We hear and read every day that medicine is in turmoil. At medical meetings our colleagues voice confusion, anger, and disillusionment. No practice or hospital seems secure. Tales abound of hospitals and practice groups shutting down and doctors leaving medicine for new careers or early retirement, and doctors advising college students not to enter medical school. Despite this manifest anguish and the negative picture from the inside, the practice of medicine apparently continues to attract wonderful young men and women to its calling. Our admissions offices in medical schools are besieged by many of the most capable college students, who are not only very bright but also truly dedicated to helping others. How can this be? I would propose that students continue to be attracted to medicine because of the unique position of physicians in the human experience. Our minds and hearts both can find a completely integrated expression in the personal encounter between the patient and his/her physician.

The problem of pain as both neurophysiological event and as human suffering is a core dialectic of this physician experience. If one considers when in the course of our evolution the event of pain became particularly human, one must consider its profoundly personal qualities, the reverberation of pain throughout consciousness, or suffering. Suffering is at once profoundly personal and private, but also the most poignant of interpersonal states. After all, some of the language with which we define those interpersonal aptitudes we consider most human, for example “empathy,” implies a capacity to understand, and even to experience, suffering in others. This is perhaps the instinct that draws us most powerfully to medicine and to the role of healer. Nowhere in medicine is empathy more needed, but often so difficult to sustain, than in the care of patients with unrelenting pain. Behavioral scientists have made important gains in helping us understand this encounter and how to use this understanding to help patients recover from debilitating pain.

Medicine also challenges our inquiring, scientific intellect, also uniquely human. The problem of understanding the neurophysiology of pain and the pain experience has challenged many of the best minds of medicine, and the response has been magnificent. We possess a detailed knowledge of the physiology and pharmacology of acute pain, and are beginning to peer into the molecular neurobiology of chronic pain disorders. And as these processes are revealed in this work, the separation of mind and body no longer becomes scientifically tenable—they must be considered inseparable. This knowledge has translated into new treatments that are highly effective. When I started medicine as a primary care physician in rural Colorado, our outpatient pharmacologic treat-
ment of chronic pain was limited to aspirin, acetaminophen and occasional use of opioid analgesics, whose use was strongly discouraged. We often relied on scientifically unsound theories of psychological causation of pain because we did not know enough about its pathophysiology. Today, pain medicine is armed with a plethora of effective pharmacologic and interventional treatments, including newer opioid preparations that we now understand how to use effectively.

Pain medicine must now find ways to translate these advances into practical and effective treatment of patients in the primary care setting. This issue of The Medical Clinics of North America provides a sample of the latest science and many treatment advances in various pain disorders, and some perspectives on the organization of medicine as it affects our ability to provide good care for chronic pain. I owe thanks to Peter Wilson at the Mayo Clinic, an esteemed editor and leader in pain medicine, for persuading me to be Guest Editor of this volume. Heather Cullen at Saunders has been both patient and persistent in helping me persuade recalcitrant authors, including the editor, to complete their papers. Colleen Healy, my editorial assistant, has been enormously helpful in contracting authors and managing communications. Alan Schwartz, an honored teacher and practitioner of primary care medicine kindly lent his perspective to our work in the Foreword. And, of course, I am immensely grateful to my colleagues who took the time to write these papers to a deadline, probably time extracted from their personal lives because of the incredible demands of academic medicine and medical practice.

ROLLIN M. GALLAGHER, MD, MPH
Guest Editor

Comprehensive Pain and Rehabilitation Center
MCP/Hahnemann School of Medicine
Broad and Vine Streets, Mail Stop 403
Philadelphia, PA 19102