Consequences of Misunderstanding Pain—
And Another View of “The Emperor’s New Clothes”

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The authors of a manuscript that I peer reviewed recently for JMCP played the common drumbeat that pain is undertreated in the United States (despite consuming 80% of the world’s opiates, 99% of the world supply of hydrocodone and two-thirds of the world’s illegal drugs). From my perspective in practice in a rehabilitation hospital, pain seems rarely undertreated, and then only briefly—except where the assertions of pain are very disproportionate to the reasonable explanations for pain. I cover the practices of the other doctors at the hospital; so, I see what everyone else is doing. And, more importantly, I see their patients. And here is what I see.

I see that nearly all of the standard patients (i.e., those with clear explanations for pain and reasonable proportion between explanation and complaint) report that their pain is being well-treated. I also see a smaller percentage of patients who have an undiagnosed condition (either present at admission or developed while at our hospital) and who report that their pain is not controlled in spite of medications while the condition is progressing. Not surprisingly, these patients respond to accurate diagnosis—not heaping on more pills. And last, I see a modest, but critical, percentage of patients with chronic, poorly-explained pain who “always” seem to have pain ratings in the range of 6 or more, no matter what medications they take. And, these patients tend to rate their pain at 6 or more chronically, and complain of their misery chronically, no matter what their providers do.

These latter patients fall into 2 groups: (a) those who constantly appear depressed and anguished and (b) those who have high pain ratings while munching snacks and watching television. In the former, depression is probably the main chronic condition; in the latter, addiction is probably the main chronic condition. Notably, they are NEVER labeled as being addicted in the chart. Addiction is a “persona non grata” diagnosis, and I seem to be one of the few physicians who uses it. No matter what is going on, no one ever carries this diagnosis as an active problem—not even when the family says this is the problem; not even when the patient’s drug consumption is dramatically and chronically out of character for the condition; not even when a Division of Occupational and Professional Licensing (DOPL) drug database report reveals very “concerning” results; not in any condition. The diagnosis of addiction is simply bad business—it generates hassles and threats to market share.

We live in a country which spends 16% of its gross national product on health care, by far the highest proportion in the world, and yet purveyors of all manner of health care services argue that we’re doing too little. How is it plausible that the United States accounts for less than 5% of the world’s population but consumes 80% of its opiates and yet “pain is undertreated?” Nutritionists have observed that Taco Bell builds its business in a country where obesity is rampant and progressing and yet it has the audacity to run an ad campaign arguing for “The Fourth Meal.” Is this a similar dynamic for asserting that need is undertreated?

Patients come to our hospital, and to the rest of the country, often obese, even grossly obese, and yet by their consumption they argue their hunger is “undertreated.” In this country we eat more calories in a day than some people of the world eat in several days, and yet if we don’t eat for a few hours we are “starving!” Despite over-consumption in this country in many aspects of life, including a cacophony of noise from media and entertainment, many people are recurrently “bored.” We can learn from this dissatisfaction despite over-consumption that addiction is rampant. We are addicted to too much service, too much food, too many drugs, too much input, too high expectations, and too much treatment for our “pain.” And, what is our pain? It is the existential anguish of expectations we cannot meet. We flee from our dissatisfaction into cravings for temporarily-quieting drugs. We flee from our dissatisfaction into cravings for temporarily-quieting food. We flee from our dissatisfaction into cravings for temporarily-distracting media. We flee from our dissatisfaction into cravings for temporarily-quieting drugs. We flee from our dissatisfaction into cravings for temporarily-satisfying consumption. We flee from our dissatisfaction into cravings for temporarily-comforting complaining.

We consume more food per capita than (perhaps) any other country in the world. We consume more opiates than any other country in the world, and we have a voracious appetite for health care services in general. We consume more consumption than most other countries in the world (we now have competitors on this front). So is it true that our “pain” is undertreated? or, is the story another version of the Hans Christian Anderson classic, “The Emperor’s New Clothes?” Any broad view of the emperor in this country reveals that the emperor is naked. It was not that this could not be seen. It was that no one wanted to see it.

In Anderson’s story, in all the conversations with invested parties, the argument was that failure to see the clothes was a commentary on the viewer—the naysayer. Likewise, in chronic pain, it is common for the skeptic to be viewed as the one with the problem. So, by this criticism of the skeptic, the Emperor paraded his delusion before his ministers, and his court, and even
to the streets. And it was only the child who could rise above investment to say what could be seen. So perhaps we need some candor in pain as well. In my opinion, we do not undertreat pain in this country, we underdiagnose it. I do not believe we treat too little. I believe we treat incorrectly.

Ultimately, the markers for the correct balance in opiate use might be best found in so-called “primitive” cultures—where there is little secondary gain by patient or provider for excess pain focus. In such cultures people routinely are injured and suffer acute pain. And, a dearth of medical services may even mean that acute injury results in chronic structural dysfunction. However, chronic pain as a major centrum for social or physical dysfunction is not common in such settings. Where pain is not pandered to there is actually less of it—in spite, arguably, of more physical infirmity. Of course, there is the obvious counterpoint: in primitive cultures people still do have pain, and of course there are those for whom life is limited and even shortened by the consequences of structural pain. Further, there will also be some whose life journey is impaired by the same kinds of psychosocially mediated pain behavior we see in the United States. Stress biology, psychologically mediated inanition, and other cognitive issues do lead to dysfunction beyond physical infirmity. But, there won’t be many nonstructural factors contributing to pain in primitive cultures, because no one gains by “buying into” this dysfunction.

The consequences of misunderstanding pain are expensive, both in terms of in money and quality of life. In my view, we might create more chronic pain than we solve because we build unworkable expectations and train people to pander to feelings of dissatisfaction. (We see other versions of this in the issues of obesity and conspicuous consumption.) Many psychosocially mediated chronic pain patients end up on disability, isolated from family and friends, and in a social netherworld even though their tests often reveal little evidence of an underlying physical cause of their pain. In the final analysis, some of the providers for these patients do much better than the patients themselves. This is not the journey intended for medicine. Maybe Paul Starr, author of *The Social Transformation of American Medicine*, was right when he argued that “the dream of reason did not take power into account” during the development of the U.S. health care system.

Pain should be treated. But first it should be understood. We have a great deal of perspective which reveals that our consumption is too high. Perhaps “the pain” which drives this does not need more opiates. Do we have the courage to see beyond vested interest? Or, will the metaphorical Emperor propagate yet another delusion?

**REFERENCES**