Editorial

“People Who Have Something Better To Do Don’t Suffer As Much”

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The title of this editorial is a quotation from Wilbert Fordyce referred to as Fordyce’s Law,¹ a statement broadly encompassing the key principles of his theoretical and applied work in chronic pain management that remains the most reliably effective approach to managing intractable and longstanding pain problems to this day. His brief statement is worth unpacking and examination. Suffering refers to the emotional distress associated with the perception of physical threat or loss in the case of nociception or “pain”. The dilemma often faced by patient and providers is the confounding of pain with suffering, and of suffering with disability, the result being unnecessary disability. The critical pain treatment task is the untangling of suffering from disability, which in part requires providers and patients to appreciate that hurt does not mean harm. In managing chronic pain the most important question is not “why is this person in pain” but rather “why is this person suffering”. Ideally our interactions with patients will facilitate learning of these principles, i.e. “each patient contact has classroom overtones.”¹ Fordyce’s Law captures the spirit of the operant approach to pain management, which focuses on helping people suffer less by doing more. In different ways each of the pain-related articles in this journal connects to these ideals.

Kennedy and Hasson² investigate pain and suffering among persons with spinal cord injury (SCI) over the course of inpatient rehabilitation using a reliable and valid self-report measure of pain and mood. Noting a well-developed empirical literature showing that pain and depression commonly co-occur, and are more severe and recalcitrant when co-occurring, the authors aimed to build on our knowledge base through a longitudinal design, a large and demographically diverse sample, and use of expanded dependent variables including interference with rehabilitation. The expected

associations between pain and mood are found, but in addition, their findings were that change in pain correlated with mood improvements, and that pain was associated with rehabilitation interference. Participants that noted no pain interference with rehabilitation had an average pain rating less than 3 on a 0–10 scale, whereas those who reported pain interference with rehabilitation had a mean pain rating of over 5. The authors advocate for early assessment and treatment of pain and distress during rehabilitation. In addition to identifying and addressing important clinical issues, the systematic use of measures of pain and psychological distress in our clinical settings may be thought of as part of patient education in terms of orienting them to various outcomes of importance beyond just nociception, raising psychological factors as treatment targets, and perhaps priming them for aspects of operant pain treatment approaches.

An additional interesting feature of the Kennedy and Hasson study is the inclusion of persons with non-traumatic etiologies of SCI; 35% of their sample had non-traumatic etiologies. Our understanding of the experiences of persons with non-traumatic spinal cord damage is limited relative to what we know about traumatic SCI. In part this is due to the exclusive focus on traumatic SCI found within the SCI Model System in the United States. The Rick Hansen SCI Registry³ (RHSCIR) in Canada was also built with an exclusive focus on traumatic SCI. However, many persons with non-traumatic spinal cord damage are being treated within healthcare systems worldwide. In Canada, 27% of persons with SCI responding to a population-based survey had non-traumatic etiologies.⁴ In the United States, the largest integrated system of care for persons with SCI is the Department of Veterans Affairs (VA), wherein the number of persons with non-traumatic etiologies is estimated to be 35%.⁵ Populations with non-traumatic SCI may differ in important ways from those with traumatic SCI, in terms of facing potentially

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progressive diseases and functional declines, being older, more representation of female gender, and greater likelihood of living alone.⁴ Additional research inclusive of persons with non-traumatic SCI is needed, including examination of whether or not findings from traumatic populations generalize to non-traumatic samples. In this issue, authors Eom, Kim, and Joo⁶ address our limited understanding of pain among persons with non-traumatic SCI by studying 48 patients with non-traumatic, non-compressive myelopathy to better understand prevalence, characteristics, and predictors of neuropathic pain. A standardized pain interview and two pain instruments were administered to patients attending outpatient Neurology appointments at a university hospital over a 6-month period. Of 58 patients assessed, 48 (82%) reported clinically significant pain problems. Of those with pain 72% described it as continuous throughout the day. Neuropathic pain was identified in 33% and these patients reported more severe pain levels than those with non-neuropathic pain. Younger age (<40 years) and non-idiopathic etiologies were associated with greater odds of neuropathic pain occurrence. The investigators also examined pain descriptor rates finding the most common descriptors to be "exhausting", "gnawing", and "heavy". In comparison, a prior study of persons with traumatic SCI found the most common pain descriptors to be "hot/burning", "aching", and "exhausting."⁷ The evocative pain descriptors used by participants in the Eom, Kim, and Joo study suggest the presence of significant suffering among persons with pain and non-traumatic SCI. Pain descriptors have long been recognized as illuminating of the suffering of patients with pain after SCI. As early as 1947, Davis and Martin⁸ observed that:

"The nature of pain assumes different attributes depending upon many emotional factors. The hot, burning pain would be replaced at times by severe crushing pressure, by vise-like, pinching sensations, by streams of fire running down the legs into the feet and out the toes, or by a pain produced by the pressure of a knife being buried in the tissue, twisted around rapidly and finally withdrawn all at the same time."

Readers will recognize the comments of Davis and Martin as occurring in an era of important developments in the fields of SCI and battlefield medicine when great progress in life-preserving measures was made and rehabilitation became a realizable target for persons with SCI. The Davis and Martin study just cited involved a primarily U.S. military sample, which reflects the surge of research and clinical work, and

federal policy development focused on SCI in U.S. military and VA settings after World War II. The current modern structure of the VA SCI System of Care, with resources and policy in many ways separate from other rehabilitation and medical populations, was established shortly after the end of World War II. Critical to the evolution of the VA SCI System of Care after WWII were the actions of political advocacy groups, some of which remain closely involved with the VA to this day. This story of the convergence of health care science and politics is not unique to SCI or the U.S., and has been noted before. In fact, Fordyce commented that politicians may have as much a role in pain care delivery as do physicians and psychologists.¹ This situation may be especially salient and concerning in times of political transition, particularly in the U.S., when an issue such as opioid misuse, a very real concern for persons with SCI,⁹ is on the national stage. Due to some degree of centralized decision-making and in spite of a reputation for sluggish bureaucracies it is our federal healthcare systems, such as the VA, that can be especially vulnerable to reckless decision-making, as the historical record shows.¹⁰

The above points underline the importance of our scientific values towards advancing and protecting our field. The development and use of rigorous consensus-building methodology, as demonstrated by Hitzig *et al.*¹¹ in this issue, is an excellent example of scientific values expressed at the level of national healthcare policy discussion. This is a report on a nationwide effort in Canada to develop a consensus on priorities for research on pain after SCI. A large expert panel was convened comprised of SCI care consumers, consumer advocates, clinicians, researchers, and policy-makers. The authors relied upon Delphi methods thereby ensuring rigorous, iterative, rational, and systematic expert opinion collection while minimizing social psychological influences. Research priorities were identified including 1) pain management and treatment, 2) measurement tools, 3) health services policy and advocacy, 4) knowledge transfer, and 5) mechanisms of pain. Importantly, specific research, policy, and clinical care projects were identified for each of the broader areas. Review of these specific projects on Table 3 of the article, particularly the Health Services Policy and Knowledge Transfer rows, shows that the work group attended to recommendations and action plans for changes in care delivery settings and work with governmental agencies, as opposed to restricting their focus to knowledge-generating research as is common for such work groups. The authors comment astutely on challenges to effectively implementing

research evidence into practice in the context of national issues. Their inclusive approach to stakeholders and other aspects of rigorous methodology stand as excellent models for how other providers and researchers may successfully navigate between the worlds of health care research, care delivery, and governmental policy. Use of these strategies and involvement in policy circles may be vital for defending the presence of evidence-based methods in our care settings and, in the end, helping people do more than suffer.

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