challenge as "opiophobia" — how to overcome community and professional reluctance to use opioids for pain. Opioids have fairly clear roles in both severe acute pain management and palliative care. However, longer-term opioid monotherapy is discouraged in most patient populations, in favour of multimodal strategies, and indications for the use of opioids have been tightened because of widespread misuse, dependence and diversion.[4]

In a world that expects quick fixes for everything, and where medicine has promised much, expectations and capacity for medical amelioration of pain often far exceed reality, to say nothing of the economic realities of increasing access to specialist services.[5-7] Pain clinics can only see a small fraction of patients who have pain; medication and procedures often do not cure the pain; and increasingly disgruntled patients shop around, often favouring medication over other harder but ultimately more rewarding strategies. Even palliative care faces real challenges in meeting increased demand in a setting of chronic diseases and an ageing population, where dying can take years and pain requires management over months, not weeks.

For the legions of patients with persistent pain that does not respond to multiple drugs and procedures, a more realistic and holistic non-medical approach is needed. Many pain services have remodelled what they do on the pioneering work of the Hunter and Fremantle services.[8,9] Patients are encouraged to wean themselves off drugs, especially opioids, and to recognise that yet another operation or procedure is unlikely to help where others have failed. Physiotherapists and psychologists work with patients' natural defensive mechanisms that lead to fear of movement and activity, and help to engender healthy pacing of activity and rebuild confidence that life is possible without pain being a barrier to everything.[9]

It is widely acknowledged that psychological factors have a big part to play in the genesis and maintenance of persistent pain.[10] Patients with long histories of refractory pain need to know and understand that the pain has rewired their brains, with factors such as failure of early nurture, trauma, accidents, drugs and alcohol, and social and economic disadvantage all potentially contributing to dependence, depression, an external locus of control, and anger. There would appear to be considerable scope for more psychodynamic work in pain management.

Community participation projects involving art, music, gardening and physical therapies can achieve surprising results for patients with persistent pain. One good example of such an innovative approach is the Blackthorn Trust, an independent service with a National Health Service contract in the United Kingdom.[11] Its work is based on the principles of anthroposophical medicine, developed from the original insights of Rudolf Steiner (1861–1925). Patients start with a conventional medical consultation, build up trust and restore lost energy with physical therapies such as eurhythmy and rhythmic massage, and become involved in a gardening community. This process allows rediscovery of the lost or impaired will and encourages a deeper understanding of mind, body and spirit.

Hospices have led the world in blending good medicine with care for the whole person in an environment that models the world and the home. Those who are damaged and suffering from chronic, non-fatal but often medically enigmatic and incurable symptoms, such as pain, substance misuse and chronic mood disorders, similarly need a nurturing but empowering model of care when medical solutions are no longer apparent. Just as palliative care tackles the reality of death head-on, so too pain medicine, and appropriately resourced primary care,[12] needs to be clearer about what can and cannot be achieved. Maybe we need more Blackthorns: community innovations that "hold" the person and the pain, in the sense of the term adopted by the late psychoanalyst Donald Winnicott — the aim is "good enough" pain relief, or the best we can do to help people to live as fully as possible when pain cannot be "cured".[13]

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