Editor’s message
Pain management in the new millennium

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In the early morning hours of January 1, 2001, as fireworks in the sky faded throughout the United States, a bright glow appeared—not heavenward, but lower...in a field—the field of pain management. A Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirement became official: hospitals, nursing homes, behavioral health facilities, outpatient clinics, home care agencies, and health plans seeking accreditation were to have in place a plan that includes:

- recognition that patients have the right to receive appropriate assessment and management of pain;
- documentation of the nature and intensity of pain accompanied by regular reassessment and follow-up;
- assurance of staff competency in pain assessment and management;
- education of patients and their families regarding effective pain management;
- appropriate planning to monitor pain and related treatment after discharge.

This requirement was so enacted to ensure that throughout such healthcare organizations, appropriate analgesia will be provided to every patient in need. As this new policy emerges, many methods available to physicians for pain management—both pharmacologic and nonpharmacologic—have received increased attention. This is good.

A JAOA Supplement such as the current one affords a great opportunity to focus on various approaches to providing comfort for suffering patients. Psychological modes of therapy and osteopathic manipulative treatment are included. Other topics are barriers among physicians that prevent proper delivery of opioid analgesia and critical issues surrounding those who care for the dying patient. Several articles focus on pharmacologic treatment.

With respect to clinical pharmacology, proper management of pain can be accomplished only when healthcare professionals clearly understand differences between addiction and physical dependence; they are not the same. Addiction is a mental disorder, properly classified as psychological dependence; a person may be addicted to anything that meets a psychological need, eg, gambling, shopping, dieting (anorexia nervosa), or drugs. Major criteria characterizing addiction include compulsivity, use despite harm, and a high rate of recidivism (relapse). In contrast, physical dependence begins with tolerance, ie, development of an adaptive process resulting from prolonged drug administration. Consequently, cells change (eg, receptor upregulation or downregulation) such that biologic activities continue as normal as possible. Thus, physical dependence occurs independently of psychological factors. An infant born to a woman who continued her alcohol addiction throughout pregnancy will be physically dependent and exhibit withdrawal after birth—but the infant is not addicted to alcohol! Clinical evidence also indicates that patients with no prior addiction history who use opioids do not automatically become drug addicts.

Healthcare professionals who fail to understand these important factors are not capable of providing effective pain management for their patients; this type of therapeutic deficiency has the potential to become a suicidogen (Goldstein FJ. J Clin Pharmacol. 1997;37(1):1-3).

All health professionals need to maximize efforts in this critical area of patient
care, most importantly for chronic pain conditions or terminal cancer. We must avoid inadequate pain management; by using combinations of advanced therapeutic modalities as presented in this publication, we can.