The Pain Decade and the Public Health

Two years ago, activated by the tragic death of Jonathan Mann in the Swissair crash over the Atlantic Ocean, I wrote an editorial, “Chronic Pain: A Public Health Problem?” [1] Dr. Mann was the new dean of our new School of Public Health, and also the founding director of the World Health Organization’s international effort to enhance AIDS awareness, treatment, and research. At our first meeting, I suggested to him that pain was an important public health problem that we might address in the work of our school and through efforts in the nation and in the international community. Initially skeptical, his interest was sparked by my remark about the high probability that most people in the world dying of AIDS, cancer, and nutritional diseases also suffered from untreated pain. We went on to discuss the lack of preventive education, basic medical services, and the treatment of suffering, even here in the USA’s poorer communities. Patients had inadequate access to pain medications such as opioids and providers had little training about treating chronic pain. Poor access to care, recently documented by a report in the New England Journal of Medicine [2], is addressed by two articles in this issue. Burton and Boedeker describe the use of television to enable distant or disabled patients to receive pain medicine consultation [3], and Gammaitoni and colleagues describe the use of a specialized pain pharmacy to improve access to medications and their quality management [4]. However, the problem is bigger than a lack of access to services. As Mossey et al. document in this issue [5], even those with excellent access to health care suffer needlessly from untreated pain.

In considering Dr. Mann’s initial response retrospectively, the theme is familiar. How many other terrible diseases have pain as a hallmark symptom, the problem that patients most care about, whereas the disease process seems to be the problem that doctors most care about. Now, thanks to the Pain Care Coalition, this perspective has changed—pain itself is now designated as a public health problem of national significance. The United States Congress recently passed H.R. 3244, and President Clinton signed into law Title VI, Sec. 1603, which provides for the “Decade of Pain Control and Research,” to begin January 1, 2001. This coalition of the American Academy of Pain Medicine, the American Pain Society, and the American Association for the Study of Headache worked diligently for this project; its success indicates what is possible when we work as collaborators. Congratulations to Phil Lippe, who initiated the idea, and to Michael Ashburn, Joel Saper, and others whose hard work accomplished this.

The significance of this law for our patients, for our research and teaching, and for the public health cannot be exaggerated. Consider the effects of a similar pronouncement for the 1990’s as the “Decade of the Brain.” The subsequent increases in funding for research in neuroscience have greatly advanced our understanding of brain function, with corresponding progress in clinical sciences such as psychiatry, neurology, and neurosurgery. Much of this new knowledge is directly or indirectly related to the mechanisms and treatment of pain. Finally, now we will have a focused agenda for the problem of pain itself, not just pain as a derivative of other research and treatment initiatives.

The potential benefits of the “Decade of Pain Control and Research” will be many, and we must capitalize on our opportunity. First, and most directly related to pain practice, the term “Pain Control” indicates an intent to focus on improving the treatment of pain through clinical research. Our field needs the epidemiologic and clinical studies that will better define our diseases and disorders and establish the effectiveness of our treatments. Epidemiologic studies will define homogeneous populations of pain patients and suggest the phenomenological illness models that will be tested by randomized, double-blind treatment trials. These studies will also suggest the designs for testing systemic interventions that might change the outcome of selected populations defined by various parameters (e.g., injured workers, enrollees in a health insurance plan, the elderly in nursing homes, primary care patients). Large, multi-center, randomized clinical trials will determine the effectiveness of the complex treatment regimens that are needed in chronic pain patients.
A second potential benefit lies in education. In order to approach a universal standard of pain control, there must also be a focus on the education of health care providers in the basic sciences and clinical management of pain. A societal groundswell of support for better pain education is indicated by recent statements in the AMA and AAMC advocating better training of all doctors in pain and palliative care and recent legislative action in California mandating education in pain management and palliative care for all physicians. Unfortunately, heretofore our educational efforts have been hamstrung by factionism at many levels of teaching. At medical schools, this occurs when pain physicians encounter departmentalism when they attempt to develop a clinical or pre-clinical curriculum for pain. As a consequence, pain education is usually an incoherent conglomeration of lectures and experiences scattered amongst the courses taught by many different departments, each with its own perspective, not a more comprehensive, pain medicine perspective. A lecture here and there is no substitute for an organized, coherent pain curriculum. As a recent example of this problem, two years ago I gave a lecture to the second year medical school class on the pharmacological and biopsychosocial treatment of pain the day following lectures by colleagues on the physiology of pain and the phenomenology of pain disorders. My material was easily understood and our planning of the sequence was applauded by students. Following a reorganization of the medical school without such planning, I gave the same lecture before these other lectures had occurred, and most of the same material was over the heads of the students. Fortunately, there are medical schools now teaching an integrated pain curriculum, such as at the University of Texas with its Catchum Project, which can serve as models for the rest of us. The AAPM has recently published a position statement supporting the establishment of such a curriculum in medical schools, and is embarking on a project to develop a model teaching program that will be donated to all medical schools. Negotiating with curriculum committees to integrate such a program into medical school curriculums will be a challenge for us all.

At another level of education, departmentalism impairs residency and fellowship training in pain. Although at the pain center we train elective residents from the departments of neurology, psychiatry, and internal medicine, and the rotation is required for PM & R residents, each department provides its own seminar series and conferences devoted to pain education and training. Why give the same lecture three times to different small groups? Fellowships often train practitioners in pain treatment related to the traditional specialty of the department. Often, only lip service is paid to comprehensive education in pain medicine. How can we address this problem? When cautious planning and cost cutting are the watchwords, most medical school and hospital leaders are unable to overcome traditional impediments to collaborative planning. The patients who want better care will, unfortunately, not have as much influence as the payers (insurers) and those, such as corporations and organizations, that contract with the payers. The Decade of Pain Control and Research may spawn funding opportunities for innovative educational programs, such as the Catchum Project.

At the national level, these problems in educational factionism play themselves out in the efforts to develop standards for the field. Readers are well aware of the issues of board certification and the efforts to obtain specialty recognition for pain medicine. In the view of many, the protection of turf, rather than the public interest, has been the watchword when organizations consider the certification of educational programs and credentialing in pain medicine [6].

A third benefit of the Decade of Pain Control and Research will be in basic research. We are at the threshold of unraveling the molecular biology of pain, and we are beginning to understand more about complex brain processes involved in the clinical phenomenology of chronic pain, such as consciousness and suffering. Heretofore, funding for pain research has usually been a derivative of other disciplines that are represented in various institutes such as for aging, cancer, neurological, arthritis, and musculoskeletal diseases. This mandate should increase the funding dedicated specifically to pain research at NIH and other agencies.

A final benefit lies in public awareness. The stigma of chronic pain and its treatment is well documented. Persons with pain fear humiliation and social isolation, and are subject to misinformation and solicitation subject to the marketplace. The public is already much more aware of the availability of treatment for pain. The cover story of the March 17, 1997 issue of US News and World Report, “No Excuse For PAIN”, and many other recent stories in the popular press, have increased public awareness of treatment for pain. Support for public education programs, such as the American Chronic Pain Association, the National Pain Foundation and the American Pain Foundation, will enable a larger percentage of our population to become informed.
about pain and their rights to respectful and effective treatment of pain. As peer-reviewed information on pain and its treatment becomes readily accessible to the public consumer, through projects such as the National Pain Foundation, the consumer will no longer be satisfied with inadequate care; and other stakeholders, such as businesses, will insist on health care insurance products, such as effective pain treatment, that will positively impact their bottom line.

The Decade of Pain Control and Research begins next month, a watershed event for our discipline and our constituency. Now is the time for us all to work together, following the example of the Pain Care Coalition, to turn this opportunity for these benefits into a reality for the public health.

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**References**