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PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



Thrown Vase by Lucie Rie, DBE . British Austrian potter(1902 – 1995).

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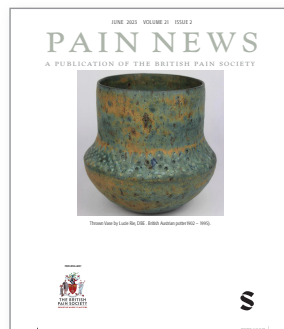
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Contraindications: Hypersensitivity to sufentanil or any of the excipients; Significant respiratory depression or pulmonary compromise.

Warnings and precautions: Sufentanil may cause respiratory depression (the degree/severity is dose related). Respiratory effects should be assessed by clinical monitoring. Patients at higher risk are those with respiratory impairment or reduced respiratory reserve. Concomitant use of sufentanil and sedative medicines such as benzodiazepines or related medicinal products may result in sedation, respiratory depression, coma and death. Concomitant prescribing with these sedative medicines

should be reserved for patients for whom alternative treatment options are not possible, or when sufentanil is used in an emergency setting. Use with caution in patients particularly susceptible to the cerebral effects of CO₂ retention. Sufentanil may obscure the clinical course of patients with head injury. Use with caution in patients with brain tumours. Sufentanil may produce bradycardia. Use with caution in patients with previous or pre-existing bradyarrhythmias. Sufentanil may cause hypotension, especially in hypovolemic patients. Appropriate measures should be taken to maintain stable arterial pressure. The duration of activity may be prolonged in severe hepatic and renal impairment: monitor carefully for symptoms of sufentanil overdose. Tolerance, physical and psychological dependence, and opioid use disorder (OUD) may develop upon repeated administration. Abuse or intentional misuse may result in overdose / death. Risk of developing OUD is increased in personal or family history of substance disorder, tobacco users, history of mental health disorders. Monitoring for drug-seeking behaviour, signs and symptoms of OUD and review of concomitant opioids and psychoactive drugs is required. Sufentanil may slow the gastrointestinal motility: Use with caution in patients at risk of ileus. Sufentanil may cause spasm of the sphincter of Oddi: Use with caution in patients with biliary tract disease, including acute pancreatitis. Opioid induced hyperalgesia, sleep-related breathing disorders including central sleep apnoea and sleep related hypoxemia may occur. A reduction in dose / treatment review may be considered. Sufentanil

has major influence on the ability to drive and use machines. Patients should be advised not to drive or operate machinery if they experience somnolence, dizziness, or visual disturbance while taking or after treatment.

Fertility, pregnancy and breastfeeding:

Sufentanil is not recommended during pregnancy and in women of childbearing potential not using contraception. Sufentanil is excreted in human milk to such an extent that effects on the breastfed newborns/ infants are likely. There are no clinical data on the effects on fertility.

Undesirable effects:

Serious side effects: Hypersensitivity, hypokalaemia, tachycardia, hypoxia, respiratory and depression, bronchitis, thrombocytopenia, anaphylactic shock, hyperkalaemia, diabetes mellitus, hallucination, dystonia, convulsions, coma, bradycardia, angina pectoris, atrial fibrillation, hypertension, apnoea, hypoventilation, pulmonary embolism, pulmonary oedema, respiratory distress, respiratory failure, respiratory arrest, hyperbilirubinaemia, renal failure, electrocardiogram T wave abnormal, electrocardiogram abnormal, postoperative ileus and gastrointestinal stoma complication.

Very common side effects: Nausea, vomiting and pyrexia.

Common side effects: Anaemia, leukocytosis, hypocalcaemia, hypoalbuminaemia, hyponatraemia, insomnia, anxiety, confusional state, headache, dizziness, somnolence, sedation, sinus tachycardia, hypotension, pharyngolaryngeal pain, constipation, dyspepsia, flatulence, dry mouth, pruritus, muscle spasms, muscle twitching, urinary retention, oxygen saturation decreased, body temperature increased and anaemia postoperative.

For full list of side effects, consult SmPC.

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Understanding medicine part 1: Hippocrates and the role of prognosis in medicine

Rajesh Munglani *Editor Pain news*

Vice President British Pain Society

Prognosis: a doctor's judgement of the likely or expected development of a disease or of the chances of getting better (Cambridge Dictionary).

Hippocrates, who was born on the island of Cos, Greece, and lived in ancient Greece from about 460 BCE to 370 BCE and died in Thessaly, is often referred to as the 'father of medicine'. His contributions to medical understanding were profound, and four of these contributions are highlighted below.

1. **Observational medicine:** Hippocrates believed that careful observation of patients and their symptoms was essential to accurate diagnosis and treatment. He emphasised the importance of recording and analysing symptoms, as well as the patient's history and environment, to understand the disease process.
2. **The Hippocratic Oath:** This ethical code, which is still used today, sets forth the principles of medical ethics, including confidentiality, the avoidance of harm, and the importance of putting the patient's needs first. Today, these fundamental issues and duty of care of doctors have been reaffirmed by the GMC and enacted into law in the Supreme Court ruling of Montgomery 2015.
3. **The Four Humours:** Hippocrates believed that the body was made up of four humours or fluids (blood, phlegm, yellow bile, and black bile) that needed to be in balance for good health. When one or more of these humours became dominant, disease could result. The disturbance could result from overindulgence in food or drink, too much or too little physical exertion, or changes in the so-called 'naturals', that is, the uncontrollable environment and climate. Because of the similarity of the natural elements and humours, certain humours were more likely to become excessive during given seasons of the year. Phlegm increased during the winter,

bringing with it bronchitis and pneumonia because phlegm was cold and wet, like the chilly Mediterranean winters.¹ In warm, wet spring, hot, wet blood increased, causing dysentery and nose bleeds.¹ This theory of disease remained popular for centuries. While it may be argued that such a theory has no place in modern medicine, the recognition – the idea that disease had natural rather than supernatural origin – caused Hippocratic physicians to observe their patients closely. Such observation of the patient included their physical condition, dietary and exercise habits. If, on the contrary, disease was thought to have a supernatural source, then environment played no relevant role and the offending curse or possession was independent of the physical characteristics of those afflicted and their environments. But, for the Hippocratic trained doctors, diagnosis and treatment began with the knowledge of the patient.

4. **Prognosis:** Closely following on from careful observation of the patient and their environment came diagnosis and prognosis. Hippocrates was known for his diagnostic skills, and he emphasised the importance of making accurate diagnoses based on careful observation and examination. He also recognised the importance of prognosis, or predicting the likely course of a disease, in order to help patients and their families plan for the future.

Hippocrates recognised the importance of prognosis, which is the prediction of the likely course and outcome of a disease. He believed that understanding the natural course of a disease was important for making treatment decisions.

Understanding medicine part 1: Hippocrates and the role of prognosis in medicine



Ars Medicinæ (Art of Medicine) is a compilation of medical texts of Greek and Arabic origin. Since the early 12th century, most of these texts were translated into Latin by scholars in the circle of the medical school of Salerno and became the basis of the medical curriculum in European universities until the 16th century. The *Ars Medicinæ* includes medical treatises on various topics such as urine, fever, diets, and cures, as well as an important tract known as the *Prognosticon* by the famous Greek physician Hippocrates. The *Prognosticon*, or Book of Prognosis, focuses on ways of predicting the likely development of a medical condition. For Hippocrates and for the medical school founded by him, prognosis was the natural result of diagnosis, which looked at the signs and symptoms of a condition. Credit British Library.

Hippocrates emphasised the need for physicians to carefully observe and analyse a patient’s symptoms and overall condition in order to make an accurate diagnosis and prognosis. He believed that a physician should be able to recognise the signs and symptoms of different diseases and predict their likely course based on their experience and knowledge.

For example, Hippocrates recognised that some diseases, such as acute infections, were likely to resolve on their own, while others, such as chronic conditions, might have a more unpredictable course. His belief that environmental and lifestyle factors could influence the course of a disease meant that a



Ivo Saliger (1894–1987), 'Der Arzt ringt mit der Todt'. The physician struggles with death. Credit Teddy Bader Which Treatment is Best? CRC Press 2023.

physician should take these factors into account when making a prognosis.

Overall, Hippocrates’ emphasis on careful observation and analysis, as well as his recognition of the importance of prognosis, helped to establish the foundations of modern medical practice. Indeed in the 2014 edition of the BMJ, the predictive power of two of Hippocrates’ aphorisms about good cognition and a good appetite in determining whether someone would die in the next 5 years was powerfully demonstrated.²

Prognosis in modern medicine and the utility of medical intervention

Understanding the expected course of a disease or condition and its likely outcome is what distinguishes physicians from most of the patients they serve. Prognosis allows for informed decision-making by both healthcare professionals and patients regarding treatment options, patient management, and end-of-life care.

If a patient has a poor prognosis, palliative care rather than aggressive treatments may be appropriate.

Understanding medicine part 1: Hippocrates and the role of prognosis in medicine

A fundamental corner stone of research is also to understand the nature of the disease and its progression, that is, its prognosis. Comparing prognosis with different treatments, especially when patient characteristics have been accounted for, can help to identify those patients who may be more likely to benefit from certain treatments or interventions.

‘The physician who cannot inform his patient what would be the probable issue of his complaint, if allowed to follow its natural course, is not qualified to prescribe any rational plan of treatment for its cure. Hippocrates’

Note

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Lucie Rie's workshop, as exhibited in the Victoria and Albert Museum, London. Credit Andreas Praefcke.

From The President

Professor Roger Knaggs



Welcome to this summer issue of Pain News.

It is a privilege and honour to be the newly appointed President of The British Pain Society following in the steps of numerous influential leaders over the long history of the Society.

The times they are a' changing

At the Annual General Meeting held on 10 May, we announced changes to the Executive Officers and Council members. We are immensely grateful to Dr Arun Bhaskar on the completion of his term as President. When Arun began his presidency in 2019 there was no indication that a global pandemic was

round the corner. He led the Society through changing times with many difficult decisions needing to be made, sometimes at very short notice. Also completing his term of office is Honorary Secretary, Dr Ayman Eissa. Ayman has focussed on exploring support for independent health and social care agencies to improve pain management, and we as a Society will consider how this can be developed and best taken forward over the next few months.

I am delighted to announce three new Vice Presidents who start a 3-year term of office; Dr Cathy Price, Dr Rajesh Munglani and Dr Ashish Gulve. None need any introduction to members of the Society. My intention is that each will have a specific area of focus and I have invited Cathy to concentrate on membership retention and growth, Raj on improving internal and external communication, and Ashish on financial strategy.

As Dr Gulve has become a Vice President, we also have now a new Treasurer, Dr Tacson Fernandez. I am grateful to Ashish for his ongoing work as interim Treasurer and Treasurer over the last 4 years and I am delighted to welcome Tacson to the Executive. In addition, Dr Neil Collighan succeeds Dr Eissa as Honorary Secretary.

Both Dr Amelia Swift and Mr Martin Hey have completed one term as elected Council members. Most recently, Amelia has chaired the Education Committee and Martin has led the Communications Committee.

Earlier in the year there was a call for nominations for up to four elected Council members. With only three nominations, no election was required. It is a pleasure to welcome Dr Manojit Sinha and Dr Mahindra Chincholkar as elected Council members for their first terms. Martin Hey was re-elected for a second term.

Our new Secretariat

As has been mentioned over the last two issues of Pain News, there have been significant changes to the Secretariat over recent months. The Society is extremely grateful to Louise Gorrington for her leadership in this transition. Our new Executive Director, Matthew Hall, has recently started work. Together with

President's message

our Association Manager, Ester Zoroa, they make a dedicated and efficient team. If you need to contact the secretariat please use info@britishpainsociety.org.uk. You will receive a prompt, and I hope helpful response.

Some of the new Executives and Secretariat have contributed to this issue of Pain News, so I hope you feel that you know them a little better and that you can put a face to their names. I look forward to working with the new Executives, Council members and secretariat over the coming years.

Communication

I hope also you have taken the opportunity to read the two e-Newsletters that have provided Society updates between issues of Pain News. If you have not received them, please let us know to ensure the e-mail address that we have recorded for you is correct. It has been heartening to see the proportion of members who have taken time to read these messages. Given the need for more regular and improved communication with the membership I intend to appoint a specific Editor to coordinate the content and frequency of the e-Newsletter.

Thank you to those who responded to the request for volunteers to help in the work about updating the vision and mission of the Society. This forms part of a larger piece of work to lead to developing strategic priorities for the next few years. We will provide further updates as this work progresses. Also, if you have a news story that you would like to share with the wider BPS community, please do let us know and we will try to ensure that this is included in the next issue of the e-newsletter or Pain News. And you may contact the secretariat using the email address above,

ASM 2024

Although it may not seem long since we met in Glasgow for our Annual Scientific Meeting this year, plans are already beginning for next year. The venue will be East Midlands Conference Centre between 13 and 16 May 2024. Please do mark these dates in your calendar. The Scientific Programme Committee will request proposals for workshops before too long, so start

thinking about topics that will of interest to fellow members and the wider pain community.

The ASM has always provided both educational and social opportunities. Over recent years there has been an unofficial meal for 'Grumpy Consultants', usually held on the first evening of the ASM. The participants (not all of whom were either grumpy or consultants) commented how this improved their overall experience of the ASM in general.

In his role as Vice President, Raj Munglani is keen to develop this concept in a more inclusive way. So, we will look to extend the evening social programme at future ASMs with optional official smaller gatherings (perhaps 'hosted' by the some of the SIGs and of course the 'Grumpy Consultants' themselves). All events will be open to all members, and we will aim to promote these as soon as possible. If you are interested in these events do get in touch.

With us all working together, I hope that these initiatives will facilitate the development of a stronger shared identity for our Society and engender a more integrated and committed membership while at the same time recognising and celebrating the wide variety of disciplines and approaches to the assessment and management of pain.

As ever, I am very keen to hear from you about any pain-related issues or how the BPS can have greater visibility, so do not hesitate to contact to me. I will take the time to read and respond to every e-mail received.

The British Pain Society remains YOUR Society and it needs YOU to flourish.

As Summer approaches, I hope that you find time for some rest and relaxation among all your work priorities.

With best wishes,



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Pain news roundup: summer 2023

Margaret Dunham *Associate Editor, Associate Professor in Nursing and Pain Management, Edinburgh Napier University*



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Easter has gone by too quickly this year; the spring lambs are gambolling their way to summer and we're almost one quarter of the way into a new century. Just as time never stops and waits for us to catch up, technology never ceases to evolve and confound current practices. Technology is both challenging and costly for all, and particularly in health care. I expect our ancestors were just as scared of the telephone and first motor cars in a similar way to how society is currently grappling variously with what to do with Twitter, TikTok and recently AI (artificial intelligence) in its various forms including chatGPT.

In a recent *Guardian* article (6 April), one of the editors considered the potential for AI to mimic existing outputs – writing, music, research papers and so on – and the concern that some of the information might not be true and/or potentially dangerous. ChatGPT is an enhanced chatbot with AI potential: it could pretend to be a health care provider in remote communications because of its capacity to mirror human conversation, also it could be used to summarise complex medical histories or translate the complexities of medical jargon into more easily understood lay language(s). But will it get things right or confuse the issues? The inherent risk of all these new technologies is that health professionals are not offered the opportunity to be part of the early development and focused application to health care use. This frequently leaves design development and potential to the mercy of commercial enterprise rather than health care need.

The use of AI in health care is something we should embrace and harness; however, there will always be the 'King Canutes' out there trying to hold back the tide of change. Some of us older ones may remember the portable scanning device, the tricorder used in *Star Trek* or a little more recently, the 'intelligent' computer Holly from *Red Dwarf* who kept the crew alive in albeit altered forms . . . Indeed, does fiction inspire science or is the fiction based on the potential within science? There are already 'intelligent' devices such as DxtER, an iPad with inbuilt AI and others that have a number of non-invasive sensors, and thereby the ability to measure vital signs, blood pressure, heart rate, oxygen saturation, skin temperature and more. But many of us already own smart watches that do a very similar job but on a smaller scale, so the possibilities are endless.

Diagnosis is invariably essential to managing both chronic and acute pain. A 2023 systematic review¹ of diagnostic tests for low back pain (disc, facet or sacroiliac joint) confirms that diagnosis is sometimes possible but that still leaves up to 90% without clear structural/pathological attribution. However, the mechanisms of how pain is experienced and expressed are still not fully understood, nor is quality care always available to those who have a diagnosis. An eloquent account of one person's experiences of living with chronic pain, supporting the need for education and further research, is detailed in the March 2023 edition of *Nature*.²

Trust in any relationship is a really important foundation, and within health care, if any intervention is to be well received and accepted, that professional relationship most certainly has to be founded on trust. Cathy Stannard and Colin Wilkinson in their recent *BMJ* editorial³ emphasise the importance of empathetic relationships in managing chronic pain and the over-reliance on medication for chronic pain management. Indeed, the global concern about opioid safety use for chronic pain continues. However, attention should not solely focus on one aspect of treatment for pain, and the use of adjunct therapies such as antidepressants and antiepileptic drugs deserves similar scrutiny. A recent review in the *BMJ*⁴ suggests that antidepressant use for chronic pain, as endorsed by the 2021 National Institute for Health and Care Excellence (NIHCE) guideline for chronic primary pain, demonstrated no equivocal evidence for the efficacious use of SNRIs or SSRIs. Sadly, many of the included studies were not of high methodological quality, demonstrating a clear need for high-quality data for use of adjunct pain medication. But who will fund all these studies if pain services and pain management are not prioritised within health care provision?

Nitrous oxide (NO₂), that wonderful short-lasting analgesic, has got a really bad press recently. Anyone working in A&E (accident and emergency) or maternity services will undoubtedly appreciate the importance of having 'gas and air', as known as Entonox, available for a range of circumstances. Yet recent reactionary panic related to side-effects has led to several hospitals in the south of England temporarily suspending access to Entonox, particularly due to 'safety concerns'.

Pain news roundup: summer 2023

However, some of you may have witnessed colleagues suffer the direct consequences of exposure to Entonox in less well-ventilated settings. Many years ago, I remember catching a medical student who fainted, next to the bed of a person undergoing a painful wound dressing change, reflecting then about its use in areas without scavenging systems. What appears to have informed the emergence of concern over the use of NO₂ is its transformation to widespread recreational use. Laughing gas has been a recreational drug for nearly 200 years, most recently referred to as 'hippy crack'. The abundance of small silver lozenge-shaped canisters littered in parks and city centres reflects its ubiquitous nature among young people in the United Kingdom. Nitrous oxide is used everywhere, because it is cheap and so easily available. It will inevitably become another regulated drug, but still not as dangerous as alcohol . . .

Another widely used recreational drug is marijuana or cannabis, with huge potential for future use in pain management

when properly evidenced and supervised in its delivery. On a sad note, the scientist who pioneered understanding of the mechanism and action of cannabis, Professor Raphael Mechoulam, has died, aged 92. He identified the brain's endo cannabinoid system. His research directly informed the current global use of medical cannabis and its derivatives. We need more pioneers of pain and health care research, some equally creative people, the 'blue sky' thinkers, to take us forward to a better second quarter of the 21st century: roll on summer.

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From the honorary secretary

Dr Neil Collighan



I have been asked to write a short article on who I am, how I got here and where I would like to go with the British Pain Society in my newly elected role as Honorary Secretary.

I grew up in the North West of England, father a consultant radiologist, mum a nurse/midwife – so you could say I've been steeped in the National Health Service (NHS) since birth! I did my medical training in Edinburgh, SHO jobs around Worcester/Hereford and registrar jobs in West Yorkshire until I landed in my consultant role in East Kent. I'm well-travelled, as you can see, and I think this gives me a broad overview of how services, particularly pain services, are and can be delivered.

When I took up my consultant role in 2009, I first put my energies into developing a neuromodulation service with a colleague, and have since looked more widely at national and international roles.

I have been involved with the British Pain Society since being a registrar and have been lucky to have had senior colleagues who encouraged my involvement in the Society. I started with filling every role in the Interventional Pain Medicine (IPM) Special Interest Group (SIG) as Treasurer, Secretary and then Chair. These roles required my interaction with the Secretariat and Council which gave me an insight into the inner workings of the British Pain Society and the drive to push on further. I also participated in the inception of the Medicolegal SIG.

As the Chair of the IPM SIG, I chaired an editorial group which developed national guidelines for the delivery of interventional procedures in the United Kingdom (and its review in 2020). I was Co-Chair of an editorial group which developed national guidelines for medial branch blocks and radiofrequency denervation of lumbar facet joints in the United Kingdom. I was Chair of a working group for the British Pain Society and Royal College of Anaesthesia Faculty of Pain Medicine, delivering a consensus statement on the use of neuraxial steroids in pain procedures.

I have also taught locally, nationally and internationally on neuromodulation and radiofrequency techniques. Most recently I have been involved in the creation of a Europe-wide curriculum for radiofrequency techniques, and look forward to its completion and delivery across the continent.

I was elected by membership to Council in 2018 (thanks to everyone who voted for me!) and continued my involvement with the IPM SIG by becoming Council liaison. I also took on the role of National Institute for Health and Care Excellence (NICE) liaison and have led the BPS responses to the more interesting documents they have produced over those years, particularly regarding neuropathic pain and chronic primary pain.

I initially joined Council under the leadership of Andrew Baranowski, who was then followed by Arun Bhaskar. Both have led the BPS in their own inimitable ways and it has been good to see the fortunes of the Society slowly turnabout. When I joined Council we were discussing levels of finance required to wrap the Society up; now, we are discussing how to move forward and long-term financial planning, to guide the society into a much better future.

I am aware there has been chat about what the Society delivers and whether this is value for money. Over the last few years, with money most definitely at a premium, it has been difficult to answer these questions. All I can say is that the future is bright and part of my role as Secretary will be to enhance that value, with the aim of increasing membership numbers and thereby improving what the BPS delivers to its membership.

Secretary Message

From the honorary secretary

How can we do this? To me, the answer lies with the members and developing the SIGs to increase delivery of services, knowledge and experience, to improve every member's ability to deliver quality services to their patients.

With the new President, Roger Knaggs, we are aiming to review the SIG groups and start to drive their importance within the BPS. Last year, there was a SIG Chair meeting and an agreement was reached regarding what is expected of each SIG. Look for more SIG content in *Pain News* and more opportunity to attend SIG-related meetings and webinars among other things. Over the coming months, we will be

supporting each SIG to enable increased activity and delivery. We hope to encourage the SIGs to develop a work plan and set priorities with the aim of establishing long-term goals and creating future pathways.

Of course, this all takes people's time and effort. I would put out a call now to every BPS member (and any future members) that volunteers are always warmly welcomed. I can't really explain how much you would gain by doing so and being part of this wonderful inclusive team, but I did enjoy my input so much I applied for the Honorary Secretary post!

BPS secretariat update

Matthew Hall



Following discussions towards the end of 2022, the British Pain Society (BPS) Council selected Kenes Group to provide secretariat services. Members of the Council worked together with Kenes to determine the optimum structure for the BPS, particularly maintaining dedicated staff and an office.

The new secretariat is headed by Executive Director Matthew Hall, who has 12 years of experience across several strategic and operational roles in professional bodies and membership organisations. He is based in London and will be focused solely on the BPS, overseeing the activities and operations of the Society, and working closely with the Council and Committees to develop and execute on strategy.

Matthew is closely supported by Ester Zoroa, Association Manager, and Louise Gorringe, Associate Vice President of Association Management, both of Kenes Group. They each possess considerable experience of managing non-profit organisations in the scientific and medical sector. They are based in Spain and Switzerland, respectively.

This structure allows the BPS to benefit from the broad expertise, resources and support of the Kenes Group, while maintaining a dedicated resource who will uphold the independence and culture of the Society.

Matthew commented on his arrival:

I have worked for several not-for-profit membership organisations serving specialist and multidisciplinary

audiences, including several Chartered Institutes. My particular interest lies in understanding membership and stakeholder engagement, and how that engagement drives strategic decision making within organisations. I have had the opportunity to research this area in considerable depth recently, as the Third Sector Scholar on Bayes Business School's MBA programme.

With that in mind, I'm delighted to be joining an organisation with such a rich history and important purpose. As I begin to settle in, I will be seeking to meet with and talk to as many British Pain Society members as possible. This is your Society, and I want to understand exactly what you expect from membership. What should we be doing more of? What should we be doing less of? How can we drive better outcomes for your patients? How can we help you thrive in your careers?

You can send me an email, call me, or even draw me a picture! However you like to communicate, I am listening. I will also be attending the upcoming Annual Scientific Meeting in Glasgow. Those of you who read our new member newsletter will have noticed the BPS are hosting an exhibition booth at the conference – you will often find me there, or we can arrange to meet around the sessions.

Before the ASM, I have been extremely busy clearing out the BPS office in eager anticipation of our upcoming office move. Although we are just moving down the corridor, the opportunity for a spring clean is most welcome. With the kind support of colleagues, I have been sorting through the various materials and documents of recent (and not-so-recent) years. Roger and I had joked that we would need a museum to display the many books and artefacts we had uncovered. Although we have no plans to begin competing with the Wellcome collection just yet, I hope we can find some interesting ways to share some of this history with you.

I had only been at my desk a few days when the Society received a handwritten letter from someone who had experienced chronic pain for a prolonged period, and was seeking help, advice, and guidance on finding and accessing treatment. For me, it was a timely reminder of the critical importance of the BPS's work and the positive and direct impact our members can have on people's lives. I look forward to supporting you as you make that impact.

Contact Matthew at matthew.hall@britishpainsociety.org

Whit a sotter!

Chris Bridgeford *Chairman, Affa Sair*



Whit a sotter I'm in. For those of you who don't speak the language I should translate it to 'What a mess I'm in!'

Now that it's 2023, I'm celebrating the 45th anniversary of being diagnosed with chronic pain. It's been quite hellish and exhausting since the beginning of the year.

I always expect a worsening of my pain levels in the winter but it seems to have been continually bad since October or so. Life has carried on as usual, of course, but any good times have been pushed into the background with a darkening gloom of increasingly painful body parts and frustration of nowhere to go for help. The usual daily battles of chronic pain were interspersed with flares that lasted longer and longer with it all merging into a long, dark, solitary passage of pain.

Even when things seem dire they can always get worse, of course. All made more difficult with a background of increasingly depressing stories on the state of the once enviable National Health Service (NHS). Whichever side of the border you live in, we're all aware of the media reports on the destroyed NHS. While politicians battle over whether the English or Scottish Health Service is worse, it's the patients who are suffering. When you have an invisible condition like chronic pain, the problem is made much worse as there's no free-flowing blood or bones sticking out to convince already stressed and exhausted health workers how bad a state you are really in.

An exhausting menu

Knowing the problems even my wee local health centre and small District General Hospital face, I recently put up with ever-increasing abdominal pain for hours before I gave in and phoned for advice and help. Unfortunately I negotiated the menu system wrongly and picked the option for medical emergencies – as I presumed the pain that had me doubled-up and screaming fitted the bill. The call handler (well known for her – let's say – argumentative style) answered with 'Do you need a Doctor?' I gave a mangled breathless response of saying 'Well, not necessarily a Doctor . . .' meaning I was

happy to speak to a clinician as I well know from my wife's work and years of my own experience that other clinicians are just as knowledgeable and capable. Before I could continue through the paroxysms of pain, I was sharply told, 'This is the line to speak to a Doctor!' Well no, actually. The menu system says it is the line for 'medical emergencies'. This shows a clear need for the difficulties of a chronic pain condition to be explained not only to clinicians but also to gatekeeper staff who are, after all, the first point of contact for most patients.

Not having the energy (or breath) for an argument, I hung up, called back again choosing option 2 for 'Appointments and General Enquiries'. It takes 52 seconds to get through the menu system to the medical emergencies option and 1 minute 4 seconds to get to the Appointments and General Enquiries option. To get through the whole spiel takes 1 minute 24 seconds. Unless you're told they are too busy and your call disconnected, you find yourself in a queue, of course, and wait and wait and hope for a pleasant call handler – most of them are, to be fair. These times may not look long on paper but believe you me, when you're doubling up in pain, they do seem forever.

I did get through to a very pleasant lady on the general line who immediately got me a conversation with the triage team – just what I wanted originally. All I wanted was some advice on whether taking a muscle relaxant (Diazepam) would be ok with the abdominal spasms. His advice was that, considering the amount of pain I sounded in, I should phone an ambulance – so I did. They arrived within half an hour and thought I'd be better off in hospital but warned that they could be stacked for up to 3 hours. However, they suggested that if they got their control to phone A&E, my wife (who had gotten home from work in the NHS by now) could take me to the District Hospital and we would be seen. Not wanting to have the ambulance out of action for so long, we decided she would take me. Sadly, control didn't phone ahead and so there was a 2.5-hour agonising wait in A&E reception.

Should've stayed at home

In the A&E department, I was put on a trolley and stayed there for the next 14 hours after which I was sent home, as there were no beds in the hospital. First of all adhesions were blamed, a chest x-ray was done instead of abdominal x-ray,

and eventually constipation was diagnosed ('No sh*t, Sherlock', as the saying goes) and an enema was given. Not the most comfortable night, no sleep, no relief, but regular attention from the conscientious nurse. Frankly, I should've stayed at home, used the enema kit I had at home and just screamed at the walls. For those who say I should stop the opiates – well, no, tried that and pain is unbearable even for me being used to it after 45 years. What I should have been doing is taking more care and using more laxatives and stool softeners. I've now got the health centre to instruct the pharmacist to put docusate capsules in my dosette box to ensure I take them every day. It's these simple joined-up schemes that make a huge difference to the patient. Problem is that it seems the patient has to come up with the answers themselves.

Is there anybody there?

To add to all the excitement a new joy has come my way – restless legs syndrome – so weird and painful. But where to get help? Thing is, I know there's no quick cure and there seemed little point in battling the health centre menu system, so I just waited for my regular 5-week phone call from GP. I'm lucky and grateful to get that these days as it saves waiting around in the health centre while the Doctor is always running behind schedule as he says and knows how uncomfortable it can be for me in the waiting room. So, it's Mr Google again. Now, I know many clinicians frown on patients googling the answers but frankly there is nowhere else to go. I suppose I'm fortunate that with all my time researching and helping other chronic pain sufferers, I can tell the bad from the good, but it's a far from ideal system that we've descended into. So, after ordering a bottle of magnesium and slapping it on, the problem does seem to be under control. Ironically, on speaking to my GP on his regular call, I found he uses it too for leg cramps after gym training. Well – as the saying goes, what's good for the goose is good for the gander!

In the last couple of years, I've also been affected by hip pain and have even had steroid injections to help. No joy. While it's gotten worse and worse over the winter, a long-time forgotten pain problem also came back to haunt me. A legacy of having ankylosing spondylitis as a teenager is the observable narrowing of the spaces between my sacroiliac joints where lower back pain has gotten to ridiculous levels again. The hip pain is piriformis syndrome, trochanter syndrome or, to put it bluntly, a damn sore hip with numbing pain down my leg. This is so bad now that every night, without fail, I'm woken to a numbing-piercing pain from hip to knee and sometimes ankle and the dreaded low back pain from AS joining the rest of my painful skeleton, musculature and nerves. What to do?

I've tried the recommended exercises from Mr Google and YouTube to no avail. There is a long wait time for real-life

physiotherapy here, with a phone call being the usual option given. You can only attend physio for 7 weeks at most now. Some 30–40 years ago, I used to go to the now sadly mothballed local cottage hospital every week for physiotherapy until the early 2000s. Those were the days. Just think how much bed-blocking and other problems could have been lessened if cottage hospitals had been allowed to stay open.

DIY is a necessity

Nowadays we're encouraged to live well with pain. That's all well and good. But when the pain is day after day, the fatigue has you unable to think and there are no real-life treatment facilities in reach – that's not an aim that's any good to most people.

I do fully accept that good mental health is crucial to coping with a life of chronic pain but again, how do you get that help without battling the stressful obstacles to reach a sparse and underfunded service on the NHS? Well, in a rural area like mine, it's a matter of DIY. I'm a long-time meditation user and enjoy the benefits of Reiki and Acupuncture but the pain lingers on. I'm convinced it has a consciousness. It hides away from the areas that are treated just to appear again later in the day on the untreated body parts. The last recommendation I got to improve my mental health was through a diabetic consultation which led me to an online 'chat' with a bot. No help to me – just more frustration.

There are a huge amount of resources available online but humans need human contact.

Insults don't help

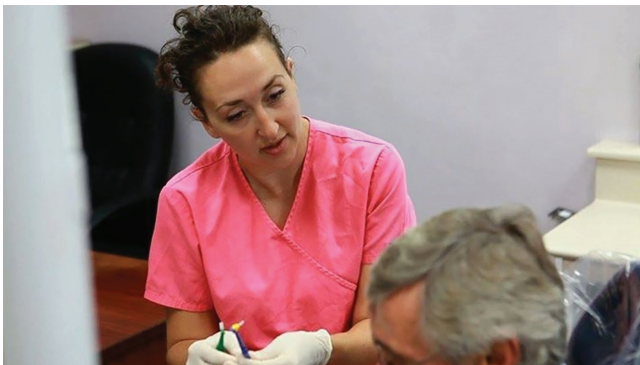
Every part of the NHS seems to work independently of the others while, up here anyway, the NHS Boards blame the Government, and the Government blames the Boards. If only the politicians in both Scotland and the rest of the United Kingdom would work together to get the NHS back to a working health service, patients might get some of the help they need. Here especially, the opposition parties do nothing but literally shout more and more childish insults across Parliament, conveniently forgetting the pandemic, and hurl meaningless statistics about. All this does nothing to help patients but has the effect of demoralising staff and frightening patients away. What would it be like if health care was taken out of political point scoring and our supposed representatives worked together to ensure the people they are supposed to serve get the best care available – free at point of use?

I'm exhausted; with no choice but to battle on – on my own.

As I said at the beginning, 'Whit a sotter I'm in' – but is it me or the country?

Key insights from stakeholder events on preventing dental pain in individuals with dementia

Dr Nicole Thomas *University of Plymouth, Plymouth, UK*



Project Team: Professor Patricia Schofield, Dr Nicole Thomas, Dr Carrie Stewart, Professor Robert Witton and Mr Ewen McColl.

Background

Chronic pain is defined by the International Association for the Study of Pain (IASP) as pain that persists beyond the expected healing time and often has no identifiable cause or clear pathway to a cure.^{1,2} While common chronic pain syndromes are documented in care homes, the prevalence of dental pain in people with dementia in the United Kingdom is not well understood, in part due to the low priority given to oral health until problems arise.³ Oral health care for people with dementia can be challenging due to complex pathways and scarce information,³ but guidance on maintaining oral health for older people with dementia is growing.⁴ Effective oral health care strategies, including staff training in oral hygiene monitoring and assessment strategies and the use of oral health screening tools, are important for preventing oral diseases and conditions.⁴

Identifying pain in older adults with dementia, including dental pain, remains challenging despite the availability of effective pain assessment tools for health care professionals and informal caregivers.^{5–8} While attempts have been made to develop scales to measure pain, they are not universally applied.^{9,10}

To address these challenges, this article reports on two stakeholder events which took place between April 2022 and January 2023. A Delphi approach was used to bring together experts and Experts by Experience with the goal of reaching a consensus on the best solutions for the assessment and management of dental pain for individuals with dementia. This iterative and collaborative process allowed for the distillation of expert opinions and insights to shape a potential intervention to prevent the development of dental pain in individuals with dementia. In addition to the stakeholder events, a discussion group with Experts by Experience also took place. This is reported in a paper submitted for peer-review in *Research Involvement and Engagement*.

Stakeholder event: April 2022

Aim

The stakeholder event brought together experts (dental professionals, dementia experts, pain experts, care home managers and caring staff, international academics) to identify current dental practices and policies for care home residents, at both local (Plymouth) and national levels. The event also aimed to identify barriers and facilitators to providing dental services in the UK care home sector and potential innovations for dental practice that could be implemented in care home settings.

Format

To help guide the discussions, the event presented preliminary findings from a systematic review.¹¹ Discussions were then held on six topics:

1. Experiences and opinions of dental pain assessment and dental pain assessment tools
2. Referral pathways and access to dental services
3. Prevention of dental pain for care home residents with dementia
4. Opinions of training needs for care home staff

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5. Opinions of knowledge exchange needs between dental services to care homes and between care homes
6. Innovations which may facilitate the findings from the previous four topics. Each of these topics were then summarised.

Findings

1. Experiences and opinions of dental pain assessment and dental pain assessment tools.

Stakeholders highlighted the need to balance objective pain assessments with personal relationships to better interpret signs of discomfort in individuals. Care homes are expected to conduct oral health risk assessments, but care providers expressed concerns about interpreting ambiguous guidance and determining who should conduct assessments. Pain diaries were seen as the preferred tool for objective information collection on potential oral pain, and oral health champions were proposed as a way to improve assessments and provide education and oral health practices for carers and family members.

It was discussed about the potential for oral health champions (designated carers within the care home) to assist with oral health assessments and assist carers/family members with education and oral health practices (which interlinks with topic 3: Prevention).

2. Referral pathways and access to dental service provision.

Care home residents faced barriers to accessing dental care, as they had often not seen a dentist for many years and did not have their own dentist. Care home staff were unsure who to refer to, and access to local National Health Service (NHS) dental services was limited. The loss of a local domiciliary contract further added to the challenges, and family members and care home service providers had limited funding for private dental care. Special care dental service providers noted that current service provision was insufficient to address the magnitude of dental health problems in this population within Devon.

3. Prevention of dental pain for care home residents with dementia.

The stakeholders emphasised the importance of prevention in dental health care for care home residents, rather than just resolving barriers to treatment pathways. They stressed the need for a collaborative approach involving dental service providers, care home staff and secondary care providers.

According to care home staff, current oral health education interventions can feel demoralising and counterproductive. They also noted that care homes bear the responsibility for dealing with increased levels of dental disease if preventive mouth care is not continued during a resident's hospitalisation.

The stakeholders also highlighted the importance of considering residents' tolerance to mouth care and defined prevention as stopping dental disease worsening within this population rather than prevention of new dental disease.

Overall, the stakeholders underscored the need to empower care home staff in delivering effective preventive measures for dental health care.

4. Opinions of training needs for care home staff.

Stakeholders discussed concerns about the lack of dementia-trained dental professionals to advise on oral health education within care homes, and the need for compassionate and sustainable training of care home staff. Dental hygienists expressed interest in getting involved in training, and the potential role of oral health champions within care homes was highlighted, but the stakeholders emphasised the importance of collaboration with care homes and standardised, sustainable training.

5. Opinions of knowledge exchange needs between dental services to care homes and between care homes.

The need for improved knowledge exchange between care home settings and academic institutions to avoid duplication of interventions and share best practices was recognised. There is a lack of published literature on oral health interventions attempted within care homes, making it difficult for service providers to learn from them. In addition, more knowledge on the health economic implications of dental pain is needed to demonstrate the benefits of collaborative interventions to policy makers.

6. Innovations which may facilitate the barriers discussed in the previous four topics.

Discussed innovations focused on facilitating the sharing of best practices and knowledge exchange through digital means, such as short videos or 'top tips' in publications, rather than dental pain assessment. One suggestion was to pilot the use of intra-oral cameras in care homes to remotely monitor oral health, with care staff streaming live to dental professionals. There was also discussion about the possible need for sensory innovations, such as using music to help relax dementia

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residents during domiciliary dental visits. A dentist was trialling the use of intra-oral images taken during an initial domiciliary visit as an adjunct to oral health assessments.

Conclusion and next steps

The stakeholder event successfully achieved its aim and objectives by facilitating discussions on key issues in designing interventions for dental pain prevention in dementia patients. The event highlighted the importance of a collaborative approach with care home staff and an understanding of the challenges they face, rather than assuming a lack of oral health knowledge. Next step proposed was to look at prevention earlier in the dementia pathway, and so those living with dementia were invited to a discussion group.

Stakeholder event: January 2023

Aim

The aim of the stakeholder event was to bring together the stakeholders from the April 2022 meetings and invite wider health care teams and policy makers to gain feedback on a proposed intervention.

Format

The event provided a framework for discussions by offering an overview of prior meetings, incorporating input from Experts by Experience. Attendees were invited to provide feedback on key topics such as health care modifications for patients with dementia, the practicality of enhancing health care teams' proficiency in dementia mouth care and dental pain risk assessments, identifying the appropriate party responsible for dental pain risk data collection, and exploring potential ways to integrate electronic health records with dental records.

Findings

The summary highlights the challenges related to enhancing health care teams' proficiency in dementia mouth care and dental pain risk assessments, including high staff turnover, time pressures and staffing levels. The lack of agreement on how to assess and report the oral health needs and risks of patients with dementia further adds to the difficulties. It is important to identify the appropriate party responsible for dental pain risk data collection and explore potential ways to integrate electronic health records with dental records to improve patient care. In addition, access to dental notes by GPs would be beneficial for patients, particularly for prescribing medications with issues surrounding high fluoride toothpaste.

At the event, it was highlighted that clear communication depends on shared definitions of key terms. For example,

professionals such as Speech and Language Therapists may have different interpretations of the term 'soft foods', making it necessary to provide more detailed information about the types of soft foods being consumed, such as purees or mashed foods.

Another important aspect discussed was the underutilization of existing resources, such as 'Mouthcare Matters', designed to support health care teams in providing optimal mouth care for patients with dementia. Furthermore, CPD training modules for health care staff do not always cover the challenges and issues related to mouth care when caring for patients with dementia. To address this, it is necessary not only to be aware of available resources but also to evaluate their relevance and appropriateness based on the lived experiences of dementia caregivers.

Conclusion and next steps

The stakeholder event proved to be a valuable platform for defining the essential components of an intervention designed to prevent dental pain among individuals with dementia. However, the event also highlighted the crucial role of co-designing the intervention with Experts by Experience, including health care staff, to ensure that the intervention aligns with their needs and expectations.

Moreover, the event stressed the importance of mapping out existing resources and identifying examples of exemplary practices from multiple regions in the United Kingdom. By examining these good practice examples, health care professionals can explore how to translate them to other regions using available resources effectively. This approach can help to ensure that all individuals with dementia have access to the same high-quality dental care, regardless of their location or regional resources. It is hoped the event's success in identifying key intervention components and the importance of co-development and resource sharing will help to pave the way for more effective prevention of dental pain among people living with dementia.

For more information on this project, email: nicole.thomas@plymouth.ac.uk

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Tai Chi Movements for Wellbeing: creating a space for healing

Betsan Corkhill

The Philosophy and Ethics Special Interest Group of the British Pain Society enjoyed a wonderfully restful retreat at Rydal Hall in the Lake District in July 2022. Our first since Covid, so it was a special few days full of great talks, walks in the sunshine, good food, wild swimming (for some) and morning Tai Chi Movements for Wellbeing (TMW).

My talk to the group shared some of the thoughts I've been mulling over in my practice and teaching of TMW.

Perhaps, rather surprisingly, my journey to this point began with my work into the therapeutic benefits of knitting. See my Knitting Equation:

I've been researching the meditative, creative and social benefits of knitting since 2005 and within this developing the

idea of therapeutic knitting. In my work with people living with long-term health problems, as a former physiotherapist and now as a Health and Wellbeing Coach, I've observed that those who struggle become somehow fractured/fragmented. Stories I've collected from knitters around the world tell of how the rhythmic bodily movements help calm the mind and are somehow 'unifying'. This combination of rhythmic bodily movement, thought and feeling seem to be important. I began to explore this more, and to look at body or bottom-up approaches as a way of influencing the mind because it is difficult to change the mind with the mind, particularly in a crisis. You can't instruct your mind to RELAX! or CALM DOWN! but you may be able to facilitate change through the body.

This led me to explore Tai Chi. Further motivation came from people attending my 'Wellbeing for People with Pain' courses.

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We'd have a session on movement and the feedback would invariably be 'We know it's good to move but we don't know how or where to start. How much to do. How to keep motivated'. It was felt that physiotherapists tended to focus on the body part that was painful in quite a mechanical way over a limited time frame, while personal trainers, through exercise referral programmes and gyms, in general, didn't know about pain and started off too intensively and too fast, causing a crash with increased pain so the person living with pain often didn't return. Of course, there are exceptions to this.

My exploration of Tai Chi soon became daunting as there are thousands of different moves and it takes tens of years to become a Tai Chi Master. Then, in 2019, I came across the TMW organisation based in Herefordshire and founded by Tai Chi Master, Richard Farmer, with his wife Marigold.

I was lucky to get a place on the TMW annual training programme in 2019 and now run regular classes. Most participants have pain, many have fibromyalgia, some live with ME/CFS, functional neurological disorder, mental health issues and more recently, Long Covid. I also run classes for the Carers Association. Carers carry a huge number of life's loads, particularly over the last few years having had little to no support during the pandemic, and their health is suffering. Online classes work particularly well for those living with fatigue as they don't have to exert precious energy getting to a venue:

Tai Chi integrates body and mind. Body movements are coordinated with rhythmic, conscious breathing and multiple cognitive and emotional components, including focused attention, heightened self awareness, visualisation, imagery and intention.

Dr Peter Wayne – Assistant Professor of Medicine, Harvard Medical School¹

The more I learn and teach TMW, the more I realise how deep the practice reaches and the depth of thought that went into choosing these particular moves out of thousands. Although the moves are simple, they hold great meaning, and as a mind/body approach it is complex.

A state of healing

At about the same time as I was investigating Tai Chi, I came across this statement from psychologist and founder of the Optimum Health Clinic, Dr Alex Howard:

You need to be in a state of healing in order to heal.

It had a profound effect on my thinking. It is one of those statements that seems so obvious but that I hadn't properly

considered before. Suffering from long-term illness is stressful for many reasons, and it is an even more stressful experience when it is 'medically unexplained' as in pain, fibromyalgia, ME/CFS, Long Covid and functional neurological disorders. You're afraid because you don't know what's wrong, why it's wrong and whether you'll ever feel better, let alone recover. In addition, there are the societal pressures such as poverty, poor housing, trying to live life on benefits and the discrimination that comes with it, to factor into the complex mix.

Most, if not all, of those who seek our help are in a state of stress or distress and are often stuck in this 'ON' state even when they don't need to be. This is the opposite state to what is needed to heal and repair. We need a state of stress to survive. We also grow and adapt when under stress, but then those systems need to return to balance. It becomes a problem when that system gets stuck on 'ON'. These systems need to learn to slide again.

When I came across Alex Howard's statement, I began asking if we were wasting our time using current methods of treatment in people who are stuck in a state of stress/distress? Should our first step be to help them experience a state of healing? That state where balance, homeostasis and a parasympathetic calming response is dominant – a state where we are optimising the potential for healing. And if this isn't possible because of their circumstances (the context), enabling them to find 'moments of balance' throughout a day where they experience 'moments of calm and safety'. I suspect that any other treatment/medication we offer in addition will then work more effectively in this state.

I've also realised that it's not about 'trying hard' or 'pushing', or 'working hard' at recovery. *It's about making or creating a space that optimises the potential for healing and recovery.*

More recently, I've been running TMW classes for people living with Long Covid. When we first met, they talked about 'trying hard', 'working hard at recovery', so at first it was more about stopping them from pushing and trying hard to recover, to get back to their previous lives. It's been more about slowing them down to create that space where healing can happen. If you're trying hard, you're probably pushing yourself into a stressed state. One lady told me that she was now 'trying softly' and I like that idea:

Nothing in the world is as soft and yielding as water. Yet for dissolving the hard and inflexible, nothing can surpass it. The soft overcomes the hard, the gentle overcomes the rigid.

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Lao Tzu²

TMW is movement with softness, safety, fluidity, rhythm, calm, relaxation and intention.



Modern life encourages us to be hard, to push hard, to be bigger, better. TMW teaches us that less is more.

When an illness is invisible or poorly understood, there is a lot of pressure from society to get back to work, to life. Individuals and groups within your immediate environment and on social media can be cruel, increasing the pressure to 'get out there and do it'. We need to recognise as a society that we need to take the pressure off. *Recovery needs us to create the right circumstances. It needs time, our respect, kindness, knowledge and support:*

Give time, space and respect to convalescence if you can.

Dr Gavin Francis, Recovery³**Post-exertional malaise**

Before I go any further, I need to address the subject of post-exertional malaise (PEM) because the moment you mention any form of movement-based approach for Long Covid or ME/CFS it gets aggressively shouted down for being dangerous. And it is if it's done in a Graded Exercise Therapy (GET) format where the intensity is increased in a fixed way over time or if the person isn't listening to their body and responding to its needs in that moment. PEM is a very real problem that can severely limit what some people can do, both physically and mentally. I find it sad that, because of the fallout and harm experienced as a result of GET, feelings are running so high on this subject that it's difficult to have a reasoned discussion about movement. All

those attending my Long Covid classes are referred appropriately.

A lady with long-standing ME/CFS who suffered harm through a GET approach has been attending my classes for several months. She practises TMW most days and says it is the only thing she's been able to do without crashing, and she is sticking at it. It's truly wonderful to watch her moving with fluidity and flow. Recently, she also told me, *'I'm having moments where I feel healed'*. When asked what she meant by this she replied, *'Moments where I feel whole, at peace, safe, where I'm not running on super high, where I'm at peace with being me'*.

As a general practitioner (GP) and an author, Dr Gavin Francis says in his book 'Recovery', *'It's about learning a new language of the body and listening to it with care'*.

One lady with ME told me that TMW has shown her that she is constantly vigilant and *'I don't need to be, because I'm not in constant danger'*. This constant vigilance was reflected in her tight, tense posture, ready to run or fight at any moment. TMW teaches people to listen in to their bodies and to do what feels right for them in that moment. Just because you did it yesterday, doesn't mean you'll be able to do it today or improve on that. And that's not only OK, it's normal because normal life is up and down.

We also teach the concept of 'Soft Limit' which is life changing for many. This is explained in more detail later, but when TMW is practised within Soft Limit it doesn't trigger a crash. I think another explanation is that conventional exercise stresses the body so, when attempted from a position where your systems are already stuck in a stressed out state, it causes more problems. TMW's gentle, rhythmic approach calms those systems through rhythmic movement and engendering a sense of safety. If energy levels are low, then participants can visualise or watch and still benefit – it's soothing to simply watch. We teach that it's perfectly OK to do that and I encourage everyone to have a go at visualising from time to time for a different experience.

The biggest problem we've encountered in Long Covid is recruitment. I've heard comments of *'Can't they see I'm ill?' 'Is this all the NHS has to offer?' 'I need proper treatment'*. People are still stuck in the idea that the only 'real' treatment is medication and that the NHS needs to 'do something to me' or 'give me something'. These are perfectly understandable feelings that we also come across in the world of pain and they need to be addressed with understanding on a wider scale.

This is what one person told me:

I remember going along to the Long Covid clinic and hoping for answers and for some sort of magic pill. It's crazy really but I was so desperate and had felt so sick for so long, I came away feeling really disappointed. The doctor recommended TMW and I thought, what is this going to do for me? I was willing to try anything so agreed. It turns out that was a great decision on my part.

Recruitment is also a problem because of the fallout from the harm done by GET. This has become an anti-all movement-based approach which is very prominent on social media, particularly on platforms such as Twitter. All of which is understandable, but we need to be able to have a reasoned discussion on the topic. We also need more clinical awareness of the benefits of an approach such as TMW and sufficient time to explain it during the clinical consultation. Most people seeking our help have multiple issues going on with their health and in their lives, and clinicians just don't have the time to explain 'Why Tai Chi?'.

A young woman with long-standing fibromyalgia and now Long Covid who has been on several pain management programmes over the years told me this – 'TMW is one of the most useful life skills I have ever learnt'.

Principles and understandings

TMW is a 12-move sequence taken from the practices of Chi Kung and Tai Chi, and while being simple, it still retains all the benefits of these practices. It can be taught purely as a movement class or to get the full value, as an introductory 6-week course that also teaches principles and understandings which can be taken into the rest of your life. This is where you get the full value which can be a real catalyst for lasting change. Following the initial 6-week course, participants can attend ongoing classes which build on and deepen their practice and understanding. The movements can be done standing, sitting, visualising or simply watching, if they're having a particularly challenging day, and we explain how to visualise effectively.

TMW is based on the recognition that the mind and body are intricately and intrinsically connected. An example, in simple terms, is if you are stressed it will be reflected in bodily tension, although the relationship is a lot more complex.

TMW also recognises that bodily movement can affect the atmosphere of the mind. This becomes a circular, intertwined

process of mind and body interacting and working together in a way that cannot be separated.

Further understandings support the value of the mind and body being in the same place at the same time. We use the sequence to bring people into this state of being present in a gentle way; learning to connect and live life from the present moment, directly encouraging the mind/body as a unified 'whole' into a healing state. This can be challenging for many, particularly if they feel pain, but I'm convinced it is THE foundation of the change that then begins to happen.

Living in your body

The reality is that most people live in their heads most of the time. I certainly did before I encountered TMW. This is particularly the case if you have unpleasant or painful bodily experiences. It became evident immediately in the Long Covid classes that people were turning their backs on their symptoms in an attempt to get on with life. They didn't want to be 'in their bodies'. There was a general recognition that they'd been doing this, as well as a general feeling of putting their life on hold until 'I'm fixed'. This is what one lady said,

I've realised my mind and body are disconnected, very far apart and I realise now that's how I've been coping. Turning my back on pain, blocking it out. Coming back into my body has made me aware of it again but I don't think turning my back on it will help in the longer term.

Another said, 'TMW has made me realise I've been living outside my body in an attempt to escape the symptoms'.

We talk about how being present in the body can help them make the most of each present moment. Philosopher Havi Carel talks about finding moments of wellness or wholeness within illness. We talk about finding safety, stability and feelings of wellness even within illness and adversity as a better option to putting life on hold. Nurturing a feeling of 'In this moment, I am safe'.

This approach of creating moments of wellness and safety also seems to work for people who carry a lot of life loads – for example, poor environment, poverty, living with or caring for family who have mental health issues. I see a number of women who are caring for partners or children with serious mental health issues that cause constant ongoing stress. Covid and problems in Social Care and mental health services have increased their burdens:

Pain is social. Pain is almost always worsened in those hurt by society: the lonely, the marginalised and the voiceless.

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Dr Monty Lyman, *The Painful Truth*⁴

I believe their pain is directly linked to what are unbearable life loads. This can be multigenerational. Some have elderly parents, partners, children and grandchildren with significant health problems. I would challenge anyone not to have pain or other health problems in the same situation. This will only get worse with the cost of living, health and Social Care crisis we are currently facing. We don't achieve anything by filling them with drugs and medicalising these issues.

Learning to find moments of safety and wellness in each day enables them to put those loads down for that moment; to find balance, safety, stability and, hopefully, healing in those moments. It's not an answer to those life problems but it helps a bit and gives them a place of safety within themselves that no one can take away:

TMW is not something I do, it's a place I go to.

TMW uses the concepts such as a visualisation of having a 'Kangaroo Tail' to enable people to feel the safety and support of the ground beneath them. People are taught to take their attention to the base of their spine and visualise this extending down into the ground, as if they had a kangaroo tail. A kangaroo uses its tail to maintain balance. People like this image and find that even when all is chaotic around them, their grounded 'Kangaroo Tail' will support them and keep them safe and stable. The idea of 'Kangaroo Tail' can also be visualised as anchoring them to bring their mind and body together in the same place at the same time. We learn to create a habit of settling into the 'Kangaroo Tail' by linking it to everyday activities such as boiling the kettle and cleaning teeth, and you can eventually learn to live your life from this grounded, present space. Participants have used it in many different circumstances including to help with sleep when the mind is elsewhere, and importantly to cope with situations outside their control such as being in crowds or social situations when anxiety starts to rise.

I'm aware that 'coming into your body' can be difficult for people who have been through a traumatic experience. Coming face to face with the real state of your health and life can be challenging, but it can uncover some important realisations. This lady told me – *'I'm really not very well, am I? This is the first time I've realised this. I really have to start being kind to myself. I need to slow down, to give myself time to recover'*. This person regards this realisation as a positive one and as a result took the decision to stop trying to push through and to give herself time to recover.

TMW brings people into a state of being present in the moment in a really gentle way through the grounded 'Kangaroo Tail' and the flow and rhythm of the simple moves. I say simple moves, but only 'simple' in terms of the actual moves. As a mind-body approach, TMW works in complex ways. The flowing rhythmic movements soothe the process of coming into that embodied state. 'Kangaroo Tail' takes them into an imaginary tail so those living with pain or past trauma find it easier. This has worked well in many different scenarios.

When a person begins to come back into their body, they can experience an increase in symptoms. Those with Long Covid experienced this at first, but then it eased off. I think this is because in this state of embodied presence, people are coming face to face with the real situation. This can be a shock. I think if you're constantly trying to ignore your symptoms, they eventually tend to shout louder. It also takes up a lot of energy so is exhausting.

In order to get over a problem, it helps to look at it. You can't climb a mountain that you pretend isn't there.

Matt Haig⁵

In this state of embodied presence, you can make a true assessment of your situation and what you need to do to improve. Those who practice TMW often talk about 'coming home to yourself'.

The paper '*An Embodied Predictive Processing Theory of Pain*¹⁶ proposes to explain pain in terms of processes distributed across the whole body from cell to whole. The authors theorise that the nervous, endocrine and immune systems function in a coordinated and coherent manner as a single complex adaptive system to maintain homeostasis. They refer to this system as the neural-endocrine-immune (NEI) system. It captures some of the complexity but perhaps the danger of highlighting three systems in this way is that we will forget that these are always interacting with all other systems, those eco systems (e.g. gut biome) within us, in complex ways as well as our immediate environment and wider world. I was particularly struck by the following paragraph:

If health is (in Gadamer's words) a 'condition of being involved, of being-in-the-world, of being together with one's fellow human beings, of active rewarding engagement in one's everyday tasks', pain can be thought of as a disruption of this 'being-in-the-world'. The result of such a disruption is that the world appears both threatening and alien to the subject.

I've discussed this with people living with pain and Long Covid. They agreed that they no longer feel at home in their body or at home in the world. I think TMW is helping people to feel at home in their body as it is, but also to feel at home in the world as they are. The 'as it is' and 'as they are' are important. Over time, you can learn to live life from this place of 'as you are in the world as it is':

It's OK to be me as I am.

Feeling safe

Feeling safe is fundamental to being in a healing place. However, I don't believe you can think your way to a feeling of safety. You need to feel it. You need to experience it. TMW encourages feelings of safety in a few ways. In a state of embodied presence, there is a natural relaxation and a feeling of calm, of being 'at home'. A feeling of safety. Kangaroo Tail gives us a means of achieving this, a useful tool to have in your toolkit in everyday life. Learning to find this safe space within us is important because it's always there regardless of what chaos is going on around you. No one can take it away.

The rhythmic movements of the sequence also enhance feelings of safety. Rhythmic movement is predictable. The brain likes things to be predictable. It makes it feel safe. The idea that you can find safety within yourself can have a profound effect on your life, whatever else is going on within it. It helps people deal with the uncertainty of life and fear:

You can relish a rainbow and a cup of tea, sunrise and a flock of birds, a cemetery walk and a friend's newborn, the first blush of wild flowers in a patch of dirt and the looping rapture of an old favourite song. You can't tidy up the White House, but you can tidy up that neglected messy corner of your home: you can't mend a world, but you can mend the hole in the polka-dot pocket of your favourite coat. They are not the same thing, but they are part of the same thing, which is all there is – life living itself through us, moment by moment, one broken beautiful thing at a time.

Sophie Blackall, *The Marginalian* (Maria Popova)⁷

It helps you realise that although you may not be able to fix the world around you, you can mend yourself moment by moment, bit by bit – they are part of the same thing.

Self-kindness and release

With the feeling of embodied presence and the support and safety of the ground beneath your feet, there is a natural relaxation in body and mind. Movements become more

graceful, they feel caressing, and you can see this happening as the quality of people's movement becomes more flowing over the weeks. Self-kindness is emphasised. In my classes we learn that self-kindness isn't about sitting doing nothing with a box of chocolates, although on some days it might, in small doses. We talk of self-kindness as being proactive in your health and wellbeing. This is difficult for many living with health problems as their own health and wellbeing is often at the bottom of their priority list. We talk about putting it as their top priority. Talking to themselves as they would to a best friend. There is usually a general realisation that this is not something they naturally do, particularly if all their energies are going into caring for a partner or child. It's interesting and wonderful to see their self respect grow and the impact this has on their behaviour. One man told me, *'I've found I don't want to put junk food into my body any more'*. When your self-respect grows, you are less likely to behave in a way that is detrimental to your health and wellbeing:

I've stopped punishing myself. I'm learning to be kinder to myself.

Returning to the TMW sequence, we encourage people to listen in to their body and ask 'What do I need in this moment, today?' We may use stroking as an act of self-kindness and compassion, and this can be highly emotional. Stroking your head as if it is the head of someone you love with kindness and compassion emanating from the heart can be a powerful experience, particularly for those who rarely, if ever, experience the touch of another. Stroking the abdomen while taking thoughts to those organs and giving them thanks for keeping you alive can be a highly emotional moment. Most think of their body as 'letting them down' but this quiet act of thanks helps to change their perspective to one of realisation that actually 'My body is doing its best to keep me alive'.

Tears

In classes for those living with Long Covid, there have been a lot of tears, and participants are encouraged to let them flow.

They recognise that they have been holding their emotions in tightly. One young woman told me,

When I first started to practise TMW the tears flowed freely and I let them, where previously I would have tried to hold them in. Now I can do the sequence without tears. I feel letting them flow was important.

Tears are the medium of our most primal language in moments as unrelenting as death, as basic as hunger and

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as complex as rites of passage. They are the evidence of our inner life overflowing its boundaries, spilling over into consciousness. Tears spontaneously release us to the possibility of realignment, reunion, catharsis, intractable resistance short-circuited . . . it's as though each one of our tears carries a microcosm of the collective human experience, like one drop of an ocean.

Rose-Lynn Fisher, *The Typography of Tears*⁸

We decided that allowing their tears to flow freely was an important and often necessary part of their healing journey – ‘Tears are evidence of our inner life overflowing its boundaries spilling over into consciousness’.

I wondered why I wasn't seeing this with other classes. The difference could well be that we are seeing people with Long Covid much earlier. We are validating their stories much earlier. I think this is something we need to be aware of with those who have been living with pain, fibromyalgia and ME/CFs for many years. Over many years, many have become adept at hiding their emotions and holding them in tight.

This is what one lady told me:

Many people with fibromyalgia live with the symptoms for years before diagnosis. They are so used to a different life they are often resigned to it. They aren't after this length of time let go as they may totally lose control. I know that's how I feel, I aren't relax at keeping my emotions in check. I am terrified my chronic pain and fatigue will overwhelm me and suck me into an abyss from which I can never climb up.

Perhaps we should consider how we can provide safe places and ongoing support to enable the release of these emotions, because this may be necessary before healing can happen.

Earlier in this article, I referred to the concept of ‘Soft Limit’, and this has been life changing for many. It is applied to the sequence but also to life and it applies to us all, so we're not stigmatising those with ill health. It's also better understood because it applies to us all. Health professionals will be only too aware of what it feels like to be pushed beyond your Soft Limit over the last few years, in particular.

Soft Limit encourages us to be aware of where we over extend, and to move and live life to the limit of our softness. It is also about not restricting yourself or holding yourself back for fear of failure, of being confident in your Soft Limit in that moment. If you are constantly holding yourself back or overextending, living beyond your Soft Limit, you are moving against tension and living life in a state of stress which will eventually make you unwell.

It's not about staying in your comfort zone, it's about knowing where your Soft Limit is in each moment and operating at that limit. We spend time talking about the process of exploring their baseline of activity and Soft Limit in the sequence and in life, and they are encouraged to think about their Soft Limit across a day, the week and their lives. I think Soft Limit is a kinder, more positive approach than Pacing. Most are familiar with the term ‘Pacing’, particularly if they have lived with pain for many years. However, they often don't fully understand it in terms of bodily systems that have become more sensitive. How it doesn't simply apply to the amount you ‘do’ in a day, it applies to all your senses. People in my Long Covid classes have found bright light, loud noise, watching action films and air temperature affect their Soft Limit. One man found watching action films exhausted him, another found cold weather drained his energy while another found watching the bug-eating in *I'm a Celebrity* caused a huge spike in her Covid pain. We discuss how Soft Limit can be applied to work, commuting, and the importance of telling family, friends and employers. We have found that because it applies to everyone, people understand. Most people know what it feels like to be pushed beyond Soft Limit and the feelings of tension/stress/distress this causes:

I've got the confidence now to say 'NO' to family and friends when I know something will push me beyond my Soft Limit, to say I need to sit down or rest now. I've realised that they've always been OK with this, it's not a problem for them. The problem was in me because I felt guilty at saying 'NO', at not being able to do what I was doing previously.

Having the confidence to say ‘no’ is good. As author Matt Haig says, ‘No is a good word. It keeps you sane. In an age of overload, NO is really a YES. It's YES to having the space you need to live’.

Soft Limit doesn't imply limiting your life as I think Pacing does. Rather, it's about self-kindness and applies to everyone. People understand it and learn to apply and physically explore it in the sequence and then translate it across into their lives. Exploring it physically helps them to better understand as they can feel the tension that occurs when moving beyond their Soft Limit or restricting themselves. Importantly, Soft Limit recognises that normal life is up and down, so you learn to assess your Soft Limit from moment to moment:

I feel like life is possible again, I know where my Soft Limit is and how far I can push that Soft Limit and not have the three-day crash I used to have. Of course, I still get it wrong on occasion, but having tools, such as Kangaroo Tail, to use and lean on when I'm out and starting to feel overwhelmed,

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has helped massively. There has been real progress and I know that TMW is a big part of this.

People find it transforms their lives whether they are fit and well or living with health problems. It's about listening in to your body, exploring and knowing your Soft Limit, recognising that it's not static or fixed. It varies from day-to-day and moment-to-moment. An activity can be OK one day and not the next so it's very much moving away from the approach of GET. It's about moving and living with relaxation rather than against tension. It's about learning to live life to your Soft Limit, not overextending or holding yourself back. Recognising when you've gone beyond and putting measures such as extra rest and self-kindness in place to counteract this. It's also about recognising that external events outside your control will push you beyond, so knowing what to do when this happens. Recognising that there will be events such as a family wedding, for example, where you decide it's worth going beyond your Soft Limit and planning these and the days around in advance. When they are comfortable with their Soft Limit we encourage them to explore nudging at it gently:

The idea of Soft Limit and Kangaroo Tail as opposed to Pacing or getting through has been a huge relief. I can now see that it could be possible to live a more stable settled life instead of having to drag up energy to get stuff done and push from one thing to another with some things getting abandoned. It's made the future seem much more positive and open.

Being slow, kindness, rest

Modern lifestyles encourage us to be constantly busy, to push harder and further, to be more, to the extent that we learn to push through. Society measures our success by how busy we are. Rest is no longer valued. As I mentioned earlier, those in my Long Covid groups were taking this into their recovery and 'working hard at it':

Rather than separating activity and resting, it's a combination of the two, in my experience, that is a more helpful approach for everyone. A greater respect for the importance of rest can coexist with an understanding of how vital it is that we remain active and engaged in the world.

Dr Gavin Francis, *Recovery*³

It's OK to be slow, to take time. It's OK to stop and rest and to show yourself some self-kindness. We shouldn't feel guilty for resting. Appropriate rest is an essential part of a healthy, balanced life that is needed for the 'whole' to make sense:

Just as we need pauses between notes for music to sound good, and just as we need punctuation in a sentence for it to be coherent, we should see rest and reflection and passivity as an intrinsic and essential part of life that is needed for the whole to make sense.

Matt Haig, *The Comfort Book*⁵

Balanced body, balanced mind

Some people have restricted movement on one side – for example, in a shoulder – causing imbalance in the body during movement. Conventional exercise will encourage you to push the restricted side to match the unrestricted one. You create a lot of tension, pain and imbalance when you do this. TMW is about moving with relaxation and balance. If you apply the understanding of Soft Limit to your restricted side and mirror its range of movement with the other side, over time your range of movement will improve. I admit I was a bit sceptical at first, but this has been incredibly effective for improving shoulder range in all my classes because they are moving with relaxation and flow rather than against tension. All participants attending my Long Covid classes had restricted shoulder movements, as do many who live with pain. As the body comes back into balance, the mind experiences that same balance.



Connection with oneself: being present in the moment

The feeling of embodied presence, the safety of the earth, the flowing movements within Soft Limit, put you in touch with the quality of your engagement with yourself and the world. TMW enables you to connect to the heart of who you are and teaches us to be compassionate towards those parts of ourselves that are challenging, and to accept the imperfections

Tai Chi Movements for Wellbeing: creating a space for healing

of humanity. It's about feeling at peace with who we are and knowing that we are enough as we are in this moment. We work on connecting to the 'you that is you', connecting to others around you, to the outside world, nature and the Earth with compassion that emanates from the heart.

We talk about connecting to the 'essence of you' – that 'you that is you' without the labels of the world. Some of the people I see have 8–12 health labels and it's easy to see how you can lose sight of who you really are. They get buried under these labels. As Matt Haig says, it does us all good to '*Check that our emotional armour is actually protecting us and not so heavy we can't move*'. It's about recognising those layers of life's armour that we have accumulated to protect ourselves from life's challenges and trauma and learning to find ourselves under those layers, ensuring that armour is not so heavy we can't move under all those labels we're given in life. It's about learning that the person that is you is still there. You may be well hidden but you are still there. Creating space between you and those labels. When you connect to that safe place within you, you begin to grow confidence in yourself as you are. Learning who you really are is important for knowing how to nourish yourself:

The best thing is that you've taught me that it's OK to be me. I am enough as I am. It's been a revelation to learn that it's OK to be me as I am.

As classes progress, we work on developing this sense of connection and identity. In the sequence there is a move called 'Here am I', which we can use specifically for this, and people can get quite emotional when practising it. They often feel a sense of empowerment as they say to the world '*Here am I as I am*', '*I am enough*', '*I have a right to be me*', '*I'm OK as I am*'. It's OK to be me within my Soft Limit. I don't have to be any bigger, or any more, and I don't have to restrict myself, I can be me and be proud of it. This is such an important message:

You don't have to continually improve yourself to love yourself . . . you were born worthy of love and you remain worthy of love. Be kind to yourself.

Matt Haig, *The Comfort Book*⁵

Modern life, social media is constantly pressurising people to 'be more', to do more. It makes people feel inadequate. This is made worse if you're living with a long-term health issue. TMW helps people to have confidence to be in the world as they are, regardless of their symptoms and labels they've been given.

As we approach the end of the sequence, we take this connection deeper and out to others in the group, the wider world and the elements that keep us alive. We are intrinsically connected to other people, animals, plants, the elements, our planet Earth. We aren't just part of nature, we ARE nature, and the Covid pandemic has given us a bruising reminder of this. TMW encourages us to feel this connection.

Breath

Moving with my breath has helped let go of the tension around my shoulders which means I can lift my arms a bit higher.

There is no breathing technique in TMW, the moves follow the natural breath. If they are unable to move to their natural breath at first because of breathlessness, they are encouraged to focus on the flow and rhythm of the moves, and over time breath becomes naturally longer and slower. In our Long Covid groups, there was an improvement in breathlessness scores across the board at the end of the 6-week course.

In later TMW classes, we bring everything together. Each time they practise the sequence, they are encouraged to notice how they feel before and immediately after. To notice the contrast as proof that change can happen.

Comments at the end of a sequence often include:

I feel calmer and slower,

It was nice to be slow,

I feel as if I've had a whole body massage,

It's a strange feeling, it makes me feel relaxed and calm but energised at the same time,

It always makes me feel better than before.

As participants progress into ongoing classes, TMW takes them into a deeper meditative-like state. With practice, they learn to move as a 'whole' – the whole of their mind/body/breath moving and flowing as one. This is important because pain pulls your attention to the body part where you feel pain, which can then become 'separated' from the 'whole'. Moving rhythmically as a whole mind/body in sync with breath enables you to reach a point where you are no longer 'doing' the moves but are 'being' them.

Tai Chi Movements for Wellbeing: creating a space for healing

Learning to move with rhythm, joy and safety as a unified, whole mind/body can enable people to experience a sense of peace and safety within themselves, creating a space that optimises the potential for healing. I would argue that this should be an essential step in our treatment of those who seek our help. An added benefit, as I have discovered, is that it can have significant benefits for you, too.

<https://www.betsan.org>

TMW Organisation – TMW Training Ltd: <https://www.tmwtraining.com/>

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All Wales analgesic stewardship guidelines



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Dr Emma Davies *Advanced Pharmacist Practitioner in Pain Management, Cwm Taf Morgannwg University Health Board; Co-Lead Author, All Wales Analgesic Stewardship Guidelines*



National Analgesic Stewardship guidelines have been launched in Wales (All Wales Analgesic Stewardship Guidelines).¹ Endorsed by the All Wales Medicines Strategy Group (AWMSG) and sponsored by the Chief Pharmaceutical Officer, the guidance issued by the All Wales Therapeutics and Toxicology Centre (AWTTC) aims to encourage Health Boards to develop guidance and pathways which lead to improvements in cost-effective prescribing, reduce analgesic-related harms and ultimately improve patient outcomes. The stewardship guidance follows on from the 2019 recommendations to improve service provision for people living with persistent pain in Wales² and supports ongoing work by the National Clinical Leads in Wales to develop a national strategy for persistent pain.

Per capita, Wales spends the most on analgesics of any of the four countries in the United Kingdom and, as elsewhere, has seen large increases in prescribing since the early 2000s. Prior to the pandemic, waiting times for 80% of pain services in Wales averaged more than 20 weeks.³ There was concern that the Covid-19 pandemic would lead to additional increases in analgesic prescribing as surgical and outpatient waiting times extended. However, in the event, reductions in opioid prescription numbers have been noted.⁴ At the same time though, Wales has observed an increase in gabapentinoid prescribing, despite efforts to reduce it.⁵ In the last 2 years, 2020–2021, Welsh deaths associated with opioids, gabapentinoids and antidepressants have risen from 163 to 219 – a 35% increase.⁶ All this comes at a time when there is little convincing evidence to support the long-term use of analgesic medicines for most long-term painful conditions and for the majority of people who receive them.

The working group who developed the guidance took inspiration from the ‘Quality Prescribing in Chronic Pain’ document produced by the Scottish Government and NHS Scotland.⁷ Unlike clinical prescribing guidelines for named conditions, analgesic stewardship focuses on the processes which influence analgesic prescribing and considers what can improve its quality, as well as monitoring analgesic prescribing habits and patterns. The Welsh document accounts for National Institute for Health and Care Excellence (NICE) and other national guidelines in its recommendations.

The integrated nature of Welsh Health Boards should facilitate cross-sector working and the development of clinical pathways with all interested primary, secondary and third-sector stakeholders. To this end, the guidance is divided into proposals for Health Boards to consider organisation-wide; proposals for clinicians to improve safe, prudent prescribing; and proposals for Medicines Management units who are responsible for monitoring prescribing trends, supporting national prescribing indicators and ensuring clinical guidelines are up to date and evidence-based. Crucially, it must be understood that analgesics are prescribed in all specialties and

All Wales analgesic stewardship guidelines

all sectors of health care, and that while pain management has elements which require specialist input, most treatment and support is provided by non-specialists.

It is recommended that Health Boards take a whole-system approach to improvement, given the impact pain and analgesics can have on individuals, carers and health care services. Professional leads for analgesic stewardship across the organisation should be created, and they should work to improve communication between services and different sectors including community pharmacy and third-sector providers. Health Boards are also recommended to develop and provide appropriate support to help people understand their pain condition and treatment options, including non-pharmacological choices. In addition, psychological input, support to remain in or get back to work and improved access to patient records to allow data sharing are all suggested areas of focus. Building services for people who develop problematic use of prescribed analgesics and assisting prescribers when concerns are raised is likely to be one recommendation that many primary care practitioners will hope will be a priority for implementation.

Suggestions for clinical practitioners are based on guidance from NICE and Scottish guidelines including SIGN. They include collaborating with people to develop a management plan and focusing on improving function, not just pain reduction. The need to discuss expectations around analgesic medicines, their risks and benefits and agreeing how dosage will be reduced and stopped if a trial period does not lead to improvement mirror those from NICE NG215 on safe prescribing and withdrawal.⁸ The suggestion of regular review of analgesic prescriptions, such as an annual review that encompasses all aspects of an individual's pain management, is not new. Its reiteration in this guideline, however, will hopefully influence Health Boards, clinicians and others to examine how that could be achieved and to consider using a wider section of the workforce. With burgeoning prescribing among allied health professionals and pharmacists, there is potential to increase access to pain management reviews, but it requires excellent communication, access to records and information sharing if it is to work.

Additionally, training and education in analgesic stewardship is fundamental to improving the use of pain relief medicines. AW TTC are looking to collaborate with Health Education and Improvement Wales (HEIW), who co-ordinate health care training and education across the country, to create new opportunities in that area. There is also a need to develop public awareness of analgesic stewardship, mirroring the work undertaken to reduce reliance on antibiotics. It is

acknowledged that it will take time to change clinical practice and to improve public understanding of the benefits and risks of analgesic medicines. It is hoped this document, along with the development of a national strategy for pain management in Wales, will mark the start of those changes.

Dr Sue Jeffs, Medical National Clinical Lead for Persistent Pain and a Consultant in Pain Management in Aneurin Bevan University Health Board:

As one of the National Clinical Leads for Persistent Pain in Wales, I am pleased to support this comprehensive document to support the appropriate use of pain medications in Wales. To have a stewardship document which aligns with value-based medicine will lead to safe prescribing and support the decisions with regards to the need for a medication. The document fits well with the aim of supporting clinicians to help support people in Wales to live the lives that are important to them, whilst living with persistent pain. The document also provides health boards with guidance to promote pathways for which medications only play a part of the support needed for people with persistent pain. Too often a greater reliance of medications occurs due to lack of other options. I hope it will lead to new initiatives to support those that need care. The overall aim is to enable sufferers to 'live well' despite persistent pain.

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Reviewing the new guidelines on pain management for Wales



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Healthcare providers and clinicians are tasked with making informed decisions about prescribing medication for pain, and two new guideline documents have been produced in Wales to support that process. The *All Wales Pharmacological Management of Pain Guidance* (November 2022) considers how prescribers can make the best choices in relation to pain medication. It also aims to 'allow timely exploration of the role of medicines for pain' and 'reduce variation in prescribing'. The *All Wales Analgesic Stewardship Guidance* (November 2022) focuses on supporting all sectors of healthcare to 'improve patient outcomes, reduce analgesic-related harm and ensure cost-effective use of analgesics'. Both documents are published by the All Wales Medicines Strategy Group.

The All Wales Pharmacological Management of Pain Guidance

While this guidance does not bring anything particularly new to the prescription forum, it is a relatively short document, broken down into sections and boxes that provide a quick reference resource for prescribing clinicians. The document also aims to help prescribers and health boards 'understand how analgesic stewardship can be integrated into treatment pathways for a range of specialities'.

The first sections are generic and include a description of the new International Classification of Diseases 11th Revision (ICD-11) category of chronic primary pain. There is also a detailed breakdown of the use of red and yellow flags as clinical indicators. The guidance highlights the fact that analgesics often play only a minor role in pain management and should always be part of a wider holistic treatment plan. Following on from this, Section 4 recommends a stepped approach to prescribing for pain, promoting the initial use of nonopioid drugs with accompanying advice on lifestyle strategies. It suggests that opioid drugs should only be prescribed in selective circumstances and then only with timely review (within 2–4 weeks).

Section 5 contains more detailed guidance on the prescription of opioid drugs, which is in line with other recommendations on opioid practice and links to the Faculty of

Pain Medicine 'Opioids Aware' resource. The guidance highlights that 'Opioids are very good analgesics for acute pain and for pain at the end of life, but there is little evidence that they are helpful for chronic pain'. The practical aspects of an initial opioid trial (a short supply of immediate-release morphine) are clearly laid out. Colour coding is used to highlight key messages (grey) warnings (yellow) and what to avoid (red). The guidance covers the duration of a trial, desired functional outcomes, dose ceiling, review (with the aid of a patient diary) side effects, dependence and detection thereof. With regard to patients starting opioids in secondary care (which can often lead to them continuing on opioids in primary care), there is a link to guidelines, developed by the Royal College of Anaesthetists, on how to mitigate against such events.

Section 6 of the document contains information about specific opioids to avoid in routine use, while Section 7 focuses on acute pain, endorsing the World Health Organization (WHO) analgesic ladder. The ladder is visually displayed in a series of steps which promote a regimen of Paracetamol ± ibuprofen or naproxen ± dihydrocodeine (preferred over codeine, which is a pro-drug). If Step 3 opioids are required, the guidelines recommend morphine IR or oxycodone IR. Tramadol should be used very cautiously if co-prescribed with antidepressants and/or gabapentinoids. Later sections cover chronic pain in general and neuropathic pain. For chronic pain, the guidelines recommend oral or topical NSAIDs ± PPIs (paracetamol may be tried for 3 days, but not continued unless effective) and analgesic antidepressants. Gabapentinoids should not be prescribed if pain is not neuropathic. With regard to neuropathic pain, the document makes similar recommendations to the National Institute for Health and Care Excellence (NICE) guidelines, except it promotes pregabalin only as a second line if the patient is unable to tolerate the side effects of gabapentin and at a maximum dose of only 400 mg daily.

Finally, Section 10 contains useful tables on adjusting the dose of specific drugs (paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs), gabapentinoids), depending on

Reviewing the new guidelines on pain management for Wales

co-morbidity, body weight, renal function and the co-prescription of other drugs. This acts as a useful reference for drug dose adjustments in common clinical situations.

All Wales Analgesic Stewardship Guidance – November 2022

This 29-page document is the first specific guidance on analgesic stewardship in the United Kingdom, and has been published in response to a 30% increase in analgesic prescribing (especially opioid) over the decade up to February 2020. There is increasing evidence that analgesics are often ineffective and have significant potential for harm, misuse, dependency, alongside increasing street value and involvement in drug-related deaths. Therefore, the aim of the new guidance is to help all sectors of healthcare reduce analgesic-related harm and improve the use of healthcare and economic resources. It is not intended for specialist practitioners or secondary care practitioners, who will follow national and local guidance where available.

The document suggests that analgesic stewardship can be improved by nominating local leads to drive and implement the policy across the health board. This would incorporate a 'whole system' approach involving primary and secondary care, hospital discharge and medicines reconciliation, community pharmacies and the third sector (to support non-pharmacological co-therapy). The approach could be further enhanced by developing support for problematic behaviour due to dependence, or developing local public awareness campaigns to highlight the limitations and risks of analgesic medicines.

The guidance extols the importance of person-centred assessment by clinical services, with the aim of forming a holistic management plan in collaboration with the patient to include non-drug therapies and encouragement of self-management. Where drug therapy is trialled, the guidance

suggests it should involve education of the patient to ensure the most effective use, balanced against realistic functional outcomes, side effects and the risk of harm and addiction. All these practices can be supported by medicines management units, with regular feedback including national prescribing indicators, audit cycles and dissemination of prescribing incidents and overdoses (to provide education and training opportunities). The document goes on to signpost aids that can help develop the above aspects of analgesic drug stewardship. These include education programmes for patients living with persistent pain in Wales, safer prescribing in prisons, and driving advice.

In addition, the guidance provides specific analgesic drug advice, which is also covered in the accompanying *All Wales Pharmacological Management of Pain Guidance*. However, the stewardship document offers more detail on a number of drugs, and interestingly, its advice on neuropathic pain follows NICE guidelines (unlike the pharmacological management of pain guidance). There are additional tables, such as the one on opioid equivalence, and equivalence of gabapentin and pregabalin. The document also covers the polypharmacy review process and the '7-Steps' approach to medication review, with a list of 'useful resources' including websites, books, short films and references.

Summary

Both documents are useful, clear and concise; however, there is some overlap on analgesic drug advice. It could have been more appropriate for the stewardship guidance to focus more specifically on delivery systems and processes, with its analgesic drug section better placed in, and integrated with, the All Wales Pharmacological Management of Pain Guidance.

Reference

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Lucie Rie: life and works



Lucie Rie DBE 1902–1995

Lucie Rie was an Austrian-born British studio potter, known for her exquisite wheel-thrown vessels and her innovative approach to glazing and firing techniques. She is considered one of the most important ceramic artists of the 20th century.

Rie's work is characterised by its simplicity, elegance and functionality. Her vessels are often thin-walled and delicate, with clean lines and subtle curves. She was particularly known for her use of a special type of glaze, which she developed herself, that produced a smooth, matte finish in soft, muted colours.

Rie's influence on the world of ceramics was significant. She was a member of the British Crafts Council, and her work was exhibited widely throughout Europe and the United States. She was also a teacher, and many of her students went on to become well-known potters in their own right.

In addition to her contributions as a potter, Rie was also an important figure in the development of studio pottery as a distinct art form. She helped to establish the idea that pottery could be a fine art and that individual artists could create unique, one-of-a-kind pieces that were both functional and beautiful. Her work helped to redefine the boundaries of traditional pottery.

Lucie Gomperz was born in Vienna, Lower Austria, Austria-Hungary, the youngest child of Benjamin Gomperz, a Jewish medical doctor who was a consultant to Sigmund Freud. She had two brothers – Paul Gomperz and Teddy Gomperz. Paul Gomperz was killed at the Italian front in 1917. She had a liberal upbringing.

She studied pottery under Michael Powolny at the Vienna Kunstgewerbeschule, a school of arts and crafts associated with the Wiener Werkstätte, in which she enrolled in 1922.



Cylindrical Pot (P100) 16 cm Lucie Rie 1960 Cylindrical pot, made of oxidised stoneware, with a pitted white glaze over dark body. Thrown oxidised stoneware with pitted white glaze over dark body. Fired to 1,250°C. Craft Council Collection.

In 1938, Rie fled Nazi Austria and emigrated to England, where she settled in London. Around this time, she separated from Hans Rie, a businessman whom she had married in Vienna in 1926, and their marriage was dissolved in 1940. For a time she provided accommodation to another Austrian émigré, the physicist Erwin Schrödinger. During and after the war, to make ends meet, she made ceramic buttons and jewellery for couture fashion outlets. Some of these are now displayed at London's Victoria and Albert Museum and as part of the Lisa Sainsbury Collection at the Sainsbury Centre for Visual Arts, University of East Anglia, Norwich.

Lucie Rie: life and works

In 1946, Rie hired Hans Coper, a young man with no experience in ceramics, to help her fire the buttons. Although Coper was interested in learning sculpture, she sent him to a potter named Heber Mathews, who taught him how to make pots on the wheel. Rie and Coper exhibited together in 1948. Coper became a partner in Rie's studio, where he remained until 1958. Their friendship lasted until Coper's death in 1981.

Rie's small studio was at 18 Albion Mews, a narrow street of converted stables near Hyde Park in London. She invited many people to her studio and was renowned for giving her visitors tea and cake. The studio remained almost unchanged during the 50 years she occupied it and has been reconstructed in the Victoria and Albert Museum's ceramics gallery.

Rie was a friend of Bernard Leach, one of the leading figures in British studio pottery in the mid-20th century, and she was impressed by his views, especially concerning the 'completeness' of a pot. But despite his transient influence, her brightly coloured, delicate, modernist pottery stands apart from

Leach's subdued, rustic, oriental work. She taught at Camberwell College of Arts from 1960 until 1972.

She received several awards for her work and exhibited with great success. Her most famous creations are vases, bottles and bowls, which drew some inspiration from Japan as well as many other places. There are other works such as buttons, which she bequeathed to her close friend the Japanese designer Issey Miyake and bowls including her own egg cup which she gave to the publisher Susan Shaw.

She stopped making pottery in 1990, when she suffered the first of a series of strokes. She died at home in London on 1 April 1995, aged 93 years.



Vases by Lucie Rie on display at Kettle's Yard, Cambridge April 2023. Credit Julia Hollander.



Blue plaque at her former home on 18 Albion Mews, Paddington, London.

She is best remembered for her bowl and bottle forms. Her pottery is displayed in collections around the world, including the Museum of Modern Art in New York, the York Art Gallery in the United Kingdom, the Carnegie Museum of Art in Pittsburgh and Paisley Museum in Scotland. She influenced many during her 60-year career and developed very inventive kiln processing. Her studio was moved and reconstructed in the new ceramics gallery at the Victoria and Albert Museum opened in 2009. She was awarded the title of Dame Commander (DCE).ⁱ

Note

i. https://en.wikipedia.org/wiki/Lucie_Rie

