
Dear Editor:

We welcome the opportunity to respond to Dr. Awerbuch. It seems that he has missed the point of our article, that the withdrawal of empathy may play a role in the stigmatization of the person in pain. His letter itself is an example of the very attitude we wish to highlight. We do not seek an explanatory model for all chronic pain—there is no role for “high priests” in this dialogue—while we do examine the role empathy might play in the clinical encounter between health professional and pain patient.

To be fair, Dr. Awerbuch does raise some important issues, such as prescribing of opioids to patients presenting with chronic noncancer pain and the categorization of chronic pain as a disease in its own right. We agree that these are issues worthy of discussion but not in the context of our article.

Dr. Awerbuch’s “first inference” is curious. The linear and necessarily dualistic thinking that characterizes those clinicians who so readily cast the problem of chronic pain into the mental domain is, simply, outdated [1]. That does not mean another dogma—neuroplasticity—is the only let alone compulsory substitute.

The historical footnote to which Dr. Awerbuch refers in his “second inference”—the Australian RSI epidemic of the 1980s and 1990s—happens to be still relevant to the practice of Pain Medicine. As the two articles referenced in our article make clear [2,3], the medical debate over pathophysiology and nosology spilled over into Australian society where the end result was stigmatization of many of those patients so labeled. In fact, the most pejorative term awarded to them happens to have been “Kangaroo Paw” [4].

Dr. Awerbuch seems not to understand why diagnosing a mental disorder on spurious clinical grounds—a type I error—proved so damaging to pain sufferers, many of whom were young women. Clinicians need to be very careful when attempting to attribute the lived experience of pain to a mental (psychological) disorder. In fact, such diagnoses at that time rested upon the dangerous assumption that the clinical phenomena could and never would be explained in terms of neurobiology [5]. This is no longer the case for many of our patients [6].

The key question is not whether the psyche has a role in the pain experience, but rather how does the concept of the psyche tie in with the current neurobiological research. For example, from animal experimental studies, we know that psychosocial stressors are as capable of activating the very same stress response systems as can physical stressors [7].

Let us put this question to Dr. Awerbuch. In terms of stereotyping, stigmatizing, and other consequences of clinician behavior, what does he consider is of more potential harm to patients: a type I error of labeling a person as having a non-disease (such as “weak mind” or “Kangaroo Paw”) or an alleged type II error of offering the possibility of a neurobiological explanation for complex clinical phenomena?

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