EDITORIAL

Twenty-First Century Pain Education: The Rediscovery of Compassion

The sociocultural dimensions of pain are as significant as its nociceptive machinery [1–7]. Andrew Greer, speaking through the voice of the African American woman protagonist in his latest novel, has said “I do not know what joins the parts of an atom, but it seems what binds one human to another is pain” [8].

In this issue of Pain Medicine, Murinson and colleagues [9] report an innovative approach to addressing the gap between the universal recognition of pain as a fundamentally intersubjective experience [10–12] and its presentation within the medical curriculum—if presented at all—as ordinary biomedical knowledge to be absorbed passively in large lecture halls. They describe their “greater vision for the course (as one) that . . . would build opportunities for emotional development . . . spur students to more deeply acknowledge the affective consequences of strong pain, (and) begin to recognize their own emotional responses to pain in self and others” [9]. To do so, they supplemented core knowledge about nociceptive and analgesic mechanisms, assessed by conventional standardized testing, with “socio-emotional” activities conducted in small groups. The latter activities consisted of written narrative, assessment of personal affective responses to nociceptive testing, reflection and discussion on the role of empathy and compassion in medicine, and discussions with pain experts. Pre- and post-testing indicated that the students not only acquired factual knowledge but also grew in their awareness of the depth of suffering experienced by patients in pain.

This successful pilot experiment comes at a timely moment. Calls for pain education to be improved not only for medical students but also practicing physicians and all health care professionals [13] are now heard throughout pain medicine [2] and organized medicine in general [14–16]. Scientific research in the postmodern era has become accustomed to formal investigation of complex processes including social forces [17] and other phenomena whose outcomes are not easily predictable [18]. Researchers, educators, and other pain scholars have made great progress in understanding and describing nuanced elements of the intersubjective pain experience that often seem to vanish when a complex analog reality is fitted into standard quantitative metrics [19]. Subtler and more elusive than the predetermined endpoints of classical analgesic trials, these intersubjective elements include empathy, compassion, altruism, the construction of narrative, nuanced preferences [20], and cultural interpretations. This movement from reduction-ism toward accommodation of subjectivity and complexity [21] is to be applauded. Not only does this movement help synthesize qualitative and quantitative modes of understanding, but a greater attention to complex patient-centered experiences can improve clinical outcomes [22] and increase patient satisfaction [23]. The meta-analyst Jadad [24] has therefore urged that the findings of randomized controlled trials be balanced with other ways of knowing such as anecdotes, rules of thumb and tacit knowledge [25].

As Murinson and colleagues note, “novel approaches are needed” to overcome “dramatic decreases in empathy during training” that may leave medical students with entrenched negative attitudes. Despite the ability of developed countries to provide access to pain control, few nations, if any, have achieved this [16]. Much has been written about this shortfall but it is clear that there are unique barriers to appropriate pain assessment and treatment, that perhaps reflect a fundamental discordance of instincts to nurture vs stigmatize [26], exclude or even prey upon weakened fellow members of our herd [6,27,28]. Faced with tremendous difficulties in understanding such conflicting responses in a quantitative fashion, yet struck by the undeniable importance of coming to grips with them, physicians have employed more qualitative approaches such as through ethics and moral philosophy [29,30].

It is becoming clear to pain researchers and clinicians that teaching about pain in the same fashion as education about other topics such as anatomy or biochemistry misses something fundamental. Pain education from a reductionist perspective, which ignores its intersubjective and moral dimensions, [6,7,30] may actually be counter-productive. Carving out a block of time within large-scale lectures to deliver material that emphasizes mechanisms at the expense of exploring the meaning and experience of individual suffering could actually lead to the unintended negative consequence of over-intellectualization. For example, this approach might reinforce students’ tendencies to detach emotionally from experiences during subsequent training that, as it draws closer to real life practice, may become more emotionally charged, awkward, and threatening. Role modeling and face-to-face dialog with peers and advocates are, as Socrates well knew, far superior to passively receiving knowledge for ethical or moral education [7]. This lesson is one that we have re-learned at Tufts, during the 10 years that our evening program on pain research, education, and policy has been offering
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certification to students of all backgrounds. Not intended as a clinical “pain fellowship,” it instead provides a broad range of courses from neuroanatomy to health policy, to enable adult learners to progress further along their individual career paths [31].

Reflecting on this exciting pain course at Hopkins, amidst my hopes for its continued success, I asked myself whether the bottom line isn’t simply to foster, in a structured setting, the innate compassion medical students arrive with, and that the hurried, depersonalized world of modern medicine constantly threatens to extinguish [32]. And then I recalled that a Boston Brahmin contemporary of Hopkins’s Osler said this over 80 years ago: “The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine—or, to put it more bluntly, they are too ‘scientific’ and do not know how to take care of patients . . . One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient” [33].

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