The burden of musculoskeletal symptomatology in the community is considerable. Regional musculoskeletal disorders predominate. If questioned closely, nearly all of us can recall low back pain last year, a third of us recall pain at the shoulder, hand or wrist, and 15% of us at the elbow. These memorable episodes last at least a week and often are recurring. Regional musculoskeletal pain is an intermittent and remittent predicament of normal life. Feeling “well” demands the sense of invincibility that we can cope with our next musculoskeletal morbidity. Feeling well symbolizes our triumph that we had the wherewithal to cope with the last episode for as long as it took for that episode to remit, to cope so well that the episode is barely memorable, if at all. Being well does not mean avoiding the challenges of regional musculoskeletal disorders; that is not possible. These challenges are as much a part of life as heartache, heartburn, headache, and the like. Therein lies the enigma of health.

It has long been common sense that a press to recourse is driven by the physical intensity of the predicament. The more severe the pain, the more likely it is memorable, the more likely one is to consume analgesics, the more likely one is to experience work incapacity, and the more likely one is to seek professional care. Epidemiology has put this common sense to the test. It is not tenable. Compromise in the wherewithal to cope with the regional musculoskeletal disorder supersedes pain and biomechanical compromise in driving our response. The science supporting this assertion is now as compelling for the predicament of upper-limb pain as it has been for low back pain for over a decade. That explains the results of a World Health Organization (WHO) survey of primary care practices around the world. The 22% (ranging from 5.5 to 33%) of patients in these practices who reported persistent pain were 4 times more likely to suffer anxiety or depression than patients without persistent pain. These people are choosing to be patients because their ability to cope with their pain is overwhelmed by confounders that lurk in the psychosocial context in which the pain is suffered.

This insight has emerged largely from studies of the plight of people in the community with discrete regional musculoskeletal disorders. Does the same insight pertain to the people, hidden in all these surveys, with persistent pain at multiple sites? Only recently has their plight been recognized. They are more likely to manifest psychological disturbance and to report other somatic symptoms than people who suffer from, or recall discrete regional disorders. They are miserable and driven to seek medical care frequently. The report by White and Thompson in this issue of The Journal demonstrates that 7% of the Amish community lives under this pall despite taking pains to stay out of the mainstream of life in North America. This prevalence is similar in the other populations surveyed by White and Thompson and in many populations surveyed elsewhere. People with persistent widespread pain are bedeviled by life challenges that may render Sisyphean any quest for some sense of being well, let alone sense of invincibility. The intermittent and remittent morbid predicaments of life that the well find surmountable are insufferable and unforgettable setbacks for those living under this pall. Hence, they take note of and report other somatic symptoms. Variations in bowel habits are very concerning, and diminished vigor seems oppressive. There is no joie de vivre.

I suspect that few suffering with persistent chronic pain are suffering in silence. I suspect that their narrative of distress is very dependent on the listener. The idioms of distress that would enlist the empathy of a clergyman are hardly the same as those that might enhance communication with a social worker, a sibling, or a physician. We have no data as to how these people select a confidant. They probably choose many and often, depending on the cultural setting. If they are seduced by the construction, “scientific medicine,” they will choose a physician. As White and Thompson point out, the Amish are long imbued with this
The majority of people with persistent widespread pain improve this sophistical treatment act. In the community, the learned, which they can recite with objectivity that narrative is laced with the clinical heuristics they have syndromes"15 and "medically unexplained symptoms" 16 labels2,14 means no more than that. "Functional somatic overwhelming persistent widespread pain." FM and its sister complaining of persistent widespread pain than "over- need but tweaking to produce the benefit that has eluded that their pathophysiological insights and theories are valid, medically explicable.

The fate of patients with persistent widespread pain learns to be a patient with "fibromyalgia" (FM). The clinician who applies the label and promulgates the treatment act must disregard the observation that "tender points" are related to generalized pain and pain behavior11. The patient is forever changed. Their narrative is laced with the clinical heuristics they have learned, which they can recite with objectivity that approaches dispassionate.

There is no more valid a diagnostic label for patients complaining of persistent widespread pain than "overwhelming persistent widespread pain." FM and its sister labels2,14 means no more than that. "Functional somatic syndromes"15 and "medically unexplained symptoms"16 denote the same subset of the woebegone. The former is difficult to define, even by its proponents, and the latter implies that one would be better off if symptoms are medically explicable.

The proponents of the FM construction are convinced that their pathophysiological insights and theories are valid, albeit as yet unproved, and their therapeutic approaches need but tweaking to produce the benefit that has eluded demonstration to date. I am concerned that this approach is causing harm today. However, it is possible that a therapeu...
instead of medicalization when she or he chooses to be a patient with chronic widespread pain.\textsuperscript{21,22}

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