

PRESIDENT'S MESSAGE

The IOM Pain Report Revisited: Setting the Stage for What's Next in Transforming Pain Care, Education and Research

On June 29, 2011, the Institute of Medicine (IOM) released its seminal report, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. This report was not only the culmination of the IOM committee's hard work but was also the fruit born of many people working behind the scenes to get the committee formed as part of the 2010 Patient Protection and Affordable Care Act. This was a particularly exciting time for me personally. I was honored to be on the IOM committee, serving with 19 extraordinary multidisciplinary members who together represented just about every aspect of pain care, education, research, and advocacy. I was also relieved to see the project finally completed: We came together in November 2010 and were given a very short time to complete the report, which was mandated to be presented to Congress the following June. We were successful because all members put aside their own biases, affiliations, and potential conflicts and focused on what was best for the person living in pain—and what was best for the United States. We were also successful because of the incredible leadership skills of the chairs of the IOM committee—Drs. Phil Pizzo and Noreen Clark. They were able to herd a group of individual, strong-willed national experts into one unified body, focused on completing the task set before us. As part of the process, we took input from thousands of letter writers, had multiple public hearings, and listened to many passionate and sometimes tearful testimonials. We did our best to incorporate all this information and give a voice to those living with pain. We released the report on time.

I was part of the press team that presented the IOM report nationally and distinctly remember the incredible excitement around the release of our report. The headlines were sensational, but true: “116 Million Americans with Pain!”¹ or “Half a Trillion Dollars a Year Spent on Pain!” The vast majority of the response to the report was positive; many felt it validated either decades of their own personal suffering or of their professional careers spent trying to relieve patients' suffering. There were some criticisms. Most of those were focused on the belief that we did not do enough (e.g., we did not devote enough space to the growing opioid epidemic; we did not call for a National Institutes of Health Institute on Pain). In the committee, we discussed all of these topics and more. We were repeatedly reminded by IOM staff (and rightly so) that we were given a five-bullet-point charge and were not allowed to

deviate from that charge. We also did not want the issue of opioids to overwhelm the broader message of the importance of pain care, prevention, research, and education. And overall, I believe we struck a good balance on the important issue of opioids—simultaneously recognizing their potential benefit in relieving pain as well as their potential for misuse, abuse, and addiction. Overall, the public response to the IOM Pain Report was highly positive.

We called for a “cultural transformation” in the way that pain is assessed and cared for. We recognized that pain management should be a moral imperative and responsibility for all of us who care for persons in pain. A controversial principle we put forward is that while chronic pain is often a symptom of another condition, it can become a disease in itself, one that significantly alters the peripheral and central nervous system. This issue has been debated extensively [1,2] and will continue to be debated. What was not debated is that pain is a uniquely individual and subjective experience. Comprehensive and interdisciplinary (e.g., biopsychosocial) approaches are currently the most important and effective ways to treat pain, particularly for the complex patient. Unfortunately, such care is often difficult to obtain because of structural barriers, including financial and payment disparities.

The IOM report also noted that there is a growing awareness of the need for effective preventative measures for pain. Many pain conditions start with an acute injury or surgery and progress to a chronic state. We are better off preventing the development of pain than treating it after it has become chronic. And although we called for increased research on the mechanisms responsible for pain and the development of safe and effective treatments, we also recognized that there is a wealth of existing knowledge. We must ensure that this knowledge is transmitted to people suffering from pain and to the providers who care for them. There is also a need for greater collaborative roles for patients and clinicians. To successfully implement this cultural transformation, we recognized that we must develop a public health and community-based approach. We called on the Secretary of Health and Human Services to create a comprehensive population-level strategy for pain prevention, treatment, management, and research. Finally, the IOM report offered a blueprint for achieving this cultural transformation.

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Why am I revisiting this IOM report, which was published approximately 3 years ago? First, it is more relevant now than ever before. I encourage everyone to read it. If you do not have the time or bandwidth to read and absorb the full 300-plus-page version, there is the 30-page summary and (for those of you living in the Twitter era) the 4-page brief. All versions of the report can be downloaded at no charge at <http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-transforming-Prevention-Care-Education-Research.aspx>. The other reason to revisit this report is that one of the primary goals of our committee was to see that this report did not sit on a shelf and gather dust. I am pleased to say that it has not. The follow-up to the IOM report is the *National Pain Strategy* (NPS) (http://iprcc.nih.gov/National_Pain_Strategy/NPS_Main.htm). The NPS is charged with developing the core IOM recommendation 2.2, which was to develop a nationwide plan to address pain prevention, care, education, and research. In my next message, I will describe the NPS, the role of American Academy of Pain Medicine, and the opportunities NPS presents to advance the recommendations of the IOM report, *Relieving Pain in America*.

SEAN MACKEY, MD
President, American Academy of Pain Medicine
Stanford, CA

Note

1. N.B. The 116 million number was subsequently revised to 100 million when we realized that we made a simple math error—something that is particularly embarrassing for me because I hold three engineering degrees. This 100 million number is also an underestimate in that it does not include children, those living in assisted living conditions, or the people serving in the military. I will also share that we then triple- and quadruple-checked the other numbers reported and they remained unchanged.

References

- 1 Sullivan M, Cahana A, Derbyshire S, Loeser J. What does it mean to call chronic pain a brain disease? *J Pain* 2013;14(4):317–22.
- 2 Mackey S. Central neuroimaging of pain. *J Pain* 2013;14(4):328–31.