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Revisiting Pains

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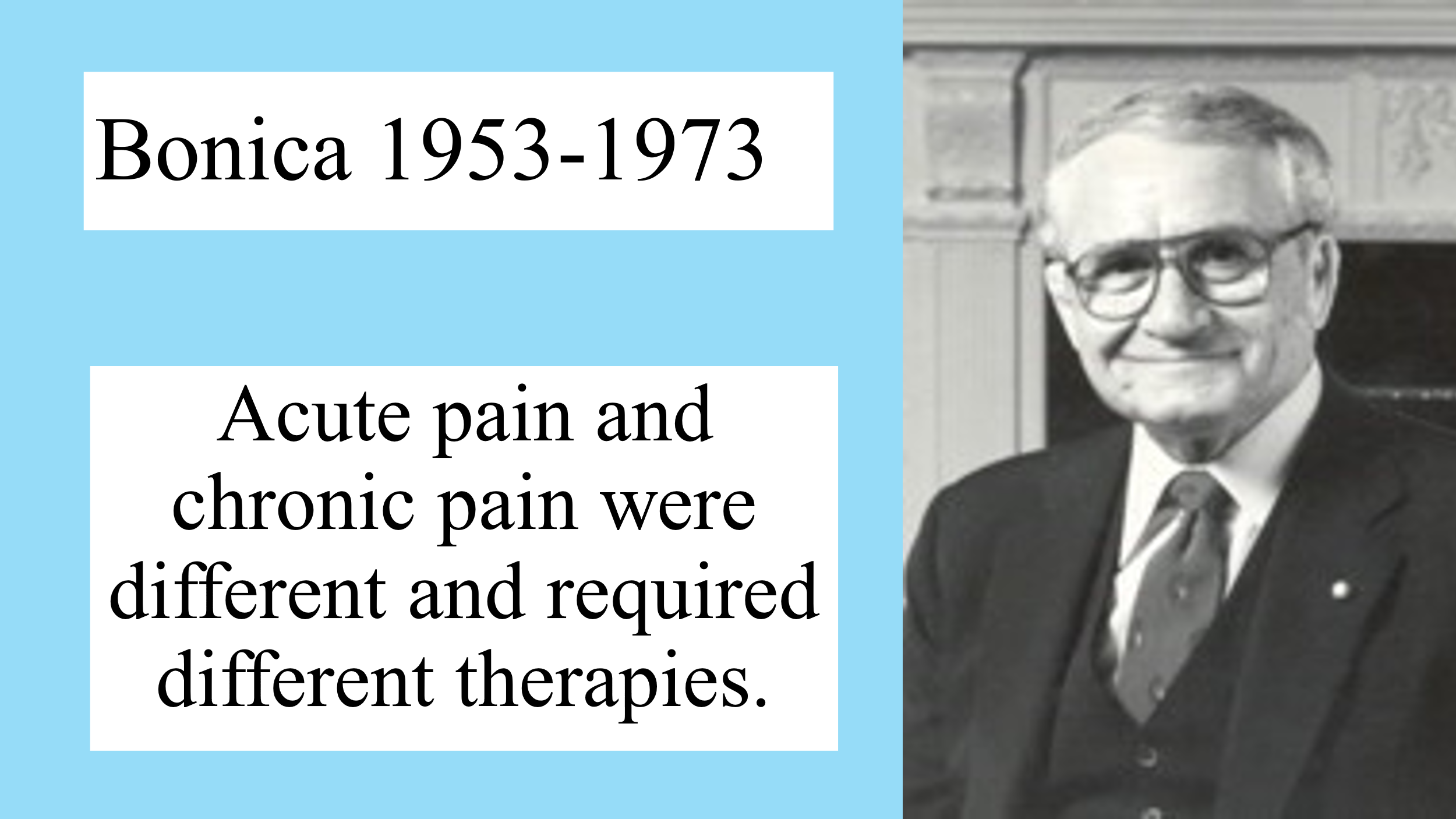
This talk is based upon a paper that Dr Jane Ballantyne and I have written which has been accepted by the Clinical Journal of Pain. Our goal is to get people to recognize that there are issues in the world of pain that need to be resolved in a variety of ways. I like to take a historical approach to things and my current thoughts are directly related to the USA where I have practiced my entire life but there are some references that can be generalised to the rest of the developed world ; my focus, however, is on the United States.

The pain world was launched in 1973. The pioneers thought that pain research and pain as a disease would lessen the burden of pain in our society. But if you read the current literature this burden seems to be even greater fifty years later.

In his book, *In Pain,*  by Travis Reider, a bioethicist who had a terrible accident while cycling and had multiple surgeries to save his leg, his dealings with the health system and the pain world are reported. He was treated with opioids and developed a nasty addiction problem which was eventually resolved and he is now back at work on the faculty of John Hopkins University. He makes the bald statement in it: “Pain medicine in this country is deeply broken…”. It is an engrossing account of all the things that did and didn’t happen that impaired his recovery.

So you might ask: why is there more pain in the population? Is it just that there are more studies that reveal more of what we have in our society? Have we better trauma care or cancer care or are people surviving longer after their trauma ? Is it that in general health care is better and more people are surviving? Or is it as proposed by the Princeton economists Case and Deaton that it is due to due to society changes or is it effects of the pain movement itself, They provide really disturbing data for a country like ours or the UK where you have lots of different social groups, but their studies are about the white male population in the USA; the uneducated, and often unemployed because they lack the skills needed in the modern world, who have a very high incidence of chronic pain as well as a variety of other ‘diseases of despair’

Is the incidence of chronic pain increasing because pain medicine has failed? Is it the unfulfilled promise of pain medicine? Or is it because we have such a disorganized health system? Is the intrusion of capitalism into American healthcare so maleficent that it causes a barrier in pain medicine? These are all possibilities that have been proposed; I won’t go into detail about any of them but bear in mind that it is unclear whether there is more chronic pain or less good pain management or both.



Everybody in the world of pain knows that John Bonica was the father of the whole thing; you could date its start from the publication of his book *The Management of Pain,* the first edition of which was published in 1953, an amazing tome that was written by one man with a few chapters by his friends. It was the first time that I am aware of that pain was a subject for an entire textbook. The single most important point that Bonica made in that book was that acute pain and chronic pain were different and required different therapies. His pain experiences came from WW2 when having finished medical school and an anaesthesia residency in he was assigned to a in a military hospital here in the Pacific north-west where large numbers of wounded servicemen were cared for and that is where he saw a lot of chronic pain. He was an unusual guy in that not only did he want to provide care but he wanted to change the world. In 1973 he convened a meeting in Issaquah WA near Seattle which involved about 300 people from all over the world and from many specialties. He summoned people to this meeting in a former nunnery which became a convention centre; and when you got out there, there was no way of leaving unless you called a taxi or walked. He kept people there for five days from eight in the morning till ten at night talking about pain. At the end of this meeting a group of stalwarts who had stayed around long enough decided that we would start a society aimed at pain. We were lucky that Pat Wall agreed to be the editor of a new journal. There were recognized needs for national chapters and for a standard taxonomy. Bonica’s point that acute versus chronic pain was a critical factor was recognized and everybody agreed that much more research was needed.

This organization took off. This was the right idea in the right place at the right time. It didn’t take long for it to grow from 300 to the first meeting in Florence in 1975 with 600 delegates, and for the upcoming meeting in Amsterdam 7000 people are expected . IASP has been a very significant force for the pain world.

A new terminology

The initial dichotomy that Bonica proposed of acute versus chronic pain has become outdated. It is much more useful to describe the dichotomy of pan as peripheral versus central. It is a more powerful method of dividing things. Peripheral pains are based upon nociception in response to tissue damage. We as healthcare providers can do two things: we can hasten tissue repair and we can block the pain until nature resolves it. As Voltaire said a long time a ago: “Nature heals, and doctors get the credit”. Ou bodies are made to heal; if you suture a laceration or immobilize a long bone fracture you are just facilitating the healing process. So with peripheral pain management we may reduce or even eliminate the pain, and then nature heals the problem and there is no longer any need for pain treatment. In fact most wounds are not painful for more than a few days. Health care does fairly well with acute pain.

We all agree that the biopsychosocial model is one we have all worked with but now we think it would be wise to change it to sociopsychobiological, because whatever comes first is considered the most important, and this has led pain physicians to think and act as if biological factors and their treatments are supreme, and we must give much more attention to social and psychological factors. At least in my country far too many physicians are biologically fixated and there is more than biology to a human being. Managing pain patients requires an understanding of the social and psychological factors that can be playing a large role in the complaint of pain. And that is particularly relevant to the other side of my dichotomy which is central pain. Central pains are based upon information processing errors in the spinal cord and brain. No nociception is required, and consequently treatments aimed at the periphery do not help. Importantly, opioids do not relieve these pains. Treating pains of central origin as if they were of peripheral origin is responsible for expensive and useless healthcare costs to say nothing of the complications and need for further surgery.

Unfortunately our method of educating doctors and pain specialists in particular leads to a tremendous focus on the periphery which is not very useful for central pain. Central pains are disease states themselves whereas peripheral pains are the body responding to injury and the system working as it has evolved. There are different processes underlying the two. With central pain there is something wrong with the way the nervous system is functioning. It is important to recognize the difference between a disease state and normal functioning. The situation is complicated because the IASP have developed a new classification scheme that makes use of two types of pain: nociplastic pain and chronic primary pain. Nociplastic is a word that I generally hate. It is defined as pain that arises from altered nociception, despite no clear evidence of any actual tissue damage, causing the activation of tissue nociceptors ….. causing pain or evidence for disease or lesion of the somatosensory system causing the pain. There is an obvious illogic in that definition: that pain arises from altered nociception despite there being no evidence of nociception which is bizarre. More importantly there is no evidence of tissue damage. Consider fibromyalgia, prototypically a nociplastic pain . People have biopsied tender points etc. and have found that there is nothing wrong in the periphery. Furthermore there is no evidence of altered processing of peripheral events. More importantly the concept suggests that there is a peripheral origin for this kind of pain, and that leads to useless care of which there are too many examples. So I believe the concept is wrong.

Furthermore, the idea that something changes in the nervous system so that one day less than 90 days a pain is acute and one day more it becomes chronic has no evidence to support it. The definition of chronic primary pain is pain that persists for more than three months and is associated with emotional distress or functional disability and is not accounted for by another condition. I don’t like this definition. What is three months? What is the magic implied in the IASP taxonomy that something happens at three months? 20 44 slide 18

Central pains do not require a nociceptive event. They are associated with what Fordyce called transdermal factors, (as having causes both inside and outside the body.) \* such as emotions and anticipated consequences.They are responsible for most of ‘high impact’ pains that impair function. They require multidisciplinary care and restoration of function, not just symptom relief.

*\*Wilbert Fordyce, “Pain and suffering: what is the unit?”,*Quality of Life Research*, 1994[*

Pain treatment, like all kinds or healthcare, is strongly influenced by the culture that surrounds it. In the USA we have no system of healthcare – we do have multiple systems and we have a financial system that pushes towards interventions. We have training programmes that all too often are procedurally oriented and another bizarre phenomenon that graduates of really useful training programmes like psychiatry, rheumatology, and primary care medicine are going into procedural-oriented pain training programmes. So we are sucking up people whose education can be useful for managing central pain states and turning them into proceduralists.

Pain management problems are greatest in the US because of the intrusion of capitalism into healthcare and the poor payment for cognitive work versus procedures. The chairman of anesthesiology in our school once told me that he could not to have his faculty working in the pain clinic because when they worked in the OR they made $1400 a day and when they worked in the pain clinic they made $400 a day and he couldn’t afford to subsidize them. As physicians we focus our training interests on our own training but we need all healthcare providers to be educated in pain and its treatment. And a pain team must be multidisciplinary if it is to be effective in dealing with central pain patients. I remember very well the trouble we had getting physical therapists to manage pain patients as if they were patients and not athletes, as they had always taught that ‘if it hurts stop doing it’. And if you are working with pain patients it is the exact reverse which is to show them that they can work through their pain.

To be economically viable multidisciplinary pain management must be focused on high impact pains. It is a complete waste of resources to put a patient with a peripheral pain problem that can be managed by a single provider into a multidisciplinary pain program. We have to focus on the people who need our services. In our country there are many disincentives to providing multidisciplinary pain management. Some are financial, some are related to the healthcare system. Some relate to the widespread opioid abuse disorders that swamp out effective pain management. If you are going to provide effective pain management in this country you have got to address this issue.

If people are trained in procedures why not use them? - this often leads to their inappropriate use. And the team approach to patient management that we require in multidisciplinary pain management programs doesn’t fit the personalities of many doctors .

Training in pain management must focus on central pain states and the use of multidisciplinary pain strategies. There are far too many single modality treatment programs often with absolutely no outcome studies to show their efficacy. There is a huge battle going on now in the state of Washington between the makers of spinal cord stimulators and the people who implant them and the state of Washington technology assessment board about evidence for efficacy. It is a huge political battle with significant economic implications; each side argues that the other side’s studies are not useful.

You can’t teach multidisciplinary pain management outside of a multidisciplinary clinic so you need these clinics to educate the next generation. And as these have become scarcer and scarcer in our country it is harder and harder to get the appropriate education. One of the critical differences between standard healthcare and multidisciplinarypainmanagement is the requirement for the active participation of the patient. Many of our patients would like to walk into your office and lie on the table and say “cure me, doctor” and that doesn’t happen. Passive therapies are of no value and often education is a key component. In our healthcare system getting reimbursement for educational activities is extremely difficult. We believe that post-residency training in pain management must be based on the recognition that peripheral pains require different treatment strategies from central pains which are the result of errors in central pain processing. We think that pain training is often led by the wrong people in the wrong disciplines resulting in more and more people who wish to earn a living doing surgery and procedures which is really not the optimum way to deal with pain management problems.

Discussion

*It is really refreshing to hear again what I heard you talking about thirty-odd years ago. I don’t think that advice has changed. Here in the UK we have had similar problems; we are not quite in the situation of having many unidisciplinary clinics; most clinics, at least in larger hospitals have some multidisciplinary components to them.*

*One of the things that has changed practice is the national guidelines issued by NICE in the UK, first in 2016 and repeated in 2021, which said that we shouldn’t be using spinal injections for back pain. Interestingly, that has now stopped people having injections but a lot of people are having RF lesioning as an alternative. And so interventionist clinicians have changed tack and have now found alternative things to do albeit with sometimes limited evidence.*

*‘*Whatsoever king may reign I’ll still be the vicar of Bray, sir’*.*

*Do you think the spinal implants don’t work either?*

I put spinal stimulators in starting in 1964 when I was a resident and I have put a lot of them over the years. My experience would tell me that some patients do benefit. I am now so out

of date that I have to be careful what I say but in the last 20 years since I retired there are new technologies involved in SCS and the proponents argue that these have solved the problems. I have heard that one before. People think that the new technologies are always better than the old ones.

I think there may be a role for SCS but it is not a panacea because stimulating the spinal cord doesn’t change central pain states.

*Talking from the perspective of a street-level bureaucrat*  GP who sees *many people in whom the central pain state is paramount and if you would like to serve them all by multidisciplinary teams that won’t happen because there are too many of them. As an alternative I see that people do quite well with good social embedding, friendships etc. but they do that as their own journey and not as a service delivered by healthcare..*

*How do you reliably define that people have central pain states as there are no tests, no fMRIs. Their stories and their interpretation are very valid but people need validation by someone with consultant status and here comes the problem: in the hierarchy of pain who says this where the buck stops or stop escalating when the escalation system is built on professional qualifications. There may sometimes be the wrong people in the wrong place but they are the ones that dominate the symbolic order. I am not asking for a solution but as a GP gatekeeper I want to protect people from iatrogenic harm but in doing so I may be holding them back from something that may help them.*

I agree with everything you have said, but we have to start someplace. The pain world, in its global sense, has simply got to come to grips with the fact that the common human belief that there is something wrong where it hurts is an error. All pain is in the brain; there is no pain in your toe. There is a wonderful quote from Bertrand Russel who went to the dentist with a toothache, and the dentist asked “where does it hurt?” He replied “In my brain of course - does anybody think that a tooth can hurt ?” So you have brought up lots of issues and I agree with all of them but when you start within the world of pain practitioners and the people educating pain practitioners that is a good place to start. We can’t provide multidisciplinary pain care to everyone who says ouch – that would be crazy - and I think that is one of the roles for a primary care practitioner has got to be someone to figure out: is the kind of patient with a high impact pain problem that is not related to tissue pathology and needs to go to a multidisciplinary pain clinic or the sort of patient that can be dealt with by a single provider. How can you be certain that it is central versus peripheral? – I don’t have an answer to that, except that you can examine the periphery and if you cannot find any evidence that there is something there then you might want to think about central pain. And there are a whole host of diseases which are in the lexicon which are simply validations for the healthcare being provided. For example non-cardiac chest pain: a heart specialist can deal with that…but wait a minute, it’s non cardiac so what are they doing? Or non-specific prostatitis: ‘itis’ means inflammation and the rule for that diagnosis is no evidence of any infection or inflammatory disease in the prostate. So all that diagnosis does is to validate urologic care, it doesn’t tell you anything about the patient. So what does it mean? Every specialty has a non-disease that validates treatment and suggests that there is there is a peripheral cause for the pain when there is no evidence for it.

You have to start someplace and everybody has a role in trying to move sentiment and knowledge in the right direction rather than the situation in the US where we have needle jockeys who say “I can solve your problem - just let me give you a few injections”.

*When it comes to teaching students chronic pain shouldn’t be a specialist subject; it should be a core part of medical education. But it’s not getting into medical schools; certainly not its*  *multidisciplinary nature*. *Why* *is there so much infighting within pain which is quite a small specialty? Why is there so much polarization between the biomedical and the holistic approaches? Why do people have so much difficulty in accessing physios , psychologists, psychiatrists, OTs etc.? Should we not be the practitioners who can help people? We must get rid of the partition which obliges people to be passed to one specialist to another rather than a multidisciplinary approach.*

If you take apart multidisciplinary pain management you destroy it. I have seen many patients who have been through the progression you describe . Their care has not been integrated. Everybody feels a different part of the proverbial elephant. There is something about the wholeness of a multidisciplinary approach … it takes the right kind of person; some healthcare providers just can’t do it – they can’t allow other people to have a piece of the territory. I don’t know how you get into selecting healthcare providers – one committee I have not served on in our medial school is the admission one, because years ago I told them that my viewpoint was that first of all you administer the personality test, then you gave them a kind of intelligence test to make sure you get the smartest of the right people. It’s he other way round, of course. They do the IQ tests first and then they interview people. So I was never asked to serve on that committee.

But it’s also training: if you train in an environment where they can see the benefits of other kinds of people with different backgrounds playing a role in the management of the patient, that is how you get the right people. You can’t tell them; you have to show them.

*One of the things we need to do is to get doctors to change the way they describe X-rays in the language they usually do, because everybody will have some changes which imply that the pain is in the periphery. I saw two people recently who had a hip or knee replacement, and when they saw the surgeon for follow-up he said “now we have to think about the other side” . They said “but I’ve no pain on the other side”, to which the surgeon replied “the x-ray is worse so you will get pain there (!) and we need to put you on the waiting list because it is so long “. How do I deal with that?*

There is now a large body of literature that says that the findings on imaging studies do not necessarily tell you what the patient’s complaints are or explain those complaints, In our institution we have a very good radiology department and they mandate adding to every X-ray report of the spine saying such and such is the percentage of people your age who have the changes on your imaging studies and do not necessarily explain the symptoms you have. This goes on every x-ray report and is a godsend for dealing with the problem you are talking about. The other thing is that if you tell a person that they have a ruptured disc they see it as a bomb going off in their spine and something terrible. There is a lot that can be done to make people understand that imaging studies do not give the final answer to what is going on in their back.

Sometimes it’s humorous: some time ago I had pain from arthritis in my hand and my internist got a Dexa scan to see what my bone mass was. This was fine and full of calcium and then my X-ray report came back with demineralization of the bones in the hand. So I can pick and choose: which one do I want? Imaging studies are useful but they are not an essential part of one’s determination of a person’s status. Knowing the patient is much more important. When you’re my age radiologists go crazy with images of any part of your body – they’re all abnormal!

*Going back to what Jens was saying: the people at the top of the hierarchy quite often use that language more than those of us at the bottom and it’s very difficult then to argue a different case when someone has been to the very top in the pain clinic, who seem to be the experts, and to tell them something completely different.*

*I venture to suggest that this is likely to be a global problem: at least in America , the UK, and most of Europe. I worked in Africa for a few weeks every year, and towards the end of that time while we were still struggling to get a few doses of oral morphine to treat dying patients and post-op pain we were being approached by big companies who wanted to sell us long-acting morphine for treating chronic pain. So I wonder what the role might be of IASP with which you have been closely associated in the past - I know there are a lot of influences on IASP – in perhaps putting the record straight, or helping pain management develop in a more patient oriented way.*

That’s a wonderful question. But I need to remind you that I retired from clinical medicinein 2008 and am now out to pasture and have no role in IASP or any other organization, but I did have a large one for a long period of time. IASP is the product of its members and its leadership reflects their viewpoints . It is certainly the least procedurally oriented of the international pain world. We have the American Academy of Pain Medicin which sends out stuff all over the world; the World Institute of Pain, and innumerable organizations aimed at special aspects of the pain world. IASP remains the one global one. It has a big problem: raising money. This is much more difficult for an international organization than a national one because of the way healthcare is funded by manufacturers who want to sell their stuff in the English part of the world so they put their money in this rather than Yugoslavia or Azerbaijan because they don’t sell anything there, compared to America or the UK where you are in a discrete economic area and it is much harder to raise money. The National Institute of Health used to give some money to IASP functions but it is much harder to get money out of them. The WHO has done something in the right direction for the world of pain, but pain is not a big part of what the WHO is aimed at, which is more to do with disease, and pain, from their perspective, is not a disease. Could IASP get money to do these things? – yes, with the right leadership and the right support from members. It will happen, like in the very beginning IASP people said ; ‘get together with the WHO and do something about cancer pain’ , and led by Kathy Foley we really pushed that. So there is a potential role.

Much depends on the human beings who are involved and what they want to they want to put their efforts into; and the money available to do things. Money for professional organizations, particularly in the US where there is scandal after scandal where the commercial world has infiltrated into the professional world (a large proportion of the doctors in this country are being paid by drug and device manufacturers) it’s astounding that there are a lot of issues involved . Yes, IASP could and should play a role but who is going to fund it?

*Can I ask you about the MBT approach? How did that work? Did the patients sit with a lot of clinicians in the room or see them one at a time?*

This may be ancient history but we started by acknowledging that not all patients are amenable to this sort of care so we screen patients by having them seen by a physician, a psychologist and an OT or social worker and evaluate them from each of their perspectives and enquire about funding - you have to have funding for any healthcare in our country. It will take a morning to see the patient, their spouse and providers and to decide if they are suitable for our program. The hit rate was around 50 or 60%. Our program was for three weeks for a 20-patient group, divided into two groups of 10 which overlapped so we always had patients in the middle of treatment when the new ones came in. We had a highly structured regime which involved physical activity , psychological , social and educational components - everything but the kitchen sink. The role of the physician was to re-educate the patient about what was going on in their body so we would sit down with them at the start with all their X-rays and explain to them what they meant and didn’t mean, and any other biologic issues. The psychologist’s role was to work with the patient to try to gain some understanding of his or her behavioural responses in relation to pain. That was on an individual basis and as a group they had physical, educational and psychological time. Everybody involved in caring for the patient was aware of the whole programme and its Gestalt. The patients were busy from 8.30 in the morning till 5.30 in the afternoon for 19 days. We relied a lot on group activities. It was amazing to see what happened – people were so responsive .One of our activities was walking; we had a hallway about 25 yards long and we knew from past experience that the average male could do that in about 19 seconds and the average female about 22 seconds because men’s legs are longer and we would set that as a target, if at the beginning of the programme it took someone two minutes. Everybody would be out there cheering them on and encouraging each other which was the kind of thing we did as much as we could. When we had patients with specific problems, for instance with their right arm, we would give them tailor-made right arm exercises. We had an OT area where all sorts of models of what they would do at work, so we could get people doing something as close as possible to their occupation, and at the end of the programme they could show themselves that they could do it. It was all about function and we never asked them about their pain level during the day, but if they came in with a pain level of 7 or 8 and they were taking X amount of opioid, and we plotted that and their walking speed on a graph; and their pain and their walking time went down and their exercise activity went up! So we could show them the graphs and show them that every day they were doing more and hurting less. We didn’t cure people but we reduced the impact on their behaviour, and that was what mattered.

I tumbled into this from my neurosurgical practice: one of my residents said to me : “Dr. Loeser, why is it that you operate on a patient and he is out of bed the next day and goes home in three days and Dr X does the same operation and is ion hospital for a week?” So I told him that when I see the patient I ask him: ”how many laps around the nursing station can you do today? You can go home when you can do three laps”. But what Dr X asks is : “how is your pain today?” .Sol if you ask someone about pain they are going to think about pain. We need to change the behaviour of pain doctors and that needs a change in the way we educate them. There are a lot of problems and I realise I am perhaps being a bit utopian, but we do need to move in that direction.

*What you have been saying applies 100% to most patients who eventually get to be seen in pain clinics, usually about five years or more after the initiating event but when I was in practice I believed in the concept of peripherally initiated pain and central maintenance of pain. And I think a lot of us believed in those days that intervention was of some value if you could use it to prevent central excitation. A prime example of this was post-herpetic neuralgia. I don’t know if this is still regarded as a justification for early intervention? This is arguably of some practical value as epidural steroids or facet blocks giving temporary relief can facilitate participation in physio or exercise regimes. In practice, of course, early referral and rapid response to this hardly ever happen, at least in our NHS*

First of all, PHN is a lousy example of what I am talking about because in the acute eruption of the viral infection the skin is traumatized and there is nociception. Long after the vesicles have healed and the patient has pain that is clearly central. Historically, my colleagues in neurosurgery tried to help but there are records of patients with PHN in a band around their chest in whom the first thing they tried was excising the skin and performing a skin graft which didn’t stop the pain. Then they did a neurectomy of the intercostal nerves and that didn’t stop the pain either. Then they cut the dorsal root, then a cordotomy, then a thalamotomy and eventually a cortical excision but nothing stopped the pain. Regarding the time issue: my wife had bad right hip pain for five years but I had trouble getting her to see a doctor about that, but eventually she had a total hip replacement. In the recovery room she told me that she had bad incisional pain but her hip pain had gone. It had been there for five years and I presume you would call it chronic as that was a lot longer than 90 days, but nevertheless it was peripheral. That is why I don’t like acute versus chronic. To go the other way, I had a patient with post-stroke hemibody pain from the day of his stroke for the rest of his life. Was this an acute pain for 90 days then it becomes chronic? – but this is a central pain from the word go. In this case we do know where an anatomic lesion is the cause of central pain but that is not usually the case.

This whole area is not nearly presented clearly enough to our students and, unfortunately most young doctors have the strange idea that the truth is what their professors told them and that perpetuates errors over and over again. I am personally trying to do something about that. I teach an undergraduate honors course on pain - 25 students, undergraduates of every kind; this is not a pre-med course - in a seminar in the spring quarter. I have done it for 13 years, and I have this ridiculous hope that by adding 25 more educated people out there I can seed the population with people who recognize the need for change. It is an uphill battle but it’s been fun and I keep at it.

*I agree entirely with your comments about nociplastic pain vs. chronic primary pain. When I explain it to patients who have central pain I use the phrase ‘nerves behaving badly’ to join all that lot up. It is a phrase that I have found incredibly useful and I think it works well because talking about nerve ‘behaviour’ suggests that the problem may not be structural and possibly caused by something that may be peripheral due to trauma in life, but there is a cause for it. The other thing about behaviour is that it is often remediable, and suggests that the nerves can be trained to behave in a different way in a different context. I explain that to patients (as a lone clinician although I work in a multidisciplinary team, and often refer on to that team ) and for many of them it is sufficient to know that they have central pain, which can explain all the things that have happened to them in life, which are often very unfortunate and complicated; and they are happy to go away without any further rehabilitation to carry on with all the physios and perhaps a psychologist. I have taught them and the fact that they understand that they have central pain is sufficient.*

That’s right on target. It is causing the patient to reframe what they think their symptoms are due to. I like this idea and it is a wonderful approach.

*In a small proportion of patients you don’t need to do anything else. And some people will ask: ‘why didn’t someone tell me this 15 years ago?’ , because they have had this problem for all this time*.

Although that is brilliant there are some people who will reject that out of hand and will say ‘I *know* there is something wrong in my back ‘ and unfortunately they can usually find someone who will act thereupon.

*It doesn’t work for everybody but there are a group of patients who whom it is a revelation that that can happen and it fits in perfectly with their life experiences*

*I think it is beautiful because it doesn’t have moral implications or connotations. If you tell people that pain is in the brain they may think you are suggesting that theirs is ‘psychological’ or ‘in their mind’ but if you don’t say it they may feel rejected. But Tim is fortunate that he can say that from his position on the top of the symbolic order and it would probably not go down so well if said by a nurse or a priest or somebody else; you need to be in his position to have more impact.*

*I would agree with that but I will only say that to a patient after I have spent an hour talking with them and mostly listening to them and showing them that you understand; the gravitas and the status is important but all too often we clinicians are guilty of not listening to patients and prescribe a treatment but if you haven’t understood the problem or have given the perception that you haven’t understood the problem there is no way anyone is going to take you seriously. But if you have listened and fitted in the story to the pattern of symptoms and explained how that can happen it is often accepted.*

*I would like to suggest that that is not a particularly good idea for several reasons: (1) People will often go back to their GP’s and say “ this very senior person has told me it’s just my nervous system behaving badly, and that encourages the GP to prescribe Gabapentin and other compounds for neuropathic pain with low efficacy.(2) It assumes that we know the mechanisms involved in central pain. I was fortunate enough to do my PhD with Pat Wall and Steve McMahon, and we debated long into the night on many occasions things like whether we really know in any clinical setting that long-term potentiation or central sensitization or any other central mechanism were actually responsible for anybody’s actual pain. I don’t think we have got any further down the track since I did my PhD . We have to be careful because if we say that all pain is in the brain – and I would prefer to say that pain is in the person – that centralizes even nociception and the brain is part of the nervous system. So we are creating a huge amount of conflation in the messages we give to people, whereas eventually we consider that pain is something that is actually constructed at the level of the person and all other things are essentially pathology in the CNS which is still part of the nociceptive apparatus as is the thalamus. So it is a huge problem - which is not to say that I wouldn’t debate any clinician’s right to say what they felt was the best thing in any situation to an individual person; but I’m not sure that some of these things are always true. particularly from a philosophical point of view. To say that all pain is in the brain, centralizes even nociceptive pain.*

Are you going to tell me that speech is not in the brain because it comes out of your mouth?

*I’m not arguing … I do not believe that the brain is either … it is certainly necessary for the pain experience but is not sufficient for that, nor is any nociceptive apparatus. Actually having embedded a person into an environment is what constructs their meaning of pain and probably influences their experience. I think we may be arguing the same thing … we are all influenced by our own model of pain …an extended or embodied model of pain fits perfectly with your own model. I’m not defending anything – we can’t study flight by looking at a feather. We can’t study pain by only looking at nociceptors or only looking at the brain. I was lucky enough to be able to study post-op neuroimaging which shows nothing and still doesn’t explain an individual’s experience of pain.*

I agree with you that it is an embedded phenomenon - there is no pain without a person, so to speak. I probably didn’t have as many hours with Pat Wall as you did but I had my share. Brilliant as he was, sometimes he was wrong.

You are raising a higher level of issue. There are physiological and pharmacological steps that we can begin to take apart so we can understand the sensory processes that are involved in tissue damage but taking them apart doesn’t give you the end result but it does give you a component, and you can learn can learn something about how the system works even though you can’t predict the ultimate outcome. To reframe the discussion: the complaint of pain is an interesting social behaviour the meaning of which remains to be determined. When Mrs. Smith says ‘I have headache’ the role of a healthcare provider is to figure out what she means. And sometimes that complaint can be related to what we do understand about how the body works, and sometimes it can’t. But it is worth trying, and trying to break it down into the pieces you can understand. in the hope that someday we will be able to put them back together again and get the big picture. We do not have that today.

*As Tim was saying, having spent an hour listening to the patient before saying what he said; he is clearly is an example of the selection of the right person being trained as a doctor. He listens to the patient before he gives an explanation which the patient is able to take in and accept. The personality of the doctor is important as the patient’s. This applies to physios and anybody else in a multidisciplinary team.*

*I would like to make a distinction between helping people with suffering and helping people’s pain because they are not the same and people can have a lot of pain but they bear it and are not suffering, especially if they know why they have it and there is nothing they can do about it. Other people suffer with pain that no-one seems to know what to do about. So the problem is that the patient has a learning problem: they haven’t learnt what to do about their pain. You know what to do about a sprained ankle, for instance, which is to minimize movement until it has healed whereas with chronic pain you have to move instead of avoiding movement for fear of hurting. This is to do with anticipation of future events or the long-lasting impact of previous events. That is all in the imagination and the imagination is constructed within the image we have of ourselves – we all think we know who we are, why what we are doing what we are doing, where we are going etc. etc. This may not always be the complete truth but it gets us through until it doesn’t. And pain brings us up short and says ‘just a minute - stop doing something. The problem with chronic pain is that it is too intense and you can’t put it into words and expecting them to talk about it I the worst thing you can do so you are quite right: don’t talk about the pain, put their minds on the future and success.*

*…..*