WHAT IS CHRONIC PAIN?

JOHN D. LOESER

Department of Neurological Surgery
Multidisciplinary Pain Center, University of Washington
School of Medicine, Seattle, WA 98195, USA

ABSTRACT. Chronic pain leads to individual suffering and to major costs for all developed countries. Previous studies suggest that both the incidence of disabling chronic pain and the amount of health care consumption due to chronic pain are rapidly increasing. Western medicine is not only often ineffective but may be one of the causes of this epidemic. This article will address the issue of chronic pain of unknown etiology and has the goals of: (1) identifying the factors which have led to our confusion about this topic, and (2) proposing alternative ways of conceptualizing chronic pain and its ensuing behaviors and social consequences. It is concluded that it is essential to discriminate between tissue damage, pain, suffering, pain behaviors, health care consumption, impairment and disability if one is to develop a meaningful conceptualization of the medical, social, economic and political problems of chronic pain. Successful treatment must be defined in behavioral terms such as restoration of normal activities. Disabling chronic pain is often a sign of overwhelming stress engendered by the individual’s failure to cope with the demands of industrialized society.

Key words: behavior, epidemiology, concepts of pain, disability, health care consumption, impairment, nociception, pain, suffering

INTRODUCTION

Throughout the written history of the Western world, physicians and their roles in the promotion of health and alleviation of pain and suffering have been described [1]. In the past 40 years, pain management has become a specialty within medicine, suggesting that what every physician knows is no longer adequate to bring modern concepts and technologies to bear upon the patient and his or her problem. Although it is easy to focus upon the rapid development of new drugs and pain treatment techniques, they are mainly applied to the management of post-operative and post-traumatic pain and that due to cancer; these do not appear to be the problem areas in the developed countries. Not that health care in these areas cannot be improved, but the issue is dissemination of available information and technologies, not the failure to understand the pathogenesis and to establish rational treatment strategies [2]. This article will address the issue of chronic pain of unknown etiology and has the goals of: (1) identifying the factors which have led to our confusion about this topic, and, (2)
proposing alternative ways of conceptualizing chronic pain and its ensuing behaviors and social consequences.

It is important to recognize that what I choose to label as "pain of unknown etiology" is often given a highly specific diagnosis by other health care providers. Suspiciously, such diagnoses commonly legitimate the type of therapy the provider is licensed to utilize. A group of providers labels the same patient as suffering from pathology in different structures and suggests treatment strategies which are disparate. An interesting example is the patient with chronic low back pain who slipped on some grease at work and landed on his buttocks. Four years of medical evaluation and treatment have not established a reasonable diagnosis and have failed to restore him to gainful employment. Nonetheless, several of his treating physicians have described their management as "partially successful", or better, on the basis of some measured improvement in range of motion, reduction in medication consumption, or affective improvement. His medical chart lists different diagnoses from five specialists (to say nothing of his naturopathic and chiropractic diagnoses and treatments). The offending broken part has been identified as lying everywhere from the limbic lobe of the brain to the intervertebral disc, to small ligaments of the back to chronic, recurrent strain/sprain of muscles, to the role of environmental factors at the home and workplace.

It is reasonably well established that in less than 15% of the patients with low back pain can an accurate diagnosis be established [3]. Honest appraisal of the myriad of patients who claim disability due to chronic pain leads to the recognition that the pathogenesis of this syndrome is largely unknown. It also leads to the conclusion that factors outside the patient's back are likely to be relevant to his or her pain behavior and disability. Finally, treatment outcome statements which do not relate to behavioral change are often of little relevance to the patient's well being or society's costs.

CONCEPTS OF PAIN

Sir Thomas Lewis, the great British physiologist who spent his professional life studying pain, was unable to define it when he summarized his studies in a book ([4], p. v). His difficulties were the legacy of Descartes; health care delivery has been plagued by the fallacy of Cartesian dualism for over 350 years. In 1979, the International Association for the Study of Pain (IASP) offered this definition: "Pain. An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" [5]. The second phrase of this definition leads to the important recognition that "pain is whatever the patient says hurts". The problem for a health care provider is to