

## The denial of chronic pain

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There is a current disconcerting trend towards dealing with chronic pain and its subsequent disability by denying its reality. The reason for this has primarily been cost containment and cost reduction. The monograph on Back Pain in the Workplace probably best reflected this philosophy wherein pain was defined as activity intolerance and disability as unemployment (1). Recently Bill 99 in the Ontario legislature has put forward changes in the Workers' Compensation Board's provision that, in essence, limit patients' medical and compensation entitlements to anywhere from six to 13 weeks depending on the nature of their job. Responsibility for rehabilitation and getting the employee back to work would be transferred to the employer. Undoubtedly, accommodations by employers are essential in enabling injured workers to return successfully to some form of employment. However, under the new proposal, the employer is only responsible for trying to provide suitable or comparable work, and the temptation to deny workers' injuries, particularly in nonunion environments, will no doubt be high.

This approach is a radical departure from previous policies. Models of chronic pain management through denial are based on the proposition that chronic pain occurs as a consequence of compensation and inappropriate treatment. Moreover, they emphasize the outmoded concept that soft tissue injuries heal after six weeks, and they cling to increasingly irrelevant behavioural models of chronic pain.

The irony of these developments is that they come at a time when we understand the physiological basis of chronic pain better than ever before. As well, the concept that chronic pain is largely secondary to compensation or psychological factors has been largely refuted. Scientific evidence of a physiological causation for ongoing chronic pain is well recognized (2-4), and even the biopsychosocial model recognizes the importance of organic factors in chronic pain.

Chronic pain disorders generally develop after a repetitive low impact type of trauma or a single high impact trauma. Much of the debate regarding persistent pain revolves around the normal anticipated time for musculoligamentous healing to occur. There has long been a misconception that all injuries should heal after six weeks. This rationale is based on a few animal studies and the clinical experience that the majority of injuries do improve within six weeks (5). However, clinical experience and follow-up studies (6,7) clearly demonstrate that not all patients necessarily get better and that there is a significant subset who continue to suffer from chronic symptoms. Some become disabled, depending on both pain intensity and psychosocial factors, such as the type of employment in which they are involved.

Ironically, in sports medicine it is well recognized that many professional and nonprofessional athletes have longstanding injuries that are soft tissue in nature, which do not get better with time or which require many months of therapy and abstention from sports. Such injuries have terminated many promising careers. The legislation in Bill 99 for the Workers' Compensation Board of Ontario proposes standards for injured workers that could not be met by many professional athletes, despite that they are highly motivated and in top physical shape, have the best medical care and trainers and receive full compensation even when injured. Fortunately, such individuals are not included in this proposed legislation, which, if extended to prominent athletes, would result in a public outcry.

The evidence that chronic pain has an organic etiology is growing and has become increasingly compelling. In the area of whiplash injuries, the work of Barnsley and associates (4) in Australia has been particularly interesting in that they were able to demonstrate that when local anesthetics are used to block cervical facets

joints, a majority of appropriate patients experience reduction in their pain far in excess of that from placebo injections. In addition, Lord et al (8) have shown in a controlled trial that percutaneous neurotomies denervating these same facet joints will significantly reduce or eliminate the pain of these individuals for longer than six months. It is interesting that this highly impressive research is largely ignored outside of, and to some extent within, the academic community (5,9).

There is also impressive evidence of significant biochemical abnormalities in disorders such as fibromyalgia; three independent studies demonstrated levels of substance P in the cerebral spinal fluid that were two to three times those in controls (10-12). As well, we know that, based on animal data, there is significant evidence of neuroplasticity in the spinal cord in response to pain stimuli, which could account for the clinical picture of regional pain syndromes (3,13). In these conditions, neurotransmitters such as substance P have also been implicated. More recently, altered regional cerebral bloodflow has offered opportunities to document a physiological concomitant of the patient's pain experience (14). Despite this impressive collection of physiological evidence about pain, the scientific evidence does not appear to be reaching legislators or clinicians who seem determined, based on ideology, to impose draconian alternative paradigms to deal with chronic pain and, in particular, its associated disability.

To justify such an approach, psychosocial factors are often implicated as causative. However, a wave of recent research has demonstrated that psychological factors are more secondary to pain than causative (7,15-17). The high incidence of psychological problems seen in tertiary care clinics reflects tertiary care selection biases, and the literature, which largely arises from such clinics, clearly also displays this bias (18). In fact, the problem may be more related to the chronic pain patient's unwillingness to accept (and subsequently adapt to) their pain and its limitations (19). Psychological difficulties occurring as a consequence of the pain and subsequent disability are often misinterpreted as causative.

Individual coping mechanisms vary but this is true in any medical disorder. Patients with rheumatoid arthritis can have significant psychological difficulties, and it has been suggested that psychological factors contribute to rheumatoid arthritis pain and functional disability, independent of disease activity (20,21). Among spinal cord injured patients with pain, over one-third of those who stopped working after the spinal cord injury said it was because of their pain and not their paralysis (22). Interestingly, pain was regarded by these patients as a significant cause of work disability, even when the individual had a more 'acceptable' alternative explanation (ie, paralysis) for work disability. It also suggests that in some patients, pain is regarded as more disabling than paralysis/paresis.

The controversy about chronic pain and disability is inevitably tied to perceived secondary gain and the availability of compensation. Recent data suggest that compensation is important, particularly in terms of the number of claims, but that its importance has been overrated in terms of pain because it accounts for only a small degree of the variance seen (6% in one meta-analysis [23]). Its effect on claims is gradational, an expected relationship. On the other hand, 'secondary gain' is a vague term that has never been well explained (24). Anybody who treats these patients regularly realizes that the concept of secondary gain also has to be coupled with secondary losses, and most of these patients continue to have pain despite that secondary losses clearly exceed secondary gains (24,25).

It is most disconcerting that the patients who will be affected by changes in legislation are those shown to be at highest risk of disability – namely those in lower socioeconomic groups, in particular those who are poorly educated, who lack transferrable skills, are older and who are more likely to perform heavy or repetitive physical labour (26,27) – most of whom would be classified as 'blue collar' workers or the 'working poor'. Many are immigrants with limited communication skills and/or working women who appear to be more susceptible to developing conditions such as repetitive strain injury, fibromyalgia and myofascial type pain. Attempts to deal

with chronic pain disability as a social problem will serve only to target individuals who are especially vulnerable to withdrawal of support. This vulnerability is further enhanced by significant changes in the availability of work for individuals without specific technical skills and a decreased willingness on the part of employers to accommodate or compromise the workplace for injured workers. This is not only true for chronic soft tissue type pain but also is reported in conditions such as rheumatoid arthritis (20).

Canada is becoming increasingly less sympathetic towards the weak, the poor, the injured and the disadvantaged. This Darwinian mindset sees such individuals as a drain on society and, in particular, contrary to the economics of profitable business. Certainly the cost of disability is an important factor that must be considered. However, we seem to have crossed a threshold where it is increasingly acceptable to demonstrate a lack of empathy or compassion for anybody who is injured and, in particular, those who have chronic pain. Governments not only fail to display compassion for injured workers, but displaying such compassion is seen as weakness for not staying the course of significantly reducing direct costs. As health care professionals and researchers we have an obligation to point out to our politicians and society in general that there is a significant human cost to proposed policy changes. Short-changing people when they are most vulnerable is going to increase suffering markedly while simultaneously swelling the welfare roles and transferring the problem to other jurisdictions. Although such measures may well force some individuals to return to work who might not have otherwise done so, the fact is that the vast majority of individuals are likely going to end up without resources at a time when they need them the most. Knowing what we now know about chronic pain, such an approach clearly strains the ethical responsibilities we have for individuals in our society who are limited by chronic pain.

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