

MARCH 2022 VOLUME 20 ISSUE 1

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



First Steps. Van Gogh 1890. Painted while he was a patient in an asylum in St Remy-De-Provence, France.

Finding wellness in the midst of illness

Healing the healers

Pain in the New Year

History of the Intractable Pain Society

Scottish Government Chronic Pain Framework 2021-22

Self-efficacy as a predictor of outcome from pain interventions

Invisible pain

I felt a funeral in my brain

ISSN 2050-4497





Third Floor Churchill House
35 Red Lion Square
London WC1R 4SG United Kingdom

Tel: +44 (0)20 7269 7840

Email info@britishpainsociety.org
www.britishpainsociety.org

A company registered in England and Wales and limited by guarantee. Registered No. 5021381. Registered Charity No. 1103260. A charity registered in Scotland No. SC039583.

THE BRITISH PAIN SOCIETY
PAIN NEWS

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PAIN NEWS is published quarterly. Circulation 1300. For information on advertising please contact

Neil Chesher, SAGE Publications,
1 Oliver's Yard, 55 City Road,
London EC1Y 1SP, UK.
Tel: +44 (0)20 7324 8601;
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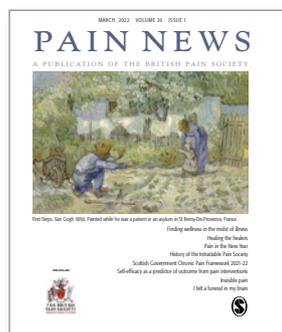
The Editor welcomes contributions including letters, short clinical reports and news of interest to members.

Material should be sent to:

Dr Rajesh Munglani
PAIN NEWS Editor
The British Pain Society
Third Floor Churchill House
35 Red Lion Square
London WC1R 4SG United Kingdom
Email rajeshmunglani@gmail.com

ISSN 2050-4497 (Print)
ISSN 2050-4500 (Online)
Printed by Page Bros., Norwich, UK

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Finding wellness within illness – part 1: healing the healers

Rajesh Munglani

Editor, Pain News



The starry night. Van Gogh 1889. Painted while he was a patient in an asylum in St Remy-De-Provence, France.

Health: *a state of complete physical, mental, and social well-being and not merely the absence of disease or illness.*

Wellness: *the optimal state of health of individuals and groups ... a positive approach to living*

World Health Organisation

The WHO's definitions of both 'wellness' and 'health' need to be challenged.

The use of the words 'positive approach to living' immediately creates a tension. If there is a positive approach, then it suggests there is also a negative approach. This 'dualistic' thinking denies the possibility that *a person can be ok and not ok* at the same time. In a world where the pursuit of happiness is drip fed to us through marketing and social media, where does contentment sit? Is contentment the same as happiness? In other words, *can I be content and unhappy and if so, is this in fact what wellness is?*

The concept of wellness has no universally accepted definition. In exploring the concept of wellness, some would say many issues are important, such as normalisation of the illness experience, independence or a seeking of autonomy and empowerment of the affected individual, and if possible,

finding meaning within the illness experience. In going through such an experience, many may need strong social support to start to discover their own motivations and beliefs and to access constructive coping strategies and cognitive reframing.¹

That all sounds rather heavy going. Ultimately, in the nature/nurture debate, is it really that remarkable that two people with the same disease react in different ways? For some, the disappointment of a failing or fragile body and mind weighs heavily upon them (and their families), while others seem, almost miraculously, to be able to 'live again' in a surprising and unpredicted way. Somehow, they still manage to engage with, and at times, even transmit joy, laughter and meaning to those around them despite suffering.

Those of us who are involved in the healing arts ultimately wish the best for those for whom we care. If we can cure, palliate or even just console, then we have done our best, but is it possible to meaningfully help our patients with their emotional, mental and spiritual suffering?

Using the WHO's definition given above, I suspect only a small minority of people in the world could be described as 'healthy'. The majority of adult human beings do not live in a state of complete physical, mental and social well-being and furthermore, most are not free from the experience of some disease. We live in the state of, and are surrounded by, imperfection. This is what unites us as people. We all know or have known loss, grief and suffering, it is what makes us human. We aspire to find meaning in such a state – it is part of our humanity. Perhaps it is here that we find the beginnings of an answer; recognising our humanity and its shared experience dispels some of the isolation and loneliness we may feel when faced with disease, illness and our shared suffering.

Wellness as a concept may be useful to explore. We seek wellness in the midst of illness and indeed attempt to continue *to live well throughout our lives*. Yet exploring what 'wellness' means and trying to measure it clinically, raises many more questions than answers. It is likely however that 'living well in the midst of suffering' is more determined by the internal

response of an individual rather than changing the environment or even curing the disease process itself (if that were possible).

But this is not a new problem at all! Many have approached the question of how to approach suffering, particularly in times past. The words of Job are recorded, it is said, in the most ancient book of the Bible. Job had been sitting in silence surrounded by his friends who failed (dismally) to give any explanation for his loss of health and death of his loved ones. When he finally speaks, Job challenges his friends and then the Divine of the Universe and is met with a response which set in context his experience of suffering within the greater magnitude of the natural world. Job was encouraged to expand his horizon far beyond his own life experience and encouraged to find meaning in the mystery of an impenetrable goodness beyond himself that he could not have imagined previously. He learns perhaps, to be contented with his burden and he came to recognise that it was part of a bigger whole; perhaps the first recorded case of ‘reframing’ and acceptance therapy.

Belief in one, many or no deities is not a prerequisite to explore the impact and place of personal suffering in the universe and indeed how to find a state of contentment within it. The questions may be profound and difficult to answer but it is always important to ask them.

Certain characteristics can be drawn from the themes of major religions and philosophies in looking for an approach to achieve a sense of peace and wellness when surrounded by turmoil. Some seek detachment from worldly troubles and achievements. Significance and meaning in life are therefore not achieved by frenetic activity at the metropolitan epicentre of our existence. Perhaps seeking to understand the concept of ‘a provincial life’ may be a good starting point. Taken literally, this is not an opportunity afforded to many nowadays, mainly because of financial and social constraints; in the main, ‘leaving city life for the countryside’ remains the prerogative of the rich. However, there is in it a kernel of truth that is worth exploring.

The ancient Greek philosopher Diogenes lived for many years in a barrel (or a large ceramic pot) in a street. Diogenes was said to have been visited by the renowned Emperor Alexander the Great. Alexander approached Diogenes with his entourage and asked him if he wanted or needed anything. ‘Yes’, replied the philosopher:

Could you move a little to one side? You are blocking the sunlight.

Diogenes was subsequently ridiculed for missing an opportunity to ask for riches, but the Emperor reportedly remarked:

Truly, if I were not Alexander, I wish I could have been Diogenes.²

The ‘provincial life’ of solitude and simplicity has been sought by theists and atheists alike, from Desert Fathers to renowned philosophers. In the 5th century, Simeon Stylites lived for 37 years on a small platform on top of a pillar. In the 15th century, Julian of Norwich lived in a cell besides a busy main road and many came to see her, seeking her wisdom and consolation. In the 19th century, Nietzsche spent his summers living in a single small rented room in the Engadine Valley, Switzerland. Buddha sat under a Bodhi tree, Jesus spent 40 days in the wilderness, while, by contrast, and not through his own choice, Jonah was swallowed by a whale for 3 days (or perhaps it felt like it) and then in further state of anguish sat under a vine as it first grew and then withered. All achieved a deeper understanding of the nature and purpose of their lives.

We may not all be in a position to spend time in an environment of solitude and contemplation, but perhaps, in our busyness, this may be achieved by an *inward solitude*. What makes the difference is not where we are but *our engagement* with all that surrounds and impacts us. Can we seek to live the provincial life – *inwardly*? And if so, how?

Alongside these thoughts, let us not lose sight of our original premise. Is it possible to help our patients achieve wellness in the midst of suffering?

Perhaps then the first place to start is with ourselves. During this time of pandemic, burnout among healthcare professionals is at an all-time high. Many patients and indeed carers who have endured Covid have subsequently suffered with long-term medical and mental health conditions. The suffering is not yet over. There is a weariness, a greyness pervading those who have given so much.

Sometimes we can do nothing about our environment, about the plagues that randomly overwhelm us, but we can find a source of resilience which is *within us*. The first sight of it becomes apparent when we *embrace* rather than dispel all that is happening in us and around us. We need to resist the dualistic approach and recognise in ourselves as whole human beings, joy and sorrow can dance together.

Today my suffering feels overwhelming, tomorrow it may be bearable.

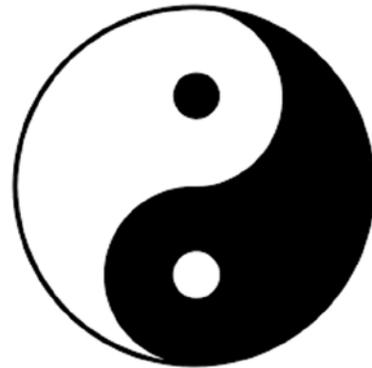
I hold both possibilities as one and remain fluid and accepting of myself and all my emotions.

Finding wellness within illness – part 1: healing the healers

Practising mindfulness enables us to welcome further all that constitutes our daily life; it scoops it all up and adds perspective and a sense of presence and ultimately meaning.

Our vision becomes clearer too when we accept, we are not alone; suffering is a prerequisite to the human condition and unites us with others who share our humanity. We only are unable to experience this oneness when we fail to share our vulnerability, when we resist being open and honest. It is here that we can begin to be content whatever the circumstances.

Finally, we need to consider the observation that some of the greatest people in history and those we have known personally were forged in furnaces of the deepest suffering, as were some of the greatest works of art and literature. Imagine a world without the works of Van Gogh such as the 'The Starry Night', without Nelson Mandela or Mahatma Gandhi and many others. Suffering may endure but so do the answers.



Acknowledgements

I wish to thank many friends and colleagues including Archbishop George Carey and Rev Jane Keiller who have commented on earlier drafts of this article but all errors, omissions and misunderstandings are mine alone.

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Jenny Nicholas



Welcome to the first issue of *Pain News* for 2022!

Spring is finally in the air, as the days get longer and the sunshine makes an appearance. If you're like me, you hadn't truly realised how much you had missed it until it reappeared, and now with a renewed energy, anything feels once again possible.

Here is a sneak preview of some of the articles we have in store for you this issue ...

- We commence this issue with a piece from our Editor, Dr Raj Munglani on 'Finding wellness within illness'. This is part 1 of a series looking at 'Healing the Healers'.
- Margaret Dunham, our Associate Editor provides us with a roundup of all things *Pain News*. We would be delighted to hear your news that we may feature in this new section of *Pain News*, so do keep us informed on what is

happening to improve your work and practice wherever you are.

- Can the Pain Self-Efficacy Score predict outcome of pain management interventions? Grevin Jones, Christian Cooke and Dr Thomas Haag share details of their project with us which aimed to examine the relationship between self-efficacy, as measured by the PSEQ score, and the outcome of theatre-based interventions.
- We share poems 'Invisible Pain' and 'I felt a funeral in my brain'
- And we finish this issue with a book review of 'The Painful Truth'.

We do hope that you enjoy this issue of *Pain News*, and we are always glad to hear your feedback!

Have your say

We would welcome your view and letters on any of the topics we have covered in this, or previous issues of *Pain News*.

We also welcome articles, so if you have a story to share, please contact us at newsletter@britishpainsociety.org. We would be delighted to hear from you!

Message from the President

Arun Bhaskar



Flexibility is the key

Dear Friends

Happy New Year and I trust this finds you well.

The relaxation of Covid-19 rules and restrictions has been accompanied by an increased demand from patients attempting to access the NHS generally and Pain Management services specifically after several months of shielding. Pent up demand for elective and even urgent surgeries that had been put on hold in the time of the pandemic has placed increased pressure on limited theatre capacity and limited number of staff. We have been busy dealing with the pandemic and continue to be busy with the ongoing workload. Unfortunately, this has led to inordinate waiting times for patients needing interventional

pain procedures. These pain procedures are often considered of lower priority as compared, for example, to those waiting for cancer surgery, coronary interventions and joint replacements.

However, one thing the pandemic taught us was our amazing capacity to be flexible and to adapt to work under challenging and changing conditions and with limited available resources. More than ever previously we have adopted wholesale digital media and virtual platforms to communicate with and support our patients. In turn, the vast majority of patients were very understanding and supportive of us during this time with a genuine concern for our well-being and appreciation for the burden we were carrying during this unprecedented once in a lifetime event for most of us.

Annual Scientific Meeting

You will have received the communication that the dates of The British Pain Society Annual Scientific Meeting had to be changed from 28–30 June to 13–15 June. This was unavoidable. With the lifting of the pandemic restrictions, many major competing events were now back on the schedule. In particular, Ed Sheeran announced that his concerts at the Wembley arena were taking place from 24 June to 1 July and this derailed our original plans; hotel accommodation prices sky-rocketed; the scenario thousands of fans celebrating outside the arena would make it impossible to hold the ASM on the originally chosen dates. We were given 48 hours to either find a suitable alternative venue (which would have been impossible at this late stage) or to accept a change of the dates. We decided on 13–15 June so as to not to clash with Her Majesty's Platinum Jubilee celebrations and the associated bank holiday weekend in early June and July was too close to the summer holidays. The organising team and the hotel staff worked together to ensure that we were not financially penalised and did so without compromising on the facilities. I am very grateful to all of the speakers and other colleagues for their support and understanding and have kindly accommodated the new dates. Only a handful of colleagues were unable to accommodate the change in dates, but we are working with them and the Scientific Programme Committee to make alternative arrangements for those sessions. Usually much time is taken for deliberation of such major changes. Unfortunately, the short time window of 48 hours meant that I had to make an executive decision. It is not how I normally work, relying on group decision making with the involvement of the Council and

other colleagues, but in these unprecedented times, we all have to learn to be flexible and adapt to respond to rapidly changing circumstances. I hope many of you can make the ASM in person; if not there is always the virtual meeting.

A view from south of the border

The British Pain Society (BPS) values every single member and prides itself to represent the multidisciplinary nature of Pain Medicine throughout the length and breadth of the United Kingdom. Active patient representation as a supporting but independent entity under the auspices of the BPS was lacking for several years. One of my agendas after becoming the President was to rejuvenate the Patient Liaison Committee and I am delighted to note that the aptly renamed Patient Voice Committee is slowly asserting its influence under the stewardship of Mrs Victoria Abbott-Fleming MBE. The impact of the patient body on how the BPS along with the Faculty of Pain Medicine is engaging with policy makers and politicians in raising the profile of Pain Medicine and Pain Management would be seen in the coming months and years. Consistent with the aim of the new agenda to increase patient input, it was decided that we would welcome articles and pieces of work from patients, patient representatives and patient charities to 'give voice' to their hopes and thoughts, and to any comments, concerns and criticisms they may have to bring to our attention.

In the December 2021 issue of *Pain News*, an article by Ms Dorothy-Grace Elder was published. She is an award-winning Scottish journalist, an honorary Professor at Robert Gordon University and founder of the Scottish Parliament Cross Party Group on Chronic Pain and a former MSP.

This article was backed up by contributions from three patients Liz Barrie, Ian Semmons who is Chair of Action on Pain UK and Kathleen Powderly who is also a qualified nurse. A serving MSP Monica Lemmon also wrote about her views in the same piece. This article prompted several responses from our Scottish colleagues, raising concerns about the way the issues were being portrayed. The concerns were that the article only portrayed one side of the story and perhaps this undermined the hard work done by professional colleagues across Scotland in trying to shape a better future for Pain Management for Scotland and in their day-to-day care of patients living with persistent pain. We discussed this matter as an Executive and as a Council and in response I write the following.

First of all, I would like to reassure all the colleagues across Scotland and the rest of the United Kingdom that the BPS is not supporting or endorsing the views expressed by the author, but in line with the aims of the Society, it is surely right to such patients and their advocates to have access to the same platform as professionals to air their concerns. We anticipate

this will lead to further positive engagement between all parties. Second, we should remember that we are collectively working together to support our patients and we must be aware of the implications of policies and pathways in one part of the United Kingdom would have a significant impact on the other three nations.

There are several aspects of this article that merits further discussion. The article opens with the statement that self-management of pain takes the patient away from specialist services. This is not correct. Self-management of pain is not DIY pain management and asking the patient to fend for themselves. Instead, self-management is the ultimate goal for all patients to be in control of their condition, to help empower them to live more fulfilled and fruitful lives while effectively managing their pain. The biopsychosocial model of pain enables us to recognise that the long-term management of the vast majority of chronic pain conditions can be done in primary care with appropriate allocation of expertise and resources, and only certain aspects of patient care need to be escalated to secondary or tertiary care for more specialised management. The concept of self-management is about supporting the patient to learn about their condition and empowering the individual patient to work with the clinicians, healthcare professionals, social care workers and social prescribers to better manage the pain and improve their quality of life. This strategy that has been established for a while is not only being explored in Scotland but also in the rest of the United Kingdom.

In the Professor Elder's article, a patient Liz Barrie writes about her situation, that she has to wait for long periods of time to receive her injection for managing her back pain. It is obvious that Ms Barrie reports excellent benefits following her injections so much so as it 'restores life'. I do believe that it would be unethical to stop a treatment that is effective for her. We also accept that for the vast majority there are a number of treatments we no longer routinely recommend and these include the use of long-term strong opioids for chronic non-malignant pain and we also no longer recommend regular injections with steroids, as the long-term risks far outweigh the potential short-term relief for the few who benefit. I, as a self-declared interventionalist myself, would recognise that repeated injections are unlikely to be a recommended approach for most patients, but it may be vital for the few. The success of such an approach has to be patient centred rather than dogma centred. We have to be flexible and be aware of patient condition, choice and medical need and use an evidence-based approach where possible and by access to especially in terms of physical and psychological rehabilitation and mobilisation as part of a multimodal analgesic strategy. In such a case of an apparent need of repeated injection, a more specialised evidence-based approach such as neuromodulation could be considered. The key again is we have to be flexible and

Message from the President

patient centred in our approach. We should also recognise that our patient pathways have to be adaptable and allow patients access to more specialised services if clinically appropriate and consistent with legally upheld principle of patient choice and involvement in clinical decisions involving their care.

The BPS has been at the forefront of making Pain Management multidisciplinary and is no longer an 'Anaesthetist-only' speciality. Hence, it is not surprising that leaders in Pain Management have evolved from other disciplines and this is true in Scotland too. Many of these colleagues have made outstanding contributions in this field of medicine and continue to represent the United Kingdom in the various committees of the European Pain Federation and International Association for the Study of Pain. The Scottish Government Framework for Pain Management Service Delivery has been out for consultation and the BPS alongside with many other organisations have given our comments and suggestions. Chris Bridgeford, Chairman – Affa Sair, outlines the framework in his article in this edition of *Pain News*. I would request all parties concerned to come together and consider the issues so ultimately patients will benefit. We need to address individual cases but also deal with the health of the wider population. We need to be flexible enough to see the individual trees and the wood at the same time.

Mr Alex Neil, Former Cabinet Secretary for Health and Wellbeing in the Scottish Government, in his article in the December 2021 issue of *Pain News* has highlighted the problems regarding healthcare delivery in the United Kingdom and the importance of tackling the situation urgently. However, I am not optimistic about more funding allocated for pain management though we do need more money for pain management, mental health and social care. We also need more investment on training not only for specialist doctors but also other healthcare specialists, but this is going to take several years to realise if it occurs at all. Increasing patient demands and expectations, lengthening waiting times for consultation and treatment and difficulties in discharge planning to ensure seamless care in the community are some of the growing challenges that need addressing immediately. Plans like GIRFT and national spinal pathways are expected to be rolled out in the near future and this would enable to make the necessary plans to deliver better care. In the interim we should ensure that we look after our current workforce and develop pathways alongside other specialities (e.g. neurosurgery, orthopaedics and rheumatology for spinal/MSK pain) to prevent duplication of investigations and treatments.

We do not have a charity for pain; yes, we have for different conditions, but not as a unified front. The National Awareness

Campaign of the BPS 'to make pain visible' needs more support from patients and professionals. I do agree the call for clinicians to support this campaign by Prof Elder, but it is not a campaign they can win by fighting alone. This is an opportunity for clinicians, patients and their carers to come together to discuss with policy makers and politicians and ensure that the best possible options are supported and rolled out.

Research in pain management

It is interesting to see publications stating that certain well-established treatments do not work on patients living with chronic pain far outnumber the ones that demonstrate benefit from treatments. The typical approach taken by such publications is to discount the results of poorly conducted randomised studies and also omitting other forms of evidence as case reports and cohort studies by stating that all of them do not meet the inclusion criteria to be even considered. As a result, we end up with only a very limited perspective. We are only looking at a very small part of the evidence – perhaps only a teaspoonful of it. It is like looking at a teaspoon of water and stating that there is no evidence that sharks and whales exist. If we only look at a teaspoonful of evidence, can we really extrapolate to what is happening in the oceans? We accept that randomised controlled trials (RCTs) provide the highest quality of evidence, but we need to accept that doing placebo controlled studies in pain management with all the complexities of a biopsychosocial condition is not often achievable so the data pool is often small.

We promote patient choice, patient-centred care and best use of resources, yet policy makers make decisions on what treatments to offer and what to fund based on these systematic reviews which have already excluded much of the available data. This puts clinicians in a difficult position as they have to explain to the patient that the treatment they were looking forward to is no longer funded. There has been awkward moments when patients were asking for a repeat treatment that worked for them for a reasonable duration of time that has now been withdrawn as it is deemed a 'low value intervention' due to 'lack of evidence' – ignoring the fact of course the evidence for efficacy is sitting right in front of the clinician. Interestingly, the recommendations seldom include suitable alternative options and patients accept the available options only because they have no other choice (so much for patient choice). The collapse of the NICE GDG for Chronic Fatigue Syndrome gives us a warning that even established psychological management options could be rejected by patients; in the age of gene sequencing, biomarkers and nanotechnology, patients have every right to demand more research into potentially promising treatment options. We have to be flexible as to what we consider to be good evidence in the choice of treatment we offer our patients.

The British Pain Society today

I read with great interest Charles' piece about the beginnings of the Intractable Pain Society in this issue and it reminded me of a soldier reminiscing about the good old days. It evoked a lot of pleasant memories, as I had researched about the beginnings and history of the British Pain Society for Pain News as part of our 50th anniversary celebrations. I found out that the first meeting of the Intractable Pain Society was held at The Christie Hospital in Manchester and this was where I started my consultant career in 2006 and went on to establish the Pain services there. Prior to that, I had my Advanced Pain Training at Salford Royal Hospitals NHS Trust, which was where Dr Mark Swerdlow practised. It was also the centre where Prof Chris Main and Dr Chris Spanswick set up their world class Pain Management Programme. The Intractable Pain Society was primarily set up to manage patients with cancer pain, but by 2006 cancer pain management was the monopoly of palliative care colleagues and pain management have evolved to be delivered through multidisciplinary teams. Gone were the days where people were doing neurolytic procedures for cancer pain, and Charles through his book was my tutor and guide when I started complex interventions with no senior consultant support. The British Pain Society is proud to be a truly multidisciplinary body and not just anaesthetists are involved in the management of pain. Regarding discussion forums, I do feel privileged to be involved with the Google group that Raj set up which does give a platform to have in-depth discussions on

issues both clinical and political to a certain extent in this day and age. We are in the process of setting a similar project under the BPS umbrella as a discussion platform. I am also hoping that more and more specialities would join hands to enrich the discipline of pain management in the future.

Elections

The next round of Council elections is around the corner and I urge you to consider putting yourselves forward for election. There is always a place for those wishing to become involved in the BPS activities and to strengthen the multidisciplinary nature of the Society. My colleagues in the executive and the current Council members have worked hard to keep the Society moving forward and now it is your turn to take the baton and continue to run the race. It was disheartening to hear comments about lack of representation from some parts of the United Kingdom or from some disciplines, despite our best efforts to encourage colleagues to stand for the election. We have tried to address this by co-opting members, but the current bylaws only give voting rights to elected council members. Credentialling in pain medicine and pain management is around the corner and hence it is important that we present a unified front for the betterment of pain management and our patients. So please consider putting yourselves forward for the upcoming elections as this is another opportunity for you to enable the multidisciplinary vision for the BPS.

Pain in a new year

Margaret Dunham *Associate Professor, Edinburgh Napier University*



Pain News
2022, Vol 20(1) 10–11
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SAGE

News & updates

As we celebrate the New Year and the Chinese New Year of the Tiger, I reflect on the last, very disrupted, 2 years of this pandemic. The impact on pain services has been extraordinary, 'normal service' has been disrupted/postponed across all non-Covid related health care provision and many of our remaining clinician colleagues are using much of their resilience and energies to get services back on track.

The spectre of this Long Covid now adds to the plethora of chronic conditions that will burden individuals for years to come. This January, the Office for National Statistics published data estimating that 1.3 million people in the United Kingdom (2.0% of the population) have self-reported Long Covid. This contrasts with the United States where it is thought that up to 30% of people who have had Covid are continuing to experience long-term effects.¹

In the United Kingdom, the NHS is doing its best to support people with Long Covid with the establishment of dedicated Long Covid services.² I sincerely hope that this does not detract from the earnest efforts to understand and support the existing population living with chronic diseases, those with chronic fatigue and chronic pain in particular.

A recent cohort study, post-discharge from UK hospitals with Covid, has noted a range of long-term (>6 months) health issues.³ Some 1170 people were contacted after discharge with offer of clinical follow-up and post hoc data analysis of associated comorbidities, perceived recovery and demographics. The identified health issues included muscular pain, fatigue and sleep problems. Of those participants who had been working pre-Covid, 17.8% were not working and a further 19.3% had experienced a health change that affected their occupation. These data present alarming and gravely concerning health-related consequences.

Celebration

One of our esteemed colleagues, Professor Pat Schofield, has received an accolade for IASP. She has been recognised in the form of a Distinguished Contribution Award from the Special Interest Group 'Pain in Older Persons' of the IASP. <https://www.plymouth.ac.uk/news/pain-in-ageing>. Pat has worked tirelessly in pain management as clinician, researcher and

advocate for over 30 years, chairing the first nursing Pain Network in 1990 and still advocating for the needs of older people and other vulnerable groups living with pain. Pat is currently working at the University of Plymouth in a clinical academic role leading and supporting research in the south west of the United Kingdom.

Opioids

Concern regarding the use and misuse of opioids continues to dominate the pain world. In the United States, there is growing alarm at opioid-related deaths and noteworthy among 'baby boomers', the rock and roll generation, use and misuse of opioids and other recreational drugs. These teenagers of the 1960s were exposed to opportunities of drug use unlike previous and subsequent generations. A 21-year, retrospective study of individuals, approaching their 70s, noted a significant increase in opioid-related deaths and visits to emergency department (ED) with opioid misuse increased by 220%.⁴

In contrast, the effects of opioid withdrawal on people with pre-existing mental health problems are less well understood. A recent retrospective cohort study in the United States considered the effects of opioid tapering, that is, the results of gradually reducing the daily dose of opioid over a 60-day period.⁵ This study comprised 113,618 people undergoing dose tapering. The subsequent incidence rate of overdosing was significantly higher compared to those not undergoing tapering. Tapering was also associated with increased rates of mental health crises. This study was observational in nature and reflects the different culture of the US health care system. However, its implications are clear: tapering of opioids, whatever the circumstances, should be considered with caution and under supervision where there are concerns about the mental health status of the individual.

The new year has seen the launch of a consultation for the new BPS-led patient leaflet entitled managing pain after your surgery. <https://www.britishpainsociety.org/british-pain-society-publications/publication-consultations/> (closing on 25 February 2022). This is proposed as a helpful guide to engage with people in need of post-discharge analgesia, and again is focused on safety in opioid use.

Clearly guidance and support for opioid prescribing is good. However, the bottom line must be respect for the individual

person's situation and the independence of the prescribing health professional who has a duty of care. To this end, NHS Scotland has worked closely with academia, clinicians and individuals with lived experience of chronic pain to produce a Scottish Guide for Opioid Prescribing for Chronic Pain. Opioid Prescribing for Chronic Pain Draft – Effective Prescribing and Therapeutics (scot.nhs.uk). The document focuses on safety, person-centred care and safe prescribing with advice regarding the review and oversight of opioid prescribing. Models of self-management and non-pharmacological strategies are promoted, with an emphasis on the importance of shared decision-making and honest conversations.

Exercise is good for you and swimming even better

To end on a much more upbeat note – exercise is good for you and swimming, in particular, is good for people with chronic pain. A recent randomised trial of 113 people with chronic back pain was subject to a swimming pool-based intervention.⁶ Aquatic exercise was compared with other physical activities as part of treatment regime for low back pain in this Chinese study. A therapeutic aqua exercise (aquacise) regime of 40-minute duration was found to be extremely beneficial; the aquacise group had reduced disability and significant functional improvement compared with the participants in the other physical therapy group and severe pain was also improved in

the aquacise group, with overall improvements on the short form health survey (SF36).

Finally, Happy New Year, keep healthy, keep strong and do share your good news, we would love to hear about what is happening to improve your work and practice wherever you are!

Please send any links or information that you would like to see in this section to m.dunham@napier.ac.uk

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The Intractable Pain Society (some recollections)

Count Dr Charles A. Gauci *Retired Consultant in Pain Medicine
(Formerly at Whipps Cross University Hospital, London)*



O tempora, o mores!

I have been asked to put down my recollections of the *Intractable Pain Society*, (IPS) the forerunner of the British Pain Society.

As a newly appointed Consultant Anaesthetist in the British Army, I started my training in Chronic Pain at the Queen

Elizabeth Military Hospital, Woolwich, in 1979 under the personal supervision of Colonel James (*Jimmy*) MacEwan, consultant-in-charge. He was an early member (but not a founder-member) of the IPS, one of the unsung heroes of pain management in the United Kingdom. In addition, I started a pain relief clinic at the Cambridge Military Hospital which

The Intractable Pain Society (some recollections)

consisted of one dedicated half-day per week together with several ad hoc theatre sessions and ward consultations. The Cambridge Military Hospital also served as the local NHS District General Hospital and a large number of the pain clinic patients were NHS civilians. I was accepted as a member of the IPS in 1980. I remember going to my very first meeting, I think in Oxford, when my mentor Jimmy MacEwan presented an early scientific paper on TENS.

To the best of my knowledge, Dr. Mark Swerdlow of Salford, who had set up a Pain Clinic in 1955, had organised a loose *Pain Group* in 1967. This informal group morphed into the IPS in 1971. Mark was its first Chairman and my old boss in Cardiff, the late Professor William Wolf Mushin CBE, was its President. Prof Mushin was a pioneer in the treatment of chronic pain and was made President for life of the IPS. Dr Mark Churcher was its first secretary and Dr J Challenger its first treasurer. There were about 16 founding members, including Prof (later Sir), Michael Bond, Dr Mark Mehta, Prof Birkenham, Dr R Maher and Dr Sam Lipton. Other early members included Prof Iggo, Dr J Hannington-Kiss, Dr John Lloyd, Dr Hugh Raftery, Dr Keith Budd and Dr T (Ken) Hardy.

The IPS was first registered as a charity in 1979. It then became the *Pain Society* in 1988, which in 2004 became the *British Pain Society*.

As I was a member of the Council of the BMA, I was co-opted onto the Council of the IPS in April 1987 and served until 1990 (by then it was the Pain Society).

The IPS was limited to doctors involved in pain management. That was its great attraction to most of us. Armed with our pints of beer, we used to have long and very practical discussions on various medical cases. I felt that I belonged to a tight-knit medical fraternity. We frequently contacted each other seeking advice on difficult cases.

Names of other active members in those far-off days which spring to mind are Chris Wells, Phil Brown, Tim Nash, John Wedley and Ray Consiglio. John Wedley and I worked very closely together to produce the very first practical handbook on interventional pain therapy, which was eventually published in 1994.

The IPS used to have joint meetings with the Dutch Pain Society. These were excellent events from which I learned a great deal. I remember Mark Mehta and Menno Sluiter (*the Terrible Twins*) presenting their early work on facet RF. As a large number of non-interventionists joined the Pain Society, which succeeded the IPS and as the Pain Society opened its

ranks to non-doctors, these meetings were discontinued, much to my dismay.

We frequently visited each other's Pain Clinics to get hands-on experience in various techniques. It was then a truly *National* Health Service, the emphasis being on the word *National*. No Trusts with their rule books and officious managers telling Consultants what they could or could not do in their clinics! You just turned up and went to your colleague's theatre where you received hands-on instruction on various procedures.

The IPS also had its own journal. These published papers of great practical help to doctors actively involved in pain management.

I look back at those days with fond nostalgia. We were a dedicated group of doctors. Most of us had no interest whatsoever in medical politics and political correctness had not yet entered the lexicon of everyday life.

O tempora, o mores!
Cicero

Further Reading ...

Charles, never one to hide his feelings, uses a Latin idiom in a not-so-subtle attempt to mourn the demise of the IPS and what took its place!

O tempora, o mores! is a Latin phrase coined by Cicero which translates literally as 'Oh the times! Oh, the customs!' A more common idiomatic rendering in English is 'Shame on this age and on its lost principles!'. Use of the exclamation mark is a modern adjunct which would not have been used in the Latin written in Cicero's Day.



Biographical note – Cicero.

The Intractable Pain Society (some recollections)

Marcus Tullius Cicero (3 January 106 BC–7 December 43 BC) was a Roman statesman, lawyer, scholar, philosopher and academic sceptic, who tried to uphold the principles of the continuity of the Senate during the political crises that led to the establishment of the Roman Empire. His extensive writings include treatises on rhetoric, philosophy and politics, and he is considered one of Rome's greatest orators and prose stylists. He came from a wealthy municipal family of the Roman equestrian order, and served as consul in 63 BC.

His influence on the Latin language was immense. He wrote more than three-quarters of extant Latin literature that is known to have existed in his lifetime; Cicero introduced into Latin the arguments of the chief schools of Hellenistic philosophy and created a Latin philosophical vocabulary with neologisms such as *evidentia*, *humanitas*, *qualitas*, *quantitas* and *essentia*, distinguishing himself as a translator and philosopher.

Although he was an accomplished orator and successful lawyer, Cicero believed his political career was his most important achievement.

His works rank among the most influential in European culture, and today still constitute one of the most important bodies of primary material for the writing and revision of Roman history, especially the last days of the Roman Republic (Wikipedia – in the public domain).

Author Note

Now a part-time semi-retired Consultant in Pain Medicine in Malta & Gozo. Assistant Lecturer, Department of Anatomy, University of Malta. Chief Herald of Arms of Malta, Former President and now Vice-President for life of the Royal British Legion, Malta GC Branch. President, St Margaret Band Club, Gozo. Retired Lt Colonel in the British Army (RAMC).

Scottish Government Chronic Pain Framework 2021–22



Pain News
2022, Vol 20(1) 15–16
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SAGE

Chris Bridgeford *Chairman – Affa Sair*

The Scottish Government Chronic Pain Framework 2021–22 is now out for public consultation as I write.

Consultation began in December 2021 and closed on 28 February 2022.

The Framework was put together by the National Advisory Committee on Chronic Pain which for the first time since its inception and included patient representation. My own charity, Affa Sair, like other new charities, was vetted and given a seat on the committee as one of the third-sector representatives along with Pain Concern, Pain Association Scotland, Versus Arthritis, The Health and Social Care Alliance and Friends of the Centre for Integrative Care.

In 2020, the Scottish Government's 'Programme for Government' set out commitments to:

- Publish a recovery framework for pain management services.
- Review the format and remit of the National Advisory Committee for Chronic Pain.
- Develop the current Scottish Service Model for Chronic Pain and to publish a new Framework for Chronic Pain Service Delivery in 2021.

In February 2021, the restructured NACCP met to begin its work to:

- Advise the Scottish Government on chronic pain to inform effective national policy and service improvement, considering available data on service provision, outcomes and harmful variation.
- Guide the improvement of chronic pain management at all levels of health and social care, including the delivery of the Scottish Government's commitments in the Programme for Government, the recommendations of the Scottish Access Collaborative report on Chronic Pain and the ongoing remobilisation and rebuilding of pain management services during and following the COVID-19 pandemic.
- Raise and maintain the profile of chronic pain with the public, NHS and Local Authority senior leadership and other relevant Scottish Government stakeholders.
- Oversee pain management content on NHS Inform.

NACCP members were asked to make suggestions for inclusion in the framework. The charities, or third-sector representatives, got together and submitted their suggestions as one report. Some of the suggestions put forward by my own charity, Affa Sair, were for a common Pain Management Programme for all of the Health Boards; Government-approved training sessions for trainee doctors and other health professionals on what living a life with chronic pain is really like; a common questionnaire for all health board areas to use when assessing patients' pain symptoms and which should be completed before the initial assessment, saving clinical time. We will keep pushing for these ideals in the years ahead.

The Framework's overall vision is for person-centred, effective and safe care that improves the quality of life and well-being of people living with chronic pain in Scotland and the aims of the new framework are as follows:

- To ensure access to appropriate information and support based on an individual's needs.
- To support people to access the care they need when they need it.
- To ensure people have a choice of effective treatments.
- To invest in training, data and research to improve care and support.

This Framework has been welcomed by Affa Sair trustees and members and commits the Scottish Government to:

- Improve the quality and consistency of information on chronic pain and make it more easily accessible. The Scottish Government will empower people to understand their condition and better manage its impact on their physical and mental well-being.
- Support people to access the right care, in the right place, at the right time by working with NHS Boards to improve how they plan and deliver care for people with chronic pain. This includes increased coordination across community-based, GP and hospital services.
- Improve the options people have in accessing chronic pain services, including digital technology where appropriate.

Scottish Government Chronic Pain Framework 2021–22

- Support people with chronic pain and healthcare professionals to better understand and agree effective treatment options to manage pain.
- Ensure people have more consistent access to effective treatment options wherever they live in Scotland.
- Work with NHS Education for Scotland, professional bodies and partners to improve training and education on management of chronic pain.
- Establish and support health and care professional networks to share best practice in pain management at local and national levels.
- Support Health and Social Care Partnerships to improve how pain management support is planned and delivered locally by promoting more consistent use of performance and quality data.
- Work with Public Health Scotland to increase national reporting and analysis of clinical and patient experience data to improve services for people with chronic pain.
- Develop and agree national standards for pain management services to improve care for people with chronic pain.
- Support pain research in Scotland to develop improved care and treatment options for people with chronic pain.

All the commitments and aims of the Framework are very laudable but of course, at the moment are only words. As with everything else in life, the proof of the pudding is in the eating. I am heartened though that under a new chairmanship the NACCP has become more open in its dealings with patients and has shown a commitment to change the previous workings of the committee. Allowing patient representation

onto the committee is a major step forward and must surely be welcomed by chronic pain patients desperate to have their plight recognised by government officials. With every new organisation, there will always be a few bumps on the road, but chronic pain sufferers should be assured that there is at long last a willingness to make changes, albeit with all the problems that come with historic problems of unacceptably long waiting lists, lack of consultants, training and staff. What cannot be disputed is that when the Framework is finally adopted, it will give chronic pain sufferers something to hold the Scottish Government to account with.

Personally, I hope this is the start of a new working relationship between the Scottish Government and chronic pain sufferers (I hate the term 'lived experience' currently favoured by government officials) where proper discussion and debate take place. Both sides must concentrate on the daily needs of those suffering intractable pain and put aside past animosity and extremist behaviour while being mindful of the real-life problems of finite budgets, manpower and the ongoing problems COVID brings.

Chris Bridgeford is the founder and chairman of the Scottish Charity – Affa Sair (Scots for 'Awfully Sore'). The charity currently has around 620 members and is open to those affected by chronic pain wherever they may live. Members are encouraged to share their experiences and ideas for coping with chronic pain in the charity's closed Facebook Group which is only accessible to members. There is a free monthly newsletter and an information-packed website at www.affasair.org

Can the pain self-efficacy score predict outcome of pain management interventions?

Grevin Jones *Senior Specialist Physiotherapist in Pain Management, Wrexham Maelor Hospital*

Christian Cooke *Specialist Physiotherapist in Pain Management, Wrexham Maelor Hospital*

Dr Thomas Haag *Lead Consultant in Pain Management, Wrexham Maelor Hospital, Wrexham, UK*

Introduction

Within chronic pain services, injection-based interventions are commonly used to help diagnose and treat chronic pain conditions. Theatre-based interventions play a significant part in the multimodal treatment of chronic pain particularly of a more musculoskeletal nature. It is often observed that outcomes can vary considerably despite adherence to best practice approach and appropriately selected patients.

An unsuccessful intervention may impact the patient negatively in terms of the potential physical and psychological harm. The provision of pain interventions also comes with significant cost implications, making it therefore of vital importance to have a predictable success rate. The following article is aimed at assessing whether the Pain Self-Efficacy Questionnaire (PSEQ) could help predict outcomes of pain interventions. The PSEQ is a prevalent and validated outcome measure used within Chronic Pain services around the world. Self-efficacy is defined as our ability to confidently achieve a goal or complete a task and whether we think it will have a positive result.¹

Defining clinical outcomes following pain interventions is challenging in many different ways. Often outcome measures are not standardised and validated. Whether or not an intervention is successful is often seen purely in technical terms, such as the type of intervention, the technology behind it and the anatomical target. As clinicians, we often experience varying degrees of success despite consistency in patient selection and the technical aspects of the pain intervention.

It has been postulated that PSEQ can be helpful in predicting outcome as supported by limited evidence in pain management approaches. As such, this can also be used to support the decision-making process for the most appropriate treatment. Unsuccessful treatment interventions are not only costly but can also be potentially harmful for the patient both physically and psychologically.^{2,3}

The National Health Service (NHS) in Wales has adopted the approach of Prudent Healthcare designed by The Bevan Commission as its main architect.⁴ The main principles in this document contain the need of care for those with the greatest health need first, making most effective use of all skills and resources, and to do only what is needed – no more, no less – and do no harm. The ability to screen patients effectively prior to interventions would be in keeping with this model of care.

The PSEQ and its validity

The PSEQ is an established 10-item measure of pain self-efficacy that is widely used in clinical and research settings. Developed in the 1980s by Michael Nicholas,⁵ it assesses the confidence of people with any type of chronic pain in activity despite pain. It covers the following domains: enjoying activities of daily living, social life, coping in general, work, coping with pain without medication, accomplishing goals, living a normal lifestyle and becoming more active, all 'despite pain'. Each is rated on a 7-point scale from 0 = not at all confident to 6 = completely confident. The total score, ranging from 0 to 60, is calculated by adding the scores for each item. Higher scores reflect stronger self-efficacy beliefs. The PSEQ is easy to complete and has a high completion rate. It can be used in assessment, treatment planning and outcome evaluation.⁶

Internal consistency is excellent and test-retest reliability is high over a 3-month period.⁷ Validity is reflected in high correlations with measures of pain-related disability, different coping strategies and another more activity-specific measure of self-efficacy. The evidence of the PSEQ's sensitivity to change provides support for its construct validity.⁸

Presentation of what we did

The aim of this project was to examine the relationship between self-efficacy, as measured by the PSEQ score, and the outcome

Table 3.

Percentage of likely outcomes from PSEQ scores	Positive	Negative
30+	27 = 75%	9 = 25%
30–	7 = 35%	13 = 65%

PSEQ: Pain Self-Efficacy Questionnaire.

Conclusion and suggestions for future discussions

It would seem that there is a relationship between self-efficacy using the PSEQ score and perceived outcome of various theatre-based interventions for patients with persistent pain.

It would appear that patients who score more than 30 points on the PSEQ are more likely to have a positive outcome, whereas patients who score below 30 are more likely to have a negative outcome.

Our project has shown that the PSEQ score may be a useful tool in assessing likely outcomes of theatre-based interventions, subject to further research involving a larger number of patients with longer follow-up intervals. The score may assist the clinician in deciding on what treatment priorities should be set, that is, pain educational sessions and/or pain management programmes prior to offering injections. This raises the question as to what extent self-efficacy could be improved prior to a planned intervention, resulting in overall improved outcomes.

Low self-efficacy is a predictor of being at risk of long-term disability and depression, while higher self-efficacy appears to enhance and maintain the long-term effects of rehabilitation.⁹ This may broach the question as to whether the patients in our project with higher self-efficacy were able to achieve better outcomes due to their ability to engage in rehabilitative approaches. Karasawa et al.¹⁰ found that higher levels of self-efficacy correlate with greater improvements in pain-related disability. Over a 3-month period following treatment options that included psychological approaches and rehabilitation, the results showed a significant 5-point increase in PSEQ score. Some previous studies demonstrated that cognitive behavioural therapy and interdisciplinary pain rehabilitation programmes improved both self-efficacy and depression in patients with chronic pain.¹¹ The improvements made in the PSEQ score may correspond to the likelihood of an improved patient-reported outcome following a theatre-based intervention. Self-efficacy has been identified as a significant

predictor of outcome alongside other predictors such as a better work prognosis and the intensity of depressive symptoms in patients with chronic low back pain.¹²

Our project has shown that self-efficacy as measured by the PSEQ can be used as a predictor of the likely outcome of a theatre-based injection or intervention, which is often not as successful as we would expect despite proficiency in procedural terms.

The PSEQ score may help to improve the clinical efficiency and cost-effectiveness of a patient treatment pathway, ensuring the patient is seen by the most appropriate clinician and thus receiving the most effective treatment in a timely fashion. This is even more important in the post-Covid era, with hugely increased waiting times for treatment and enormous pressure on resources.

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Philosophy & Ethics SIG Summer Retreat 2022



Pain News
2022, Vol 20(1) 20
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Book your place online now at: <https://www.britishpainsociety.org/mediacentre/events/>

Best wishes

Maureen Tilford, *Secretary, British Pain Society, Philosophy and Ethics Special Interest Group*

tilford.maureen@gmail.com

Dear colleagues,

I would like to invite you to join us at our Summer retreat at the 17th century mansion, Rydal Hall, Cumbria, in the beautiful surroundings of the Lake District from 19 to 22 June.

Our aim this year is to enable everyone to reflect, recharge and relax, and the theme is 'Understanding Pain in a Complex World'

Our programme is structured around interesting speakers and discussion along with time off in the afternoons to enjoy the gardens, parkland and the surrounding hills and lakes. Rydal water is a few-minute walk away so wild swimming is an option for the courageous!

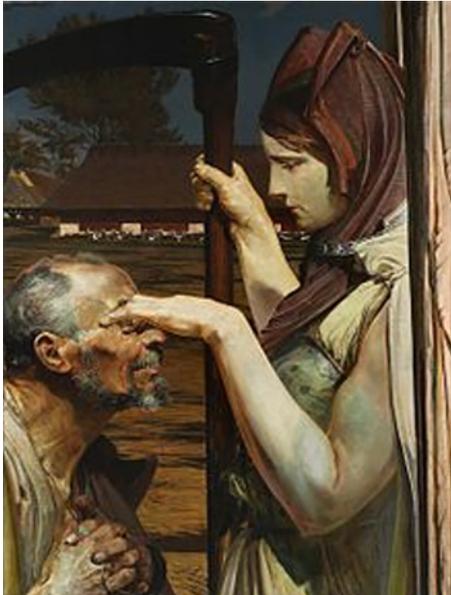
In the evening, you might head off to the local hostelry, The Badger.

Some people as an alternative to staying in one of the rooms prefer to camp in the grounds or stay in one of the yurts or Eco-Pods. Partners are welcome.



Funeral in my brain

Emily Dickenson



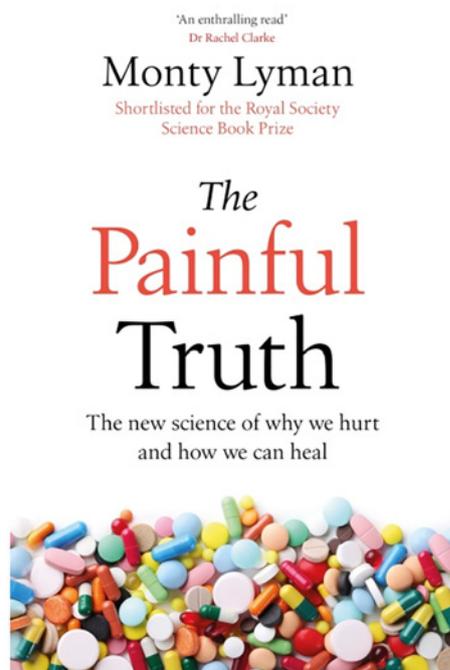
Śmierć ("Death"), a 1902 painting by Jacek Malczewski.

I felt a Funeral, in my Brain,
And Mourners to and fro

Kept treading—treading—till it seemed
That Sense was breaking through—
And when they all were seated,
A Service, like a Drum—
Kept beating—beating—till I thought
My Mind was going numb—
And then I heard them lift a Box
And creak across my Soul
With those same Boots of Lead, again,
Then Space—began to toll,
As all the Heavens were a Bell,
And Being, but an Ear,
And I, and Silence, some strange Race
Wrecked, solitary, here—
And then a Plank in Reason, broke,
And I dropped down, and down—
And hit a World, at every plunge,
And Finished knowing—then—

The themes of confusion, madness, despair and the irrational universe are explored in this poem written by Emily Dickenson in 1861.

Book review



***The Painful Truth: The New Science of Why We Hurt and How We Can Heal*, by Monty Lyman; Bantam Press, 2021.**

Reviewed by Neil Berry

[I discovered this book thanks to a recent review by Talia Drew, a trainee clinical psychologist, writing in The Psychologist. Talia described it as a 'brilliant book' and the author, Monty Lyman, as 'a brilliant and engaging storyteller'. I am inclined to agree.]

A few years ago, I asked Lorimer Moseley: 'If neuroplasticity plays such an important role in the development of chronic pain, how reversible do you think those changes are?' His immediate answer was 'Completely'. 'Why then', I asked, 'have I seen so few patients leave our clinic pain free?', and Lorimer argued that the factors and mechanisms involved are many and complex so change often takes time. He also said, however, that his own outcome data indicated that a significant minority of patients do report complete recovery on discharge and at follow-up.

I hope that Lorimer would see that as a reasonable summary of our discussion. It was a discussion that has left me

wondering whether Lorimer and I might have been working with different populations or, perhaps, whether Lorimer and his colleagues, while apparently singing from a very similar hymn sheet, were adding an important voice or harmonic which I had missed. If so, I am inclined to wonder whether hope may be that key element: hope in the likelihood that pain intensity can be significantly reduced, not by medical interventions but through the application of a range of pain management strategies. I certainly encouraged patients to believe that improved physical function, psychological well-being and quality of life are realistic goals, but I generally avoided the suggestion that a major reduction in pain was a likely outcome. Indeed, I often implied that it was unlikely.

This book has reawakened those questions in me because the author, Monty Lyman, writes very positively about the potential for pain management strategies to reduce or even cure chronic pain states. Now, I am well aware that there are dozens of books available with overoptimistic titles which sell to the chronic pain sufferer the idea that if they just do this or that or think this or that or eat this or that, they will be cured. This is not one of those. It is very much an evidence-based book with 34 pages given up to references, many of them contemporary and many of them new to me. There are a number of familiar and respected names including Lorimer Moseley, Irene Tracey and V. S. Ramachandran, and I struggled to find fault with Monty's choice of references or his understanding and reporting of his sources.

A quick glance through the book could give the impression that it is mainly devoted to psychosocial aspects of pain as there are chapters concerned with attention, distraction and hypnosis ('*Do I Have Your Attention?*'), placebos and nocebos ('*The Expectation Effect*'), cognitions ('*The Meaning of Pain*'), emotional and motivation processes ('*No Pain, No Gain*') and interpersonal, social and cultural processes ('*I Feel Your Pain*', '*Pulling Together*' and '*Belief as Relief*'). However, Monty's model of pain is very clearly a bio-psycho-social model and, when writing about psychosocial processes, wherever possible, he makes links to neuroscience. He rejects dualistic thinking and, at several points in the book, he objects to the view that chronic pain states are essentially 'psychological':

Implicitly or explicitly, most people and most medical organisations are under the thrall of 'dualism': the body and

mind being completely separate entities. This thinking is not just disproven by modern pain science. It's not just inadequate or even offensive to the millions living with persistent pain ... This thinking is destroying lives. (P.xvi)

In his final chapter, 'The Pain Revolution' (subtitled 'A new hope for persistent pain'), Monty paints a broad-brush picture of 'the most promising tools for tackling persistent pain'. Reflecting a major theme in the book, he suggests that 'treatments that work are treatments that make the brain feel safe in its body'. He makes it clear that the book is not intended to be a self-help book but he proposes three broad categories to summarise the methods that are likely to prove effective:

- Alteration: *Altering our brain's context (through body, mind and environment) for it to feel safe.*
- Visualisation: *Weakening pain by stealing back your brain.*
- Education: *Knowledge is power.*

The Alteration section emphasises the value of movement and evidence-based psychological therapies: mindfulness-based stress reduction (MBSR), cognitive behaviour therapy (CBT), acceptance and commitment therapy (ACT) and emotional awareness and expression therapy (EAET). In the second section, Visualisation, Monty more cautiously proposes that visualisation methods may prove to be a powerful way to bring about neuroplastic changes but recognising the need for more evidence, he finishes the section with 'But watch this space ...'. The final section, Education, Monty suggests, is

the most important therapy ... changing one's framework to one fed by modern pain science – that pain is an output of the brain, our protector and defender, and not an informant of tissue damage – requires a complete conceptual shift: a pain revolution.

I would have been very proud to have written this book and I think that many readers might assume that Monty Lyman is a psychologist who specialises in pain management. He writes convincingly when dealing with psychological topics. However, he writes equally convincingly when dealing with neuroscience,

neuroanatomy and neurochemistry; indeed, far more convincingly than I could. So who, you may ask, is Monty Lyman? If this book is as good as I believe it is, why have we not heard of Monty before?

Monty Lyman wrote this book while working as a junior doctor based in Oxford. (How he found the time, I do not know!) By his own account, he does not claim to be a pain specialist and a look at the GMC register reveals that his name was only added in 2018. Yet this is his second book. (His first, *The Remarkable Life of the Skin* was shortlisted for the 2019 Royal Society Science Book Prize, was a Radio 4 Book of the Week and a Sunday Times Book of The Year.) I certainly enjoyed reading this book and I learned a lot from it. Monty clearly knows how to research a subject but he does not simply display academic skills. He is not afraid to include his own personal and professional experience and he writes with a level of wisdom worthy of an experienced pain specialist. I, for one, would be pleased to welcome him as a member of The British Pain Society.

Returning to my conversation with Lorimer Moseley, this book has certainly strengthened my niggling concerns about outcomes in pain management. I have been left wondering whether pain professionals should be more prepared than I was to encourage people with chronic pain to believe in the possibility that the intensity of their pain can be substantially reduced by the appropriate application of a range of cognitive, behavioural, emotional and social interventions.

In my view, the book is rightly aimed at a wide audience that includes the general public – especially people with pain – and health professionals. Monty makes it clear that his own understanding of pain has changed radically thanks to his research for this book and he expresses the hope that reading this book will significantly change how pain is understood and managed in clinical settings. On the face of it, that sounds very bold coming from a junior doctor who may still be in his twenties, but I believe that this book has the potential to do that. Indeed, if a health professional were to ask me which single book on pain I would recommend that they read, this is the book which I would choose.

Invisible pain

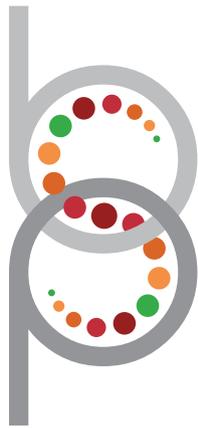


Pain News
2022, Vol 20(1) 24
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by Chris Bridgeford

Iron bars. Heavy hot iron bars, strike again and again.
Pulverising the bones, muscle, skin and fibres.
Crushing, pounding the body.
Nothing remaining to be seen.
The pressure pushing down, trapping, imprisoning the body.
Squeezing, crushing, adding heaviness upon heaviness.
No energy or will to move to seek comfort.
Nothing remaining to be seen.
Tentatively moving to sit, to lie, to find comfort.
Waiting for the sharp dullness of agony
to hit and envelop the weary body.
Nothing remaining to be seen.
Fearfully waiting to be touched.
To subject the body to being sharply, roughly, scraped.
No red, bleeding, blistering marks appearing.
Nothing remaining to be seen.
The tingling builds.
Changing sensation to become a dull all-pervading feeling.
There but not there.
Inside and out with, painfully dull tingling.
Nothing remaining to be seen.
The drill bores into the rock-hard clumps of muscle.
The impeding fibres screech when it breaks through.
Burrowing, ripping, then hardening again.
A miniscule passing in reality but an eternity to the mind.
Nothing remaining to be seen.

It begins like a hole of deep pain developing in the bone.
Then, slowly spreading out, fading yet remaining.
Affecting more of the limb and progressing to the body.
Nothing remaining to be seen.
Searing, incendiary, instantaneous pain.
At first, a flash from ankle to opposite elbow.
Then erratically shooting around nerve pathways.
Nothing remaining to be seen.
Cruel sharp claws, ripping through muscle, fibre and skin.
Twisting and digging, pulling apart then tightening the sinews.
Making it impossible to remain in courteous silence
Nothing remaining to be seen.
A sharp, penetrating stab to the chest holding you in place.
Too fierce to move.
Too excruciating to breathe.
Nothing remaining to be seen.
Exquisite pain.
Quickly growing from deep within.
Soon enveloping the physical body.
Then surrounding around and above.
Nothing remaining to be seen.
A crushing, enveloping, squeezing vice of pressure.
Causing the bones to cry out in growing agony.
Sometimes one small part of the exhausted body.
Sometimes spreading from knees, through shins to ankles.
Nothing remaining to be seen.



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UK/MYO/20/001a Date of preparation: Oct 2020

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