

Ethics



Ethical Insights to *Rapprochement* in Pain Care: Bringing Stakeholders Together in the Best Interest(s) of the Patient

James Giordano, PhD¹, Michael E. Schatman, PhD², and Gerhard Höver, PhD³

From: ¹Institute for Psychological Sciences, Centre for Philosophical Psychology, University of Oxford, UK; Center for Neurotechnology Studies, Potomac Institute for Policy Studies, Arlington, VA; ²Pain and Addiction Study Foundation, Bellevue WA; and ³Moral Theological Seminar, Rheinische Friedrich-Wilhelms Universität, Bonn, Germany.

Dr. Giordano is Professor of Neuroscience, Philosophy and Ethics, Institute for Psychological Sciences; Centre for Philosophical Psychology; Fellow, Blackfriars Hall, University of Oxford, UK; and Director, Center for Neurotechnology Studies, Potomac Institute for Policy Studies, Arlington, VA. Dr. Schatman is Research Director, Pain and Addiction Study Foundation, Bellevue, WA. Professor Höver is Chair, Moral Theological Seminar, Catholic-Theologic Faculty, Rheinische Friedrich-Wilhelms Universität, Bonn, Germany.

Address correspondence:

James Giordano, PhD
Center for Neurotechnology Studies
Potomac Institute for Policy Studies
901 N. Stuart St., Suite 200
Arlington, VA 22203
E-mail: jgiordano@potomacinstitute.org
james.giordano@bfriars.ox.ac.uk

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Advances in medicine have produced an elongated lifespan often burdened by chronic disorders. Throughout the lifespan and at end of life such disorders can give rise to intractable pain. Although clear distinctions about the respective role(s) for pain therapeutics and palliative medicine remain debatable, both are involved in chronic pain care. Such care has reached a point of crisis fueled by tensions within and between clinical, administrative, and economic factors. We call for a strategy of *rapprochement* to reconcile these tensions as a means to facilitate more effective and ethically sound pain care. We describe roles and values of principal stakeholders: palliative- and pain-care physicians, chronic pain patients, insurance providers, and hospital administrators and elucidate how dissonances between these groups may contribute to inefficacy of the pain care system and sustain chronic, maldynic pain. We discuss how such values affect use of evidence and resources and explicate frameworks for an ameliorative *rapprochement* model that acknowledges and balances relative needs and values of all stakeholders. While we have tried to depict why *rapprochement* is necessary, and possible, the more difficult task is to determine how this process should be articulated and what shape a profession of total pain care might assume.

Key words: Pain medicine, palliative care, ethics, policy, collaboration, *rapprochement*

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Rapprochement (n., Fr.) – to bring together, as in a reconciliation of divergent perspectives and/or values.

INTRODUCTION: SCHISMS IN THE CURRENT CULTURE OF PAIN CARE

Previously, we have asserted that advances in medicine have produced an elongated lifespan for patients suffering from chronic disorders (1). Both throughout

the lifespan and at the end of life, such disorders can give rise to chronic and often intractable pain. Thus the question arises how such pain, that cannot be cured, will be treated and managed. In this way,

a relationship between pain therapeutics and palliative medicine becomes evident, although clear distinctions about the respective role(s) for these disciplines — both alone and in conjunction — with respect to chronic pain remain debatable. In general, the failure of the medical community to effectively manage pain that cannot be cured has been increasingly exigent. We contend that chronic pain care has reached a point of crisis (2-9). To date, an interplay of clinical, administrative-legal, and economic factors have contributed to the problems of practical pain management, and difficulties and tensions that exist when attempting to define the character of chronic pain therapeutics and palliative medicine.

Can we demarcate the boundaries where one stops and the other begins? If we use a literal definition of palliative medicine (i.e. “to lift above” the experiential impact of disease and illness), and claim that its principal impact is focal to chronic intractable pain, then what is the scope and nature of care that must be rendered, and what discipline does this represent? Moreover, numerous factors contribute to inefficient, if not ineffective, practice in both disciplines. While these issues may have led to the point of crisis, each and all can be engaged as opportunistic domains in which improvement could be articulated. Specifically, we believe that meaningful attempts to reconcile and resolve tensions that arise in, and between, clinical, administrative, and economic components of both disciplines could facilitate increased effectiveness in the medical care of chronic pain as both profession and practice. In other words, we call for a strategy of rapprochement.

Dissonance between pain clinicians and the other supply-side stakeholders has impacted the scope and quality of care that can be provided to pain patients, and while the effects of such dissonance may be increasingly evident, this is certainly not a recent development. Much has been written regarding pain physicians’ (and patients’) conflicts with both private and public health insurance providers (10-22). Similarly, the hospital industry’s alleged de-valuation of chronic pain management programs, and the recent, negatively perceived impact of the pharmaceutical industry (23-28) and medical device manufacturers (29-33) play important roles in deepening and widening this schism. As well, there has been some concern that governmental policies may be somewhat insensitive to the needs of chronic pain patients; recently physicians have expressed worry that limitations imposed upon

access to specialty pain services is becoming problematic, not only for civilian patients, but also for veterans returning (with poly-traumatic injuries and chronic pain) from combat engagements in Afghanistan and Iraq (34,35), with military and veterans’ care clinicians reporting a perceived lack of support for long-term pain management (36,37).

In light of recent epidemiologic estimates regarding the prevalence of chronic pain (e.g. > 25 million in the United States alone), the public health impact of such disorders becomes evident. Manchikanti et al (38) note that public awareness of both chronic pain and potential deficits in pain care, is increasing, as the social manifestations of chronic pain become more explicit. Thus, the public has become a notable stakeholder in chronic pain care, as costs associated with pain care borne by actuarial disbursement become transferred to the general social economic infrastructure.

Certainly, many pain care practitioners are frustrated by the imperfection of the system as a whole, perhaps in response to the dramatic challenges faced in the efforts to render treatment in a pluralistic environment in which the needs of chronic pain sufferers must be balanced with numerous other needs and agendas.

In light of this, it is easy for pain clinicians to be critical of other stakeholders’ possible contribution(s) to the inchoate nature of pain care, and the overall lack of support that it receives. Yet, it is equally important to bear in mind (and reinforce) the role that clinicians play in the conduct, tenor, scope, and enactment of pain care — as both an individual and public “good” (39,40).

Despite the ideal of a virtuous practice model (41), perhaps the best for which we can realistically hope is that pain clinicians make efforts to engage intellectual and moral virtue(s) to uphold the primacy of patients’ best interests as the focus of ethically sound pain care (42). While this calls for some relative subordination of clinicians’ own interests, this should not incur subjugation of clinicians’ autonomy to practice in accordance with moral values and prudential judgment. Moreover, it is unrealistic to assume that pain clinicians should (or would) practice without some economic self-regard and social respect (43-46). Few would begrudge the clinician’s desire to earn a respectable income, and we acknowledge that market forces exert strong effect(s) in this regard. While a complete discussion of the factors influencing the professional interests of pain clinicians is beyond the

scope of this essay, suffice it to say that pain clinicians differ from the other supply-side stakeholders in the system in that their sources of motivation must not simply be profit and cost-containment, but rather the implementation of “care,” which axiomatically entails practical utilization of resources to most fully uphold the medical fiduciary (in both therapeutic and moral dimensions).

To be sure, achieving a perfect balance among all of the potential stakeholders in pain care would be a Herculean task. Yet, we believe that for positive change to occur, some level of consonance must occur both among groups of supply-side stakeholders and between supply- and demand-side stakeholders. In this regard, we opine that it is reasonable to define a potential strategy to initiate and sustain the changes necessary toward such goals. Thus, we describe a *rapprochement* model that acknowledges and balances the needs of the patient (as the primary stakeholder), physician/practitioner, health insurance, hospital industry, and government agencies.

THE ROLE(S) OF PRINCIPAL STAKEHOLDERS

A: Physicians and Patients

An important premise underlying our model of pain care emphasizes the mitigation of chronicity, as this we believe will 1) sustain a public orientation to the problem of pain, 2) directly link pain (research and) care to the implementation of social/public good, and 3) manifest formidable impact on many of the stakeholders involved in pain medicine (47). Given the literature illustrating, the staggering (medical, actuarial, and lost-work days’) cost(s) incurred by chronic pain, it becomes obvious that measures to avoid its development would produce substantively positive epidemiologic and economic effects. To do this it becomes important to understand 1) the patho-etologies of chronic pain and its effects (viz.- behaviors, disabilities, etc.), 2) how chronicity impacts the lifeworlds of patients and families, and 3) how to develop and direct concentrated effort(s) to subvert these processes. In these ways, we recognize the multi-factorial, bio-psychosocial aspects of both chronic pain (as symptom, disorder, and phenomenal illness; viz. – maldynia) and its treatment(s) (48-53).

The frequent failure to identify chronic pain syndromes early in pathogenesis and/or effectively account for the diverse bio-psychosocial impact of chronic pain can be seen as a major factor in both the

epidemiological prevalence of such pain syndromes and perhaps the nature of the illness phenomenon of maldynia itself (54). Thus, while maldynia may not be an iatrogenic illness vis-à-vis its being directly caused by “the physician,” per se, it is, in fact, reflective of the systemic dissonance in pain care that spans from research to practice to policy (what is often referred to as bench-to-bedside-to-boardroom) and has instantiated a failure of the medical system to address and effectively manage intractable chronic pain (53,55).

Rectification of this problem would therefore involve translation of academic pain research to first-line practitioners as a means toward augmenting awareness of the pathologies of pain, its effects, and instantiating technically right and ethically “good” treatment approaches. To some extent, paradigmatic change that enables transfer of information from basic and clinical research (as well as guidelines for the ethical use of such diagnostics and therapeutics) would directly serve to increase the expert knowledge of clinicians in practice, and practice outcomes could then be used to further direct and shape both research and guideline/policy development (56-58). A reasonable hope is that such an approach would be well embraced by health insurance providers, as viable means of disease and illness management and cost-containment (59).

Physicians, however, cannot be held solely responsible for the prevention of chronicity, as patients themselves are at least to some degree instrumental in the implementation of physician efforts. The characteristic “Western” health care system has implicitly reinforced the expectation that pain patients will be the passive recipients of treatment, rather than actively participating in deliberative conjunction with physicians to discuss values, needs, and options for care (60,61). This is not to infer that we endorse an “acquiescent model” of pain care in which patients (as “clients” or consumers) can “insist” upon various treatments that physicians must render (as “providers”). To the contrary, we seek to develop a system that upholds bilateral autonomy of patients and physicians; the patient having the capacity to voice values and goals relevant to the discursive approach to care options that the clinician makes available, based upon his/her knowledge of the pain disorder, current treatments for such disorder and those treatments that could be most viable in this particular patient in whom the disorder is manifest (40,62). We have posited that economic models that balance demand- and supply-side contin-

gencies, such as those suggested by Ani Satz, might be valuable in providing the policies and financial infrastructure necessary to implement such a scheme of pain care (63-65).

Bodenheimer and colleagues (66) have suggested that "...self-management education for chronic illness may soon become an integral part of high-quality ... care," and while this would support the next step in the paradigmatic "evolution in sickness and healing" that Horatio Fabrega (67) claims will (or must) occur in the near future, the extent to which this has actually occurred, or is occurring in pain care to date, remains unclear. While such far-reaching changes remain speculative, a contemporary model of patient engagement and participation in care has been shown to produce superior health care outcomes (66,68-70), including less reported pain (69,70) and cost-efficiency (69). We pose that in light of what we know about pain, and with respect to creating new models of pain care, the mindset of patients suffering from pain needs to be changed, such that patients have some extent of responsibility in the care process (71). At very least, this mandates a commitment to treatment and respect for physician and the circumstance(s) of the clinical encounter. In this context, Braden's self-help model has been applied to chronic pain management, with empirical validation that it is robustly effective in chronic pain populations (72).

As steward of knowledge and skill, physicians are ideally positioned to beneficently minimize the asymmetry of relational capability (and power) within the clinical encounter, and inform patients about the meaning and importance of signs and symptoms, diagnosis, and prognosis; discuss patient goals and values (73,74); and assume a partnering, supporting, or in some cases, more explicitly directing, role toward treatment options and the importance of patient co-participation. In this way, the role of the physician can be seen as both providing knowledge and skill(s) and motivating, directing, and sustaining patient responsibility by offering proposals that 1) validly afford beneficial treatment options, 2) inspire increased medical adherence, and 3) facilitate patient independence (75-79). We believe that rapprochement cannot occur, or exist without a revision of patients' views about the nature of chronic pain and its care (e.g.- appreciation of possibilities for curing and/or healing-based management approaches), and their relative responsibility to the clinical relationship. All parties involved must reconsider the paradigms under which they function,

and it would be unjustifiable to expect the medical system (as broadly defined, and inclusive of physicians and patients) to be the only entity that contributes to positive change.

B. The Corporate-Administrative Sector

As previously mentioned, the insurance and hospital industries have been reproven for their relative inconsistencies — if not failure — to endorse pain management programs, despite a considerable body of literature to support the cost- and clinical-efficiency. This is particularly true of multi-disciplinary pain care. Given this evidence, it might be assumed that there would be almost unanimous agreement among stakeholders regarding the need to support multi-disciplinary clinics. However, this is not the case. Early multi-disciplinary chronic pain management programs were typically housed in academic medical centers, where scientist-practitioners were motivated (to a large degree) by the development and implementation of effective diagnostics and treatment (80). Unfortunately, as the popularity and demand for these programs increased, some pain clinics became little more than vehicles for diverse, non-coordinated (and thus ineffective) care, despite continuing to enjoy substantial profit. It was soon recognized that 1) the empirical literature supporting the clinical efficacy and cost-efficiency of the multi-disciplinary approach did not generalize to all programs that were simply called "multidisciplinary," and 2) these types of (pseudo) "multi-disciplinary" programs developed a reputation for "taking on all comers," irrespective of prognosis. Indeed, the positive empirical outcomes documented in the literature reflected the work of programs in academic medical centers, where quality of care, rather than profit, had been the priority.

In response to the deterioration of quality in multi-disciplinary pain care, subsidy and support for all such programs declined, as it became difficult to justify the costs of funding treatment that was becoming particularly ineffective. Hence, under circumstances that essentially amounted to "throwing out the baby with the bath water," several hospitals closed their (valid and truly) multi-disciplinary programs in order to avoid substantial financial (and in some cases, reputational) loss.

Here, we can see how the ethics of medicine were overcome by market forces and the corporate ethos. The business ethic of cost-containment and profitability has been described in terms of its impact on chronic

pain management (21,22). Under the market model in which much of medicine — including pain care — operates, the opportunity to be profitable (or at least solvent) is difficult to deny. Still, we feel that if any steps toward reconciliation are to be realistic, it is critical to question the focus and direction of hospitals' fiduciary obligation with regard to chronic pain care. It has been noted that "...matters of hospital management do not figure prominently on the medical ethics agenda" (81). Often, hospital ethics committees are more concerned with legal issues than moral dilemmas, given the prevailing conditions in an increasingly litigious society and risks of liability (82). This may reflect recent findings that even non-for-profit hospitals are becoming progressively more profitable (83) and so it would be naïve to believe that administrators are not challenged, to some degree, by attendant legal and economic pressures. Ells (84) has suggested that in the current climate of scarce resources, hospitals are not obligated to provide unremunerated services other than in certain emergency situations. If this is true, then we query whether hospitals are obligated to provide long-term integrative and/or multi-disciplinary chronic pain management services if insurance providers do not pay for them. Biller-Adorno and colleagues (81) have argued that hospital managers should use an evidence-based approach to determine those services that the respective facility will provide. Clearly, there is strong evidence to support that integrative and multi-disciplinary chronic pain management programs represent highly effective treatment(s) for chronic pain of benign origin (85-92). However, even if hospitals are ethically obligated to the communities that they serve, it has been noted that they must maintain their financial solvency in order to ensure that the practical range of community health care needs is met (93). Funding under- or non-reimbursed chronic pain management programs could therefore necessitate eliminating other services that are equally, and perhaps more, important to the community. Even though there are grounds to view chronic pain management as a fundamental clinical obligation (94) and perhaps human right (95), this does not, in and of itself, dictate that pain care should subordinate other valid and valued clinical services that a particular hospital can and/or should provide.

What then? It has been suggested that if the private sector is unable to provide adequate chronic pain management services, then this responsibility should be borne by the government (21,22). To be sure, there

is a considerable social cost of un- and/or under-treated chronic pain, and given the fiduciary of the government to support the well-being of its people, this may be sufficient reason to consider governmental involvement in supporting widely available, effective pain care. Although currently faced with numerous tribulations other than the chronic pain crisis, it is apparent that governments are progressively accepting a commitment — at least in part — to improving the scope, quality, and availability of pain care (for example, the National Pain Care Act in the USA, Ethik Charta der Deutschen Gesellschaft zum Studium des Schmerzes, and UNESCO Charter on Pain and Suffering) (96). However, we are still confronted with problems of how to decide what types of pain care to support and provide and how such provision(s) will actually be afforded and realized.

THE UTILITY AND USE(S) OF EVIDENCE

Recently we have discussed how these problems and questions might, and perhaps should, be resolved through the use of evidence that informs what approaches to diagnosis and treatment are effective and good for specific types of patients in particular situations (97,98). Evidence-based medicine (EBM) can potentially benefit not only chronic pain patients, but the stakeholders involved in service provision as well, despite the fact that EBM has been criticized as fortifying a purely consequentialist orientation (in that it maintains that the worth of an action can be assessed through the measurement of its consequences). This characterization is partly true, as EBM is focused upon outcomes; however, it is important to recognize that a consequentialist approach necessitates choosing between competing claims of benefit, and any such claims reflect the relative values of those stakeholders involved in the process of weighing the evidence, effecting treatment(s), and judging the outcome(s) (99). This requires that different types and levels of evidence be evaluated not only in terms of outcomes, but with respect to the worth that such outcomes (as well as the dimensions and extent of information and knowledge that are contributory to such effects) have for the stakeholders (58,100). With multiple stakeholders involved in clinical pain care, some system of values-ranking is necessary to facilitate practical utility of the evidence-based approach (101,102).

Clearly, the primacy of patients' best interests should be placed atop this hierarchy, but given such utilitarian focus, we are then forced to consider what

form of utilitarian approach is “best” (e.g. mean-based, welfarist orientations [viz.- greatest good across populations] versus a focus upon more specific groups of chronic pain patients [viz. greatest good within certain populations], or some combination of both) (103). Even in the ideal, wherein some combinatory approach is devised and used, this too must be balanced with what types of evidence are germane and appropriate for particular cases (104), how evidence directs the use and access to certain types of treatment (105), and ultimately how meaningful values’ distributions within and between stakeholders (so as to accommodate both need/demand and supply/availability) should be structured so as to enable provision of, and access to, therapeutic resources in real-world situations (75,106).

RAPPROCHEMENT IN PRAXIS

In light of this, we propose a compromise-based orientation to determining the utility and use of evidence. By definition, the process of rapprochement entails reflective appraisal of perspectives, how differing types of information has contributed to such perspectives, and how information can be exchanged and shared so as to allow compromise and intersection of values hierarchies between the parties participating in, and benefiting from, the use of particular evidence sets. Thus, it is both appreciative and analytic. Given that the environment of pain care involves multiple stakeholders, it can be seen that such a compromise-based approach to EBM would become progressively more complex as the number of interested parties increases.

This dictates that the analytic and reflective components be integral to the planning and implementation phases of the decisional-process, so as to account for the circumstance(s), agents involved, values, possible actions, outcomes, and relative effect(s) that these outcomes incur on specific stakeholders. Toward this end, protocols for evidence-based pain care could be coupled to methodologies for ethical decision-making, using a multi-step process of 1) factual analysis, 2) identification of agents’ involvement and values, 3) assessment of situational factors, 4) entertainment of viable, possible decisions, 5) contextual evaluation of how such decisions differentially affect stakeholders as relevant to the foci of concern, 6) execution of decision(s) and actions, and 7) subsequent analysis of outcomes’ impact(s) (107). This approach is relatively easy to execute, enables prudential casuistic analyses,

grounds rapprochement to the philosophical basis and ethical framework of pain care (2,108,109) and sustains EBM as a powerful tool that can benefit all involved stakeholders — at least to some extent, to facilitate better allocation of limited medical (and financial) resources critical to pain care (64,81).

STEPS TOWARD RAPPROCHEMENT

A first, yet significant step toward the goals of maximizing practical and moral effectiveness of pain care is for pain physicians and academic researchers to create a unified community in which each party learns from, and therefore mutually benefits the other (56, 57). Although the various stakeholders in chronic pain care have a history of inchoate group dynamics, it is not unreasonable to believe that a common ground can be reached through a process of education, exchange, and compromise. Tregunno and colleagues (110) have claimed that “...the identification of unique and divergent stakeholder interests in an integrated framework may enhance organizational learning and change by enabling stakeholders to see different conceptions of performance, thereby helping them to discover new adaptive opportunities.” An expanding body of literature has strengthened the implications of, and suggestions for, a collaborative paradigm in pain care. For example, Loisel et al (111) posit that studies should involve all relevant stakeholders in order to develop strategies that are effective, efficient, and capable of being implemented, and Franche and colleagues (112) suggest that all relevant stakeholders need to be involved in preventing pain-related disability, by collaborating to achieve common goals.

Given the adage that learning precedes change, we believe that enhanced education by and between stakeholders involved in the care of chronic pain will be necessary if some of the prejudices that have developed between the groups are to be overcome, and positive collaborative efforts toward paradigmatic shift is to occur. To re-iterate, evidence can serve as the foundation for this educating process, but here too, caution must be taken to avoid bias toward or against certain types of evidence that might be based simply upon prima facie considerations (113). Biller-Adorno and colleagues (81) have warned against the potential misuse of EBM to emphasize dissonance between stakeholders; such an antagonistic employment of evidence will only further impair any attempts at rapprochement in pain care. Therefore, while results of meta-analyses and systematic reviews are important (and may be vital to

a more homogeneous overview of various types and viabilities of treatments), other, more specific studies (including case-series, and in some cases, n-of-1 reports) are also necessary to most practically (and, we argue, ethically) serve the needs of patients and clinicians in particular contexts and circumstances. The combination of both broad and more punctuate evidence is equally important to sound policy development (114,115) as any meaningful attempt at *rapprochement* in pain care will gain traction only when such appropriate evidence-based practices (including those practices of determining the utility of the evidence itself; i.e.- meta-evidence-based practice) acknowledges and address all stakeholders' interests.

Rapprochement also requires helping non-patient and non-physician stakeholders understand the potential long-term implications of providing or not providing treatments (such as multi-disciplinary pain care) that may appear expensive at first glance, but that have been empirically demonstrated to greatly reduce future health care burdens and risks on both individual and social levels. This will avoid what neuroscientist and futurist James Olds refers to as "tripping points" — issues of unrecognized importance that have the potential for considerable (negative) effect in the future (J. Olds, personal communication). Recognition of such tripping points cannot be myopic, but must seek to "peer around corners" and engage the full calculus of socio-cultural variables that affect pain care, both on national levels and more internationally.

Despite our expressed hope that international efforts will initiate improved understanding of pain and more effective, uniformly capable and sound pain care, we wish to emphasize that any of these "top-down" policy-based efforts require "bottom-up" participation, and thus argue that pain physicians will be required to spearhead the movement toward *rapprochement* between the stakeholders in pain care if any real positive change is to occur in the near future. Physicians are the obvious choice to provide leadership in the effort to convince involved stakeholders that a stance of genuine collaboration will be of paramount — and most far-reaching — benefit for all involved. Historically, physicians have functioned as primary educators in the medi-

cal system, and Chen and colleagues (116) have recently re-asserted the charge to physicians to accept such responsibility as change agents by working with other stakeholders in socio-medical contexts. This is consistent with the position previously voiced by Chervenak and McCullough (117) who have claimed that physicians bear a major responsibility to shape the organizational cultures that support the fiduciary and professionalism of medicine.

CONCLUSION

Earlier in this essay, we suggested that pain care is in a state of crisis. The definition of crisis as a "time of change" does not dictate whether such change is positively or negatively valent. In fact, by definition, a crisis represents a point of "potentiality" at which future directions and trajectories are contingent and determined. We have tried to show that for pain medicine, these contingencies reflect 1) knowledge to date of pain, its effects, and its treatment(s); 2) changing socio-economic trends and circumstances; 3) availability of technical, financial and social resources, and 4) values systems of medicine, societies, and culture at-large. Therefore, any determination of the scope and direction of pain care is reliant upon 1) understanding these contingencies, 2) acknowledging and appreciating the worth and relative hierarchies of stakeholder values, 3) recognizing the ends and goals of pain care as profession and practice, and 4) engaging resources as necessary to affect progress. Hence, it becomes clear how learning can and must precede change, and how change must derive not from the system, but from the agents that determine its function and relationships. This is especially the case given that the change we call for entails and embodies *rapprochement*. Thus, while we have tried to depict "why" *rapprochement* is necessary and possible, the more difficult task ahead is to determine "how" this process should be articulated and "what" shape a profession of total pain care might assume. We remain dedicated to these pursuits.

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