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Maldynia as a Moral Judgment?

Why then 'tis none to you; for there is nothing either good or bad, but thinking makes it so. To me it is a prison. Hamlet Act 2, scene 2, 239–251.

We are dismayed to learn that "maldynia" has now entered Pain Medicine's lexicon [1] due in large part to the efforts of the American Academy of Pain Medicine to categorize pain "on a neurobiologic basis as eudynia (nociceptive pain) . . . or maldynia (maladaptive pain)" [2,3]. These concepts, which were first suggested in 1998 by Lippe [4], are worthy of close examination.

In order to maintain the credibility of Pain Medicine, Lippe saw two issues demanding resolution. First, "a semantic confusion about taxonomy" and, second, "a conceptual ambiguity about pain itself." He argued that by resolving the taxonomic confusion, dialogue would be facilitated within the specialty and a better understanding of pain would *ipso facto* ensue.

Lippe rejected out of hand the idea advanced by Morris [5] that pain was a pluralistic concept. Rather, he asserted "the biomedical basis of maldynia." In Lippe's medico-centric view of pain, "maldynia" was neither a symptom nor a syndrome but an "illness with endogenous and exogenous components." Thus defined, "eudynia" becomes a teleologically beneficial mechanism, whereas "maldynia" is "useless and destructive," and with questionable scientific legitimacy within the clinico-pathological model (which is of course the basis of biomedicine).

So, on the one hand, we now have "eu-dynia" or "good" pain, variously described as "nociceptive pain", "pain as a symptom of disease" and "acute pain", while on the other there is "mal-dynia" or "bad" pain, again variously described as "maladaptive pain", "primary pain diseases (*sic*)" and "persistent pain" [2].

This extraordinary attempt to invoke neurobiology in order to reduce the complexity and unpredictability of pain to a moral binary appears to be flawed, and particularly so when neurobiology is necessarily silent on such judgments as "good" and "bad."

Clinicians cannot help but make moral judgments [6]. Therefore when such poorly understood conditions as many chronic pain syndromes do not accord with a clinician's mode of thinking and practice, patients can be placed in moral jeopardy. An emotive description of a person's pain as "bad" could easily add to the burden carried by an already stigmatized section of the community [7]. Moreover, when a patient's "good" pain turns into "bad" pain, will the clinician be blamed for failing to address purportedly relevant psychological and/or social factors, or will the blame for treatment failure be shifted to the patient?

We are concerned that this latest attempt to categorize pain maintains a simplistic binary approach that is unlikely to facilitate dialogue within the specialty and, in turn, unlikely to lead to a better understanding of the lived experience of pain.

JOHN QUINTNER, FFPMANZCA*
DAVID BUCHANAN, MA, PhD†
MILTON COHEN, MD FFPMANZCA‡
*Pain Medicine Unit, Fremantle Hospital, Fremantle, Western Australia
†School of Nursing and Midwifery, University of Tasmania, Launceston, Tasmania
‡Department of Rheumatology and Pain Medicine, St. Vincent's Hospital, Sydney, New South Wales

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