The modern pain clinic

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Pain relief clinics have evolved along two major philosophies. In Canada, Australia and Western Europe a medical model approach (symptom = disease → "cure") has encouraged anaesthetists to become involved in and ultimately direct pain relief clinics. These clinics have concentrated on technical skill at nerve blocking, destructive neurosurgical procedures and sophisticated pharmacological manipulation. Outpatient management has been the rule with relatively little follow-up. Most research efforts have been drug-based.

In the United States the emphasis has been mainly psychological and, generally speaking, the focus of management has concentrated on improving coping skills. Thus relaxation, stress management, behaviour modification, drug withdrawal and various forms of psychotherapy have been utilized, usually without any major input from physicians. Inpatient management for extended periods is common.

A third approach using "traditional" medicine and initiated by the increasing fascination of the West by the East includes acupressure and acupuncture, various forms of massage including reflexotherapy, transcendental meditation, herbs, music and colour therapy and numerous types of stimulation. Many of these (e.g., TNS, acupuncture) have been incorporated into one or both orthodox treatment programs. Others are used only by enthusiasts or remain "on the fringe."

Until recently there were no objective assessments of efficacy of treatment — each group claiming that theirs was the only way to treat chronic pain and that all others were at best naive and at worst, negligent. Recent prospective and retrospective studies of chronic pain patients are notable for the appallingly low success rates of all treatment modalities. Adverse effects are common, ranging from permanent physical harm (paralysis, incontinence, dysesthesia) to iatrogenic drug addiction and including disrupted families and suicide.

Anaesthetists often fail to recognize mental illness even when "primed" to look for it.^{1,2} Other specialists also fail to recognize, or even look for, anything other than organic reasons for symptoms.^{3,4}

The only clinics which have produced convincing evidence of long-term efficacy with minimal harm are those employing a multi-disciplinary approach to treatment and a comprehensive assessment before any treatment plan is devised.⁵⁻⁸

It is clear that the single specialty clinic, whether that be anaesthesia, psychiatry, rehabilitation, etc., does more

harm than good and "success" rates are significantly worse than simply leaving the patient alone.⁹

Comprehensive assessment of patients complaining of chronic pain reveals major problems in all areas of their life and includes over-dependency with abnormal illness behaviour, marital and sexual disharmony, drug abuse and mental illness (usually depression) as the rule.¹⁰⁻¹² Physical disease is uncommon and if present is rarely important as a cause of symptoms. Doctor-patient and doctor-doctor relationships may become seriously disordered when chronic pain is involved and may make treatment of the patient in isolation impossible. Most patients have significant reinforcers to remain sick.

Such complicated patient-relative-doctor triads are unlikely to improve with a simple approach and require multidisciplinary management for any success. Traditional medical treatment may make the situation worse by reinforcing abnormal behaviours, altering coping and expectation, distorting relationships, and producing iatrogenic disease which is often permanent. Treatment of the patient alone may be totally ineffective, so should involve relatives and sometimes the involved and enmeshed physician.

Care of the careers is also important and may make a fee for service approach uneconomic since even assessment requires a very heavy investment of time and may most nearly be compared to psychotherapy in its emotional demands. Multidisciplinary treatment is very staff-intensive and may require many personnel simultaneously to achieve success. Personal experience in Canada indicates that few if any provincial health care providers are willing or able to fund such a complicated and expensive effort, even though there are ample studies to suggest that in the long term these are very cost effective, not least in the reduction of health care consumption by chronic pain patients. In the foreseeable future multidisciplinary pain clinics are unlikely to feature largely in Canadian health care or anywhere else in the world without substantial support at government level.

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