
Dear Editor,

The first inference to be drawn from the article by Cohen et al. is that patients become (or are likely to become) stigmatized where a doctor fails or declines to authentically present a clinical presentation using the template provided by “the scientific revelations of neuroplasticity that provide plausible neurobiological explanations for complex sensory and motor phenomena which would have once been dismissed as residing in the mental domain” [1]. The second is that doctors who do not toe the party line i.e., who fail to endorse this explanatory model themselves run, the risk of being stigmatized. One cannot help but be reminded of the Australian repetition strain injury (RSI) epidemic of the 1980s and 1990s in which the high priests of RSI demonized as “incompetent” those doctors with the temerity not to diagnose RSI in those presenting with unexplained, upper limb pain occurring in an occupational setting [2]. Now in Australia, RSI is a historical footnote.

The authors advocate the management of chronic unexplained pain through the prism of holism rather than dualism, but fail to make it clear why diagnosing a “mental disorder” should be any more likely to lead to “inappropriate treatment and . . . poor treatment outcomes” than for example, prescribing narcotic analgesics for chronic nonspecific low-back pain. We fail to understand why the authors should demonize the diagnosis of a “mental disorder” when we know that more than 50% of patients with a mental disorder present with physical complaints [3] and that in depressed patients 70% of complaints are physical [4].

The assumption by the authors appears to be that “psychological” formulations of illness represent a delinquent “default,” but appear to be naively oblivious to the possibility that notionally “plausible neurobiological explanations” may be an egregious default.

The authors’ position on chronic unexplained pain echoes the viewpoint that chronic noncancer pain should be recognized as a disease entity in its own right [5]. This has evolved from the concept of central sensitization, which we know may result from nerve damage or from persistent peripheral nociceptive input. This presents few intellectual challenges where there is objective evidence of either nerve damage or injury to somatic or visceral structures. However, now, central sensitization appears to have become the explanation du jour of medically inexplicable pain, which typically follows injury that may be so subtle as to be unassociated with any discernible abnormalities often without a critical clinical assessment based on anatomical and physiological principles.

That some patients may feel stigmatized by the notion that their illness is due to a “weak mind” simply reflects lay ignorance of the role of the psyche in pain. That some doctors may share this sentiment is of greater concern. The logical extension of this idea is that Pain Disorder be expunged from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition because its diagnosis may be offensive or “stigmatizing.”

Not acquiescing to a patient’s viewpoint of a medical condition does not preclude a doctor from being empathic even if a naive patient feels stigmatized by the experience. Iatrogenic stigmatization may be hurtful but is likely to be less harmful than iatrogenic illness, an almost inevitable consequence of a type II error (diagnosing a condition that is not present or that does not exist).

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References