How Bad Is It on a Scale of 1 to 10?
An Analysis of the Human Experience of Pain and How We Approach It

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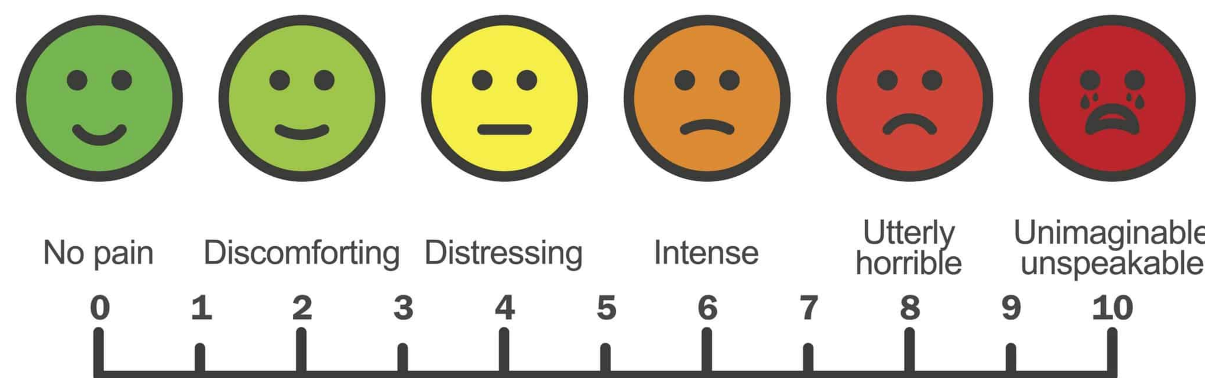
THE DILEMMA

Audrey's case is not unique. Pain, while multimodal and multifaceted, is still being approached by medical care with single digits (i.e., "How bad is it on a scale of 1 to 10?") and unimodal pain regimens (i.e., local lidocaine). And, because pain is both physiologic and subjective, medicine has not progressed far in its elucidation of it. That leaves the question: how could we better approach pain?



THE NEUROBIOLOGY OF PAIN: A COMPLEX SYSTEM

As Dr. Peter Latham wrote in the early 1800's, "it would be a great thing to understand pain in all its meanings." Not much has changed since then.

Neuroscience has added both answers and questions to the pain literature. Some authors have argued for a delineation between pain and nociception, with the latter being an object of sensory physiology. Others, with the help of fMRI and PET technology, have argued that neural patterns shed light on pain's "infinite variety." Regardless, pain is known to be a combination of both innate physiology, emotional valence, and past/prior experience with pain.

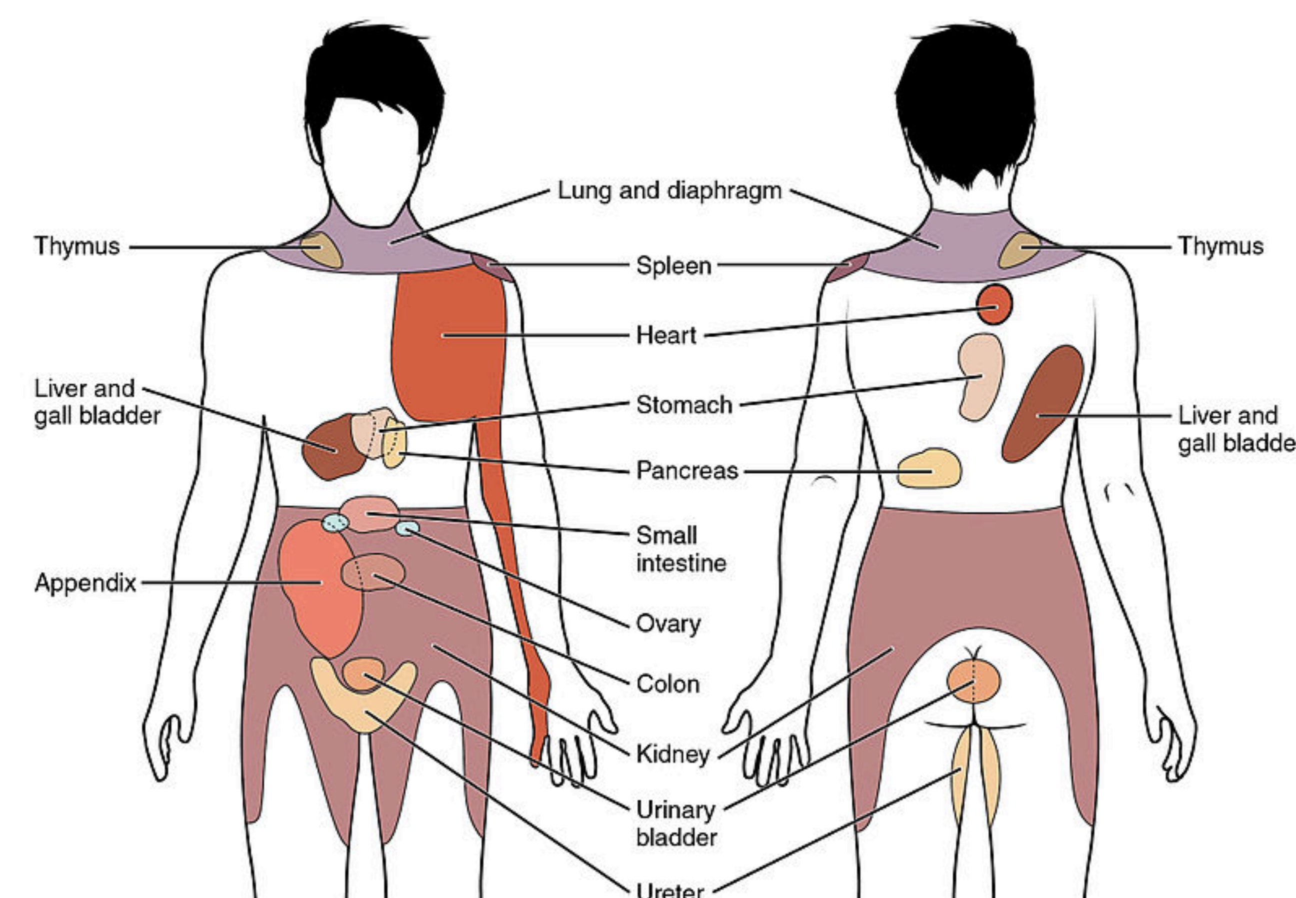
An individual's response to pain, then, is unique and unpredictable. Furthermore, if pain is multimodal (and both physiologic and subjective), our treatment of it must also be multimodal.

THE CASE

Audrey was a 26-year-old female who presented to our hospital in late-April with fevers, chills, and bone pain consistent with acute leukemia.

As part of the work-up for her condition, Audrey had to undergo a bone marrow biopsy, an invasive procedure that involves the insertion of a long needle into the ilium with the intention of aspirating marrow. After we consented her for the procedure, we informed Audrey that most patients only require local lidocaine injections to control their pain.

In response, she warned us that she had a history of being "pain sensitive"— that she was anxious and afraid of what the procedure would entail. After a short discussion with vague reassurances, we moved forward with the biopsy. In the hours that followed, Audrey writhed and screamed with every probe of the needle. Her heart rate soared, and her tears soaked the sheets of her hospital bed. On rounds the next morning, the team referred to Audrey as "sensitive" and "difficult," openly contemplating her future ability to handle chemotherapy.



ETHICAL REFLECTION and a MULTIFACETED APPROACH

Ultimately, Audrey's experience and our modern interpretation of pain together warrant a robust ethical reflection. Our understanding of pain must, apparently, be multifaceted. I argue that this approach includes:

the neuroscience of pain

the individual human in pain

the cultural context of the medical encounter and the patient's understanding of their pain

the consequences of the patient's prior experiences with pain

the ultimate purpose (and end goals) of "treating" pain

It is only with this multidimensional approach that pain (and the "pain experience") can be addressed in the medical setting, as science and technology continue to present more answers (and questions) towards our understanding of it.

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