

Rethinking chronic pain

To live with chronic pain is to live with daily challenges around simple tasks that others take for granted. It often means being disbelieved, stigmatised for not getting better, or judged as not coping. It might mean living with poor mental health and self-esteem, absenteeism from school or work, the breakdown of relationships, and socioeconomic disadvantage. For society, the costs are staggering: low back pain is the leading cause of years lost to disability and chronic pain costs billions of dollars through health system expenditures, productivity losses, reduced quality of life, and informal care.

The *Lancet* Series on chronic pain debunks a common misconception of chronic pain as an indicator of ongoing injury, requiring suspension of activity. Instead, chronic pain is often a product of abnormal neural signalling, with biopsychosocial dimensions requiring a multimodal treatment approach. But chronic pain is complex and treatment can be fraught, as concerns about UK guidelines show. Many clinicians and patients lack an understanding of treatment options; they might rely on medication alone. Use of costly neuromodulation techniques is also rising, despite a limited evidence base, as synthesised in the Series. Over-reliance on drugs or devices may be spurred on by aggressive industry marketing, lack of access to multidisciplinary services, such as physiotherapy or psychology, and perverse financial incentives for shorter consultations, drug prescribing, and invasive interventions. In low-income and middle-income countries (LMICs), limited access to any opioids, fear of opioids, and cultural beliefs about pain are further barriers.

The opioid crisis has prompted clinical and regulatory attempts to curb all opioid prescribing, leaving patients feeling angry, abandoned, and further stigmatised. The right balance needs to be struck. For some people (eg, those with cancer pain), opioids might be essential; for others, opioid deprescribing might be appropriate. But either path should be embedded in a multimodal treatment plan, with appropriate safeguards and support, and treatment for dependence if needed.

Thinking on chronic pain needs to be reset. For clinicians, a strong therapeutic alliance is critical to help patients understand their pain, shift expectations, and set realistic, individualised goals that prioritise function and quality of life, rather than complete pain relief. Shared decision making can empower people to manage their pain, with

more nuanced discussion of therapeutic options and the risk–benefit ratio. Patients need reassurance that they will be believed, respected, and supported, and not blamed if a treatment does not work. Language is a powerful tool to enable and encourage. The Series discusses a new pain category—nociplastic pain—exemplified by conditions, such as fibromyalgia, that lack biomarkers. Naming a condition enables management and research to be refined, as well as validating the experiences of patients hitherto dismissed by clinicians.

Care for chronic pain should be grounded in the community, not by default (due to lengthy waiting lists for pain clinics, or an absence of clinics in LMICs), but by design, provided by a broad base of well trained, multidisciplinary health workers, with pain clinics to support more complex cases. The Essential Pain Management course, for example, has proven useful in over 60 countries. Financial incentives for quick fixes must be removed and longer consults and high-value care rewarded.

Clinical studies should incorporate patient priorities alongside meaningful comparators and outcomes (covering benefits, harms, and costs). Population studies should seek effective and feasible solutions that integrate health promotion with non-communicable diseases, healthy ageing, and rehabilitation. Policy makers and regulators must prioritise pain, seeing the cost of inaction. For the wider public, measures are needed to raise awareness of chronic pain, dispelling misconceptions that discourage care seeking and removing stigma.

In Patrick Radden Keefe's searing analysis of the opioid epidemic, *Empire of Pain*, he anatomises how the phenomenon of chronic pain was weaponised by a pharmaceutical company to serve a marketing campaign for Oxycontin. The results were devastating—abuse, addiction, and thousands of preventable deaths. There are many guilty parties to be held accountable—from doctors who seemed to see no limit to the prescription of opioids for chronic pain, to regulators who failed to ask crucial questions about the consequences of more liberal treatment regimens. One perverse outcome of this public health emergency is that chronic pain now risks being stigmatised, marginalised in the shadows of societal suffering. Such an outcome would be a further human tragedy. Chronic pain is real. It deserves to be taken more seriously. And this *Lancet* series explains why. ■ *The Lancet*



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For more on [Essential Pain Management](#) see <http://www.essentialpainmanagement.org/>

For more on [population studies on chronic pain](#) see *Pain* 2018; 159: S43–48