"Psycosomatic medicine, behavioral medicine, just plain medicine", title of the 1986 Presidential address to the American Psychosomatic Society by Professor Bernie Engel of John Hopkins and NIH, came at a time when traditional constructs such as the dualism of mind and body in health and disease and the ‘black box’ of behavioral inputs and outputs were being eroded by investigations of behavioral neurophysiology and the impact of cognitive processes on emotions and behaviors and their impact on health. Engel said, "Neurally mediated physiologic responses fulfill all of the criteria for behavior and obey all of the laws of behavior subject to the anatomic and physiologic constraints inherent in their structures and functions. It is illogical and wrong to assert that neurally mediated responses interact with behavior. THEY ARE BEHAVIOR (Dr. Engel’s capitalization). These principles are a legitimate and necessary part of the training of all medical students, residents, and fellows [1]."

Finally this moment has arrived, with widespread recognition of the impact of cognition, emotion and behavior on health outcomes of our population, with a particularly strong research foundation in the psychology of pain medicine and pain practice. However, in those early days this was Engel’s vision of what medicine should become, and it seemed distant at the time. I was privileged to be in Professor Engel’s audience that day and was inspired by the power of his message having created a behavioral medicine service in 1982 at the University of Vermont [2] strongly influenced by experiences in family practice such as Lamaze in maternal deliveries, by mentoring from Dartmouth’s John Corson (psychologist out of McGill) and Gary Tucker (psychiatrist out of Yale co-author of the influential work, Behavioral Neurology [3] with neurologist Jonathan Pincus), and by the program of psychologist Frank Keefe and cardiologist Red Williams at Duke. Similar programs were developing across the country. Many of us taught such principles in our medical schools and residencies into the 1990s, and some of us were supported by the NICI Education Branch into the mid-1980s; but all were similarly challenged to penetrate standard medical training and practice.

Unlike other medical specialties, psychology was present at the birth of pain medicine, an essential and influential partner in the development of pain care in all chronic care settings. Building on behavioral research and seminal constructs such as biopsychosocial medicine and the gate theory of pain, in the 1970s and 1980s University programs such as at Washington (Bonica and Fordyce), McGill (Melzack), Duke (Keefe and Williams), Yale (Turk and Kerns), Stony Brook (Stone and Friedman) and many others developed psychology clinical and research training programs. These leaders in turn trained another generation of more specialized health and pain psychology leaders to become faculty in universities around the country who are now poised to lead the effort proposed by Dr. Damall and her colleagues in this issue [4]. Pain psychologists have led national programs in pain-related research at FDA and NIH (Turk and Dworkin) and the VA (Kerns), pain management policy in health systems such as the VA (Kerns), and entire university research programs (Tait [St. Louis], McGrath [Dalhousie] among others). Large health systems such as the VA now by policy include pain psychology as essential to implementation its Stepped Care Model and sponsor national training in pain psychology and pain rehabilitation (Murphy [Tampa]). Now the concepts and practices of pain psychology are penetrating primary care practices where most pain care occurs, particularly in population-based health systems such as Kaiser and the Veterans Administration. Pain Medicine has developed under the leadership of Dr. Kerns as a founding Senior Editor and Dr. Edwards as the founding Co-editor of the Psychology, Psychiatry an Brain Neuroscience Section, and Drs. Cheattle, Knudson and Keibles presently Co-edit sections of the journal. Drs. Keefe, Turk and Jensen edit important pain journals.

I believe we can safely say that Professor Engel’s goal, although buffeted by the spurious winds of a commercial health care system that fragmented care in the 1990s, has now achieved the status of inevitability. Due to rising health care costs our country now has no choice but to recognize human behavior as a core foundation of the daily practice of health and medicine, including pain medicine, and indeed as a foundation of public health globally. Focused and widespread training in pain psychology, as recommended in this issue’s paper by Beth Darnall and her distinguished colleagues has been long in development and is well overdue. The 2011 IOM Report calls for adequate pain training in all relevant clinical disciplines as does the resultant National Pain Strategy [5]: the strong presence of competent pain psychologists imbedded throughout the
system to train our students, trainees, clinicians and teams, is essential to our specialty, to our field and to our national health care system.

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