

EDITORIAL

The Social Forces Healing Patients with Painful Conditions: What Happens After COVID-19?

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Picture your patients, many already socially isolated by the activity-limiting pain from which they suffer, now further absented from the healing touch, empathy, and compassionate demeanor you deliver at each office visit and during each pain-relieving procedure. Have patients ever told you that your team's reassuring and committed presence in their lives is helping them get better? Or that they looked forward to their thrice-weekly physical therapy appointments, weekly pain therapy groups, or monthly support groups, which helped them try self-management for pain and stick with a physical and psychological therapy regimen? This effect, an aspect of the biopsychosocial (BPS) model that is so foundational to the conceptualization and evolution of our specialty, is now often given only lip service in our health system practices. Because of medicine's comfort with identifying the physical evidence of diseases and injuries, first in procedurally treatable anatomy and then in pharmacologically treatable molecules, the "bio" domain historically has always been at the forefront of medicine's treatment of pain. However, the presence of psychiatrists and psychologists on John Bonica's first pain teams changed this, giving the "psycho" and "social" aspects of pain a foundational place in pain medicine's birth as a specialty. Our first national/international pain organizations—the International Association for the Study of Pain (IASP), the American Pain Society (APS), and the American Academy of Pain Medicine (AAPM)—were multidisciplinary. With the growth of clinical research in psychological therapies for pain, the "psycho" has grown commensurately. The "social," present in many patient encounters and group experiences during treatment, was expressed formally in the development of the interdisciplinary pain rehabilitation programs of the 1980s and 1990s, which proved effective before being closed down by the penetration of managed care throughout our health care system.

COVID-19 has transformed the lives of billions in diverse communities across the globe. It will also likely transform our health care systems and how we care for pain. I wonder what will happen to the "social" aspects of pain management. I write this last Editorial, after 21 years of work as Editor-in-Chief of *Pain Medicine*, with the sincere hope that COVID-induced awareness of the importance of public health in our nation, as well as the nation's recent focus on opioid use related to pain, will translate into better care of pain after COVID. This care includes the restoration and promotion of the social conditions so critically important to the outcomes of care. In their seminal editorial, "Time to Flip the Pain Curriculum," Dan Carr and Ylisabyth Bradshaw challenged a curriculum that gives preeminence to a mechanism-based focus on anatomy and molecules while often overlooking sociocultural group processes that, through social neuroscience mechanisms, affect both the experience and reporting of acute and chronic pain conditions as well as the success of its treatment [1]. Today, as we emerge from the pandemic, can we preserve and enlarge this BPS component of pain care, which has been so diminished by COVID-related isolation?

Our journal has documented our field's experience with COVID's early effects on pain medicine practice [2–9], including telemedicine [8] and perioperative pain management [9]. Importantly, the journal has also thoughtfully considered COVID's challenges to ethical practices [10, 11], to our education and training programs [12–16], and to the intertwined public health crises of pain and substance abuse [17, 18] that have been largely eclipsed by the pandemic. Evaluation of the clinical outcomes of changes mandated by the pandemic will help inform the future design of clinical practice and training. Our responsibility is to study the impact of these changes and to incorporate promising practices approaches that can be studied in health systems to prove

their effectiveness in populations. However, our pre-pandemic progress in developing economically viable models of pain care that address population health is now threatened.

Many in-person clinic visits are now replaced by virtual visits that, for many conditions, have not demonstrated benefits beyond convenience and are reimbursed at lower rates. The canceling of well-reimbursed procedures during the pandemic challenges the economic viability of an interdisciplinary model of pain practice and clinical training. Pain procedures support the less highly reimbursed aspects of personalized, multidisciplinary interventions, such as psychosocial and integrative care. Will we regress to past clinical practices that led to the overutilization of particular “bio” interventions to meet administrators’ health systems’ targets, such as income from procedures and higher patient satisfaction scores associated with high-volume brief medication visits for opioids? These practices led to the “opioid crisis” and the precipitous cessation of care, often mandated by practice administrators, with its unintended clinical consequences to mental health and disability. In the absence of personalized multimodal care, neither procedures nor opioids reduce disability rates from painful conditions, but alone they increase the direct and indirect costs. In this environment, can we sustain a gradual evolution of practice toward an accessible, value-based, truly BPS stepped care model, or as Carr and Bradshaw propose, a “sociopsychobiological” model? [1] Our progression to an outcomes-based clinical care model that is perceived as valuable to our communities and health systems may hang in the balance.

COVID-19 refocused attention away from the public health problems associated with painful conditions such as disability, depression, suicide, the overuse of opioids, and the related rise in rates of opioid-associated addiction and overdoses, both intentional and unintentional. I have no doubt that we will once again improve our readiness to address epidemics of infectious disease, as we have in past times after pandemics. Nevertheless, as this pandemic recedes, Eric Schoomaker, former Surgeon General to the Army, asks whether the consequences of interrupted care for approximately 30 million Americans with moderate to severe chronic pain associated with multiple medical conditions will become a focus of the public health establishment once more [18]. Will attention be paid to the societal costs of rises in anxiety, depression, disability, and suicides, which are well documented not only in patients with pain but also in clinicians—whether on the front lines of primary care, emergency medicine, intensive care, or pain specialty clinics? Will we be able to sustain our colleagues’ ability to provide the compassion and social support so needed for healing, and care for our patients effectively [19]?

Thus, our challenge as we emerge from the pandemic is to recover some of the practices that were beginning to change in our health system to benefit our patients. Can

we accelerate those that were showing benefit? Studying the effectiveness of implementing proven therapies in clinical practices and deploying these effective practices more widely have long been weaknesses in our clinical research enterprise. As Robert Kerns and Cynthia Brandt pointed out in their introduction to their recent *Pain Medicine* supplement describing the projects of the NIH-DOD-VA Pain Management Collaboratory, “. . . a significant gap exists between the evidence of the effectiveness of numerous nonpharmacological approaches to pain management, including several complementary and integrative health approaches, and the routine integration and availability of these approaches in clinical practice” [20]. Several projects described in the supplement evaluated interventions that emphasize the importance of relationships. The challenge to these projects is to test the feasibility of rolling out these interventions across health systems in a way that demonstrates their effectiveness and, even more importantly, their cost-effectiveness. The VA Health System is motivated by its limited budgets and fixed costs to test the cost-effectiveness of these interventions, whereas our other more expensive American health systems, unlike developed Western European health systems, are too heavily influenced by the need to generate income [19].

Back to the question of the social costs of a pandemic for the effectiveness of pain care. We are the only specialty that has truly directed the vision of George Engel and so many other leaders toward BPS medicine. Although psychiatry professes acceptance, in reality it has generally ignored the “bio” below the brain, whereas pain medicine generally accepts the “bio” from the brain to the toes and integrates the psychological aspect, including behavioral neuroscience. Although several psychological interventions have been studied for their effectiveness when they are delivered by phone, we are weakened by the pandemic in the “social” domain of treatment. This issue of *Pain Medicine* contains two papers that describe clinical programs whose effectiveness relies on the “social” aspect of the BPS model in pain management.

Marnin Romm and colleagues from the University of Miami present the results of their meta-analytic examination of the effectiveness of group-based pain management programs [21]. They find that group programs focused on learning self-management to improve quality of life have measurable benefits in improving physical function and reducing psychological distress. They helpfully discuss the evidence for the different specific interventions and the potential mechanisms of these interventions for inducing healing change. Their paper dissects the methodological issues in demonstrating effectiveness of the “group support” construct in pain programs, particularly the limitations imposed by heterogeneity in study samples and methods. Their work confirms the importance of the social support construct as a critical factor

involved in the healing process—a factor of which our field must be mindful as we emerge from the pandemic.

Pain psychologist Jennifer Murphy and her colleagues, in their paper “The Resurrection of Interdisciplinary Pain Rehabilitation: Outcomes Across a VA Collaborative,” show the potential for ultimately addressing some of these methodological limitations by using standard measurements in their retrospective evaluation of outcomes across six rehabilitation programs [22]. They describe the VA’s long effort to develop a health system-wide program that supports the rehabilitation component of the Stepped Care Model that Bob Kerns and I articulated in our 2009 directive (VA Directive 2009-053). Implementation of stepped care, directed by VA’s Central Office under Pain Director Friedhelm Sandbrink, Deputy Director Sanjog Pangarkar, and Administrator Pam Cremona, is supported by Primary Care leaders Steven Hunt and Lucille Burgo, by Dr. Murphy and rehabilitation colleagues, and by their respective leadership teams across the entire VA health system [23]. Although the evidence is incontrovertible that interdisciplinary pain rehabilitation programs are effective in improving function and making return to work possible for patients disabled by painful conditions, these programs have no viability in the fee-for-service commercial health system. Who amongst the insurance companies and the hospital accountants cares if someone with disabling pain cannot return to work? A cynical view is that these patients have expensive chronic conditions. If regular fee-for-service pain care does not work, patients can just apply for workers’ compensation; if that does not work, they can apply, with no guarantee of success, for the meager support of Social Security Disability. Either outcome sentences patients and their families to dependence on meager taxpayer support at near-poverty level, sometimes for a lifetime. A decade ago, there were only two VA pain programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), in Puerto Rico and Tampa, in the latter of which psychologist Michael Clark and colleagues initiated training for personnel from other interested hospitals. Dr. Murphy’s impressively sustained community leadership formalized pain rehabilitation, the top step of “pain stepped care,” into a system-wide program with leaders from some 20 other facilities, of which six contributed to the project described in the present issue. A powerful social force in these programs is the “team” approach, in which patients work with staff and other patients to develop new skills that support physical and psychological coping, such as reducing the effects of catastrophizing.

The 2019 Department of Health and Human Services (HHS) Inter-Agency Best Practices in Pain Management Report relied on a supportive, inclusive group process that brought together all stakeholders to consider and articulate what was needed to address our societal problem of effective BPS pain management in the context of the opioid crisis [24]. The experience of *stigma*, a

psychosocial construct related to social relations, was identified as one of only four cross-cutting topics affecting all aspects of pain care. The others were *risk assessment*, *education*, and *access to care*, the latter of which also involves the “social,” as socioeconomic disparities play such a central role in access to quality pain care in our health system [25]. Central to preventing stigma is the process of providing social support while we educate and care for our patients. As society recovers from the traumatic battering from one to two years of pandemic, let’s not let society forget the daily battering experienced by patients with chronic pain, which may last a lifetime rather than two years, or forget chronic pain’s extraordinary public health costs. Let’s be sure we purposely consider and build in the “social” of BPS pain care while redesigning our clinical and teaching programs in recovery from COVID.

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