When Pain Persists: Implications of a New Chronic Pain Report

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With all the debates and foot-dragging on the order of Richard III as to where health care needs to go, I get the unmistakable impression that much of the true conscience of American medicine lies within recent reports from the Institute of Medicine.

Just a decade after having released its groundbreaking and eloquent treatise arguing for the reconstruction of the American health care system from the ground up, with an emphasis upon prevention, the IOM has struck again with a new and important conceptualization of chronic pain.

For far too long there has been hand-wringing over the fact that a minimum of 116 million Americans experience chronic pain every year, with a national cost ranging between $560 billion and $635 billion. This turns out to be a conservative estimate because children and military personnel have not been included.

Prevention and pain treatment are thwarted by inadequate treatment, delay or outright inaccessibility of health care.

Chiropractors, are you listening? There are five basic concepts in the IOM report, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, that relate to the chiropractic profession directly:

- *Chronic pain can be its own disease*: Because neuroplastic adaptations to an initial episode of pain occur, chronic pain turns out to have a distinct pathology unto itself. It causes distinct changes in the nervous system that often worsen over time and has significant psychological and cognitive correlates as well.

- *Comprehensive treatment with an interdisciplinary approach* is often needed for prevention and management.

- *There are distinct roles for both patients and clinicians*: The effectiveness of pain treatments depends greatly upon the clinician-patient relationship, never upon the clinician alone.

- *Chronic pain requires a public-health and community-based approach*: Large numbers of people are affected with disparities in occurrence, treatment, and prevention, all of which clearly make chronic pain a public health issue.
• There are transformations in pain perception: This is experienced by both those suffering from it and those treating it.

From these principles evolved a number of directives from the Institute of Medicine, including the following: 2

• A population-level prevention and management strategy is needed: Specifically, Health and Human Services should develop a comprehensive plan with specific goals, actions, and timeframes. Better data are needed to help shape these efforts, especially for groups of people currently underdiagnosed and undertreated. To address this issue, federal and state agencies as well as private organizations need to accelerate their data collection on pain incidence, prevalence, and treatments.

• There must be an awareness that pain varies from patient to patient: This means health care providers should tailor pain care to each person’s experience, an element that more and more is being recognized as being an integral part of the evidence in evidence-based medicine. 6

• Federal agencies and other stakeholders should redesign education programs to address gaps in knowledge: Implicit in this directive is the need for interdisciplinary recognition, cooperation and respect.

• Given the burden of pain in human lives, dollars, and social consequences, relieving pain should be a national priority.

sharp pain - Copyright â Stock Photo / Register Mark The areas of overlap of these missions and directives with the mission and practice of chiropractic are both numerous and meaningful. We could begin with the root theories of none other than D.D. Palmer, who expressed:

"Life is the expression of tone. In that sentence is the basic principle of chiropractic. Tone is the normal degree of nerve tension. Tone is the expression in function by normal elasticity, strength and excitability of the various organs as observed in a state of health. Consequently, the cause of disease is any variation of tone – nerves too tense or too static." 7

This wording is nothing less than the ground substance of the Institute of Medicine putting the focus upon the nervous system’s adaptation to (and transmission of) pain. We can then move through the 35 years of the most rigorous outcomes research on acute and chronic low-back pain and, following the latest synthesis of findings, which has been shown to yield the best and most clinically meaningful evidence, demonstrate that spinal manipulative therapy is in fact recommended for most patients with acute and chronic low-back
pain.\textsuperscript{8-9}

The inescapable conclusion when you combine the history and capabilities of chiropractic with both mandates from the Institute of Medicine\textsuperscript{1-2} is to promote chiropractic to the ranks of first health-care provider in instances of chronic low back pain in the absence of red flags. Under the same conditions, the same could be argued for even nonmusculoskeletal conditions\textsuperscript{10} – all in the interest of the early, noninvasive, and cost-efficient intervention to manage pain and thus satisfy the directive of the Institute of Medicine.

While most patients do not yet regard chiropractic as a means for establishing maintenance care – despite recent key studies providing supportive evidence worth noting\textsuperscript{11-12} – an interesting directive has recently been put forth by Floreani, who suggests that chiropractors would do well to develop and disseminate the concept that they may be in an ideal position to deliver well-being care, strengthening the capacity of the body to live well.\textsuperscript{13} What can be said about chiropractic in its current state is that it adheres closely to models of patient-centered care,\textsuperscript{14} precisely what has been mandated by the Institute of Medicine.

Put quite simply, adhering to the principles of the Institute of Medicine should be of considerable benefit to chiropractors, naturopathic physicians, acupuncturists, applied kinesiologists, homeopaths, and other health care professionals who have gone on record as attempting to serve the needs of the entire patient in an early and more readily treatable stage of dysfunction, if not altogether preventive. Such is not to absolve each of these health care professions of total blame, however, for, like orthodox medicine, each has shown that it is in need of meaningful interdisciplinary collaborations in order to achieve these ultimate goals as stated in the Institute of Medicine reports. Continuing policies of arbitrary and capricious exclusions of health care alternatives in both insurance reimbursements and practice would mean nothing more than that the Institute of Medicine’s recent efforts have gone for naught.

References


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