The Complete Pain Physician

Doris K. Cope, M.D.
Committee on Pain Medicine
Rajindar K. Wadhwa, M.D.

In the "Admonitions of Hippocrates on Learning the History of Medicine," Hippocrates recommends that a physician "ought also to be confidential, very chaste, sober, not a winebibber and he ought to be fastidious in everything, for this is what the profession demands."[1] Additionally "he ought to hold his head humbly and evenly; his hair should not be too much smoothed down, nor his beard curled like that of a degenerate youth."[2]

In the actual care of patients, a complete physician should hold the following standards:

For those who are ill, you ought to get up early so as to inquire about the preceding night, finding out the order of the causes [of the ailment] and the necessary treatment. At midday pay another visit, not so much to see about the patient's food as to plan for the beginning of the cure. For a third time, visit at about nightfall, staying for an hour in order to make arrangements for him to pass the night [comfortably] so as to be fortified to meet the next day unimpaired ... .[3]

John J. Bonica, M.D., defined for many the standard of care for the pain physician in the 20th century. He lamented the then current focus on specialization of treatment by identification of a correctable lesion with resultant fragmentary care of a chronic pain patient. In the very first chapter of his landmark text, *The Management of Pain*, he wrote:

The progressive trend toward specialization has led practitioners in the various specialties to concern themselves only with their own narrow approaches to pain. Thus the anesthesiologist attempts to treat all patients with chronic pain with nerve blocks, the neurosurgeon by cutting pain pathways, the orthopedic surgeon by surgical operations, the general practitioner and internist by prescribing drugs and the psychiatrist by traditional psychotherapy. This type of tunnel vision is particularly likely to occur when a specialist practices alone and sees these patients in the isolation of his office. This approach precludes viewing the pain problem within the perspective of the many diagnostic and therapeutic strategies that may be applicable to the particular problem and choosing which are best for the particular patient.[4]

John J. Bonica, M.D.

In his evolving new standard of care, the holistic view of a patient in pain superseded the contemporary culture that pressed toward increasing medical specialization and compartmentalization of patients' problems. Dr. Bonica answered this trend in medical thought by the establishment of a multidisciplinary pain center at the University of Washington in 1945. His model grew and was adopted in other large university settings such as the University of Pittsburgh, among others.

The heart of this model was the incorporation of many viewpoints for the diagnosis and treatment of the pain patient with a cadre of professionals working in concert at the same place and time to plan treatment for each patient. What was that training like on a day-to-day basis? (See accompanying commentary on page 17.)

Doris K. Cope, M.D., is Director, University of Pittsburgh Medical Center (UPMC) Pain Medicine Program, and Professor of Anesthesiology, UPMC, Pittsburgh, Pennsylvania.

Rajindar K. Wadhwa, M.D., is Clinical Associate Professor, University of Pittsburgh, and Co-Chair, Pain Committee, Jefferson Regional Medical Center, Pittsburgh, Pennsylvania.

Thanks for the Memories, Dr. Bonica

Following is the firsthand account of one anesthesiologist, Rajindar K. Wadhwa, M.D., who spent time with Dr. Bonica at the University of Washington and at his interdisciplinary program.

I consider myself blessed to have worked with world-renowned anesthesiologists such as P.C Lund, M.D., Gertie Marx, M.D., and Robert Hingson, M.D. It was their teachings that encouraged me to explore and enhance my knowledge in chronic pain management. Yet it was the inspiration of another great man, John J. Bonica, M.D., who changed the course of pain treatment as we know it today.

In 1981 Peter Winter, M.D., my chair at the University of Pittsburgh, gave me an opportunity that changed my life. Dr. Winter arranged for me to go to the University of Washington for a mini-sabbatical to learn and observe the management of chronic pain from Dr. Bonica, a man often regarded as the patriarch of pain clinics. In my time there, I quickly became impressed by how effectively patients were managed by a multidisciplinary team approach. The team consisted of orthopedists, neurosurgeons, internists, psychologists and anesthesiologists, all of whom met weekly to discuss patient management in a grand round.

During my two-month stay in Seattle, I did not have the opportunity to see Dr. Bonica in the pain clinic or the grand rounds, as he himself was suffering from chronic pain. I was fortunate, however, to visit him in his home, where he was being managed by his anesthesia colleagues, and to witness the nerve blocks and trigger-point injections being administered to him there. He was a wonderful host and teacher, and in one of our more memorable discussions, he explained to me why the condition of human beings suffering with neck and lower-back pain is a factor of evolution. In our discussions of Darwinian theory, Dr. Bonica suggested that early man's rising above his ape-like existence by standing erect caused an uneven distribution of weight on the spinal cord, thereby making man more vulnerable to back and neck injury and chronic pain. Thus his study of pain went far beyond the current manifestations in the patient.

In one of my visits, I asked him if he felt comfortable and safe getting treatment at home, and without hesitation, he said that he did. If indeed that were true, I wondered if pain clinics could be opened outside of hospital boundaries. Dr. Bonica assured me that if I felt comfortable and had faith in my own abilities, then I should do it. He further noted that a pain clinic outside of the hospital would be more economical to both patients and insurance companies. His approval gave me the courage to open one of the first pain clinics outside of a hospital in 1982. Today we have many outpatient pain clinics and a specialty of pain medicine that is recognized by both the American Medical Association and our patients.

My sincerest gratitude goes to Dr. Bonica for his hospitality, his knowledge and his inspiration. He will be missed, but his contribution to pain medicine will never be forgotten.

In conclusion, it is interesting to note that five decades later, with the demand for more, quicker and less costly care in our even more streamlined modern world, the multidisciplinary or interdisciplinary model is now often considered cumbersome and, even more deadly, nonreimbursable. Yet still, all the diagnostic skills of the internist, the procedural skills of the anesthesiologist, the surgical skills of the spine surgeon, the rehabilitational skills of the physiatrist and the acumen of the neurologist and psychiatrist are required to adequately treat any given pain patient.

So how do we answer this dilemma today? It seems that except for the rare, well-funded integrative programs, all the above skills are called into play in just one physician, the pain physician. So it falls on us who are training the next generation of pain physician to utilize our fellowships to ever build these diverse skills, relying on multiple specialties, to create that one physician who can understand, diagnose and treat the pain patient with ever-increasingly complex modalities.

References:

1. Anonymous. Admonitions of Hippocrates on Learning the History of Medicine. In: Carmichael AG, Ratzan RM, eds. *Medicine: A Treasury of Art and Literature*. New York, NY: Hugh Lauter Levin Associates, Inc; 1991:53-54.
2. Ibid.
3. Ibid.
4. Bonica JJ, Loeser JD. History of Pain Concepts and Therapies. In: Loeser JD, ed. *Bonica's Management of Pain*. Philadelphia, PA: Lippincott Williams & Wilkins; 2001:3-16.