Pain Rx: 3 Barriers

1. Inadequate education about pain assessment and treatment, safe and effective pain management

   - "Little or no attention is paid to things invisible…although they may be more important than things which strike the sense"

     -- Francis Bacon, 1561-1626

2. Emphasis on nociceptive mechanisms rather than the social determinants and dimensions of pain

   -- "Time to flip the pain curriculum?" – Carr & Bradshaw, 2014

3. Stigmatization and marginalization of patients being treated for pain, and their conflation with opioid abusers

   -- "Patients with pain need less stigma, not more" – Carr, 2016

PLUS: Gaps, discordance between evidence-based best practice and payment structures, e.g., multidisciplinary incl behavioral Rx, MAT

[Carr, 2018]

Pain: Policy Changes (1)

1. Recognize pain as a disease *per se*, that is widely under- or mistreated. Implications:

-- strengthen evidence base (c/w cancer, CVD…)

-- fund best practices based upon best available evidence

2. Broaden types of information, synthesis to go beyond RCT/ P<0.05/ meta-analyses

-- very relevant to interventional practice

3. Balance procedure-based guidance with patient-centered guidance to prioritize resources for patients at highest risk [Carr, 2018]

Pain: Policy Changes (2)

4. Embed respect for diversity of populations and variability of individuals and guidances, regulations, laws and regulatory policies

5. Support – or at least be consistent with -- the National Pain Strategy and the Federal Pain Research Strategy

6. Revisit CDC guidelines and the unintended consequences of their implementation and generalization

[Carr, 2018]