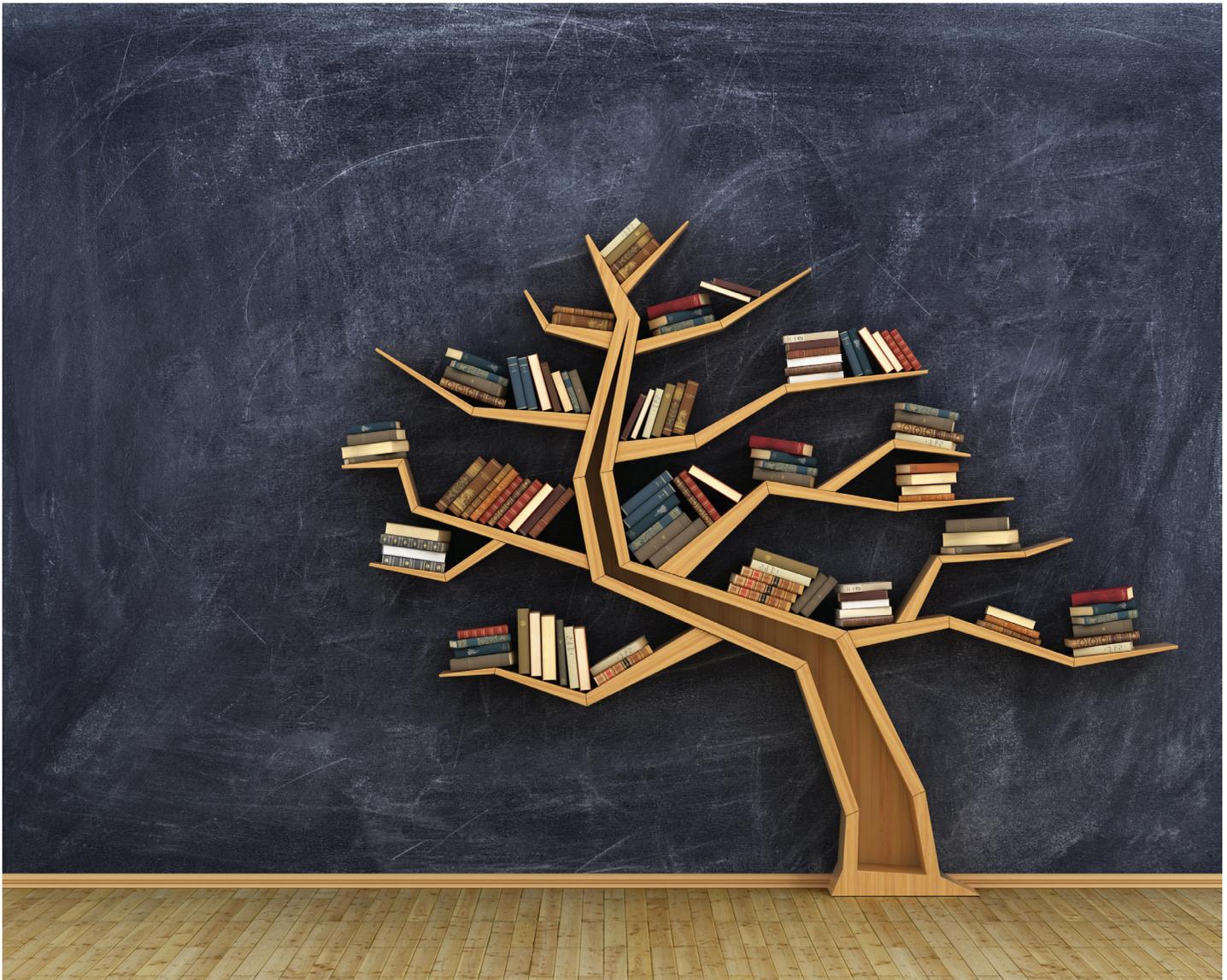


JUNE 2018 VOLUME 16 ISSUE 2

PAIN NEWS

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Focus on pain research day

Consent in Pain Medicine

**Increasing access to psychological services (IAPT)
and pain services**





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THE BRITISH PAIN SOCIETY
PAIN NEWS

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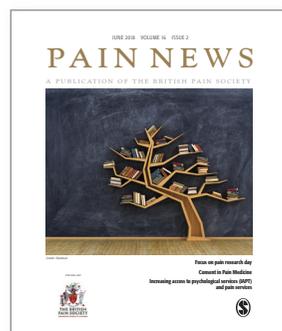
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Jenny Nicholas



It was a pleasure to see so many of you recently in Brighton, and I hope you enjoyed this year's ASM as much as I did! As it has every year in my 11-year tenure

here at the Society, it has inspired me to broaden my thinking and try something new so here I am, writing my first ever 'Guest Editorial' for *Pain News*.

It's not hard to find inspiration when working with the diverse group of people the Society brings together. With a variety of topics, ranging from medicolegal issues, to audits, this edition alone has a little bit of something for everyone.

Our Pain Education SIG has written about its new free to access web book 'A practical guide to incorporating pain

education into pre-registration curricula for healthcare professionals in the United Kingdom'. And will be pivotal as we celebrate the IASP Global Year for Excellence in Pain Education, 'Bridging the gap between knowledge and practice' in 2018.

Our spotlight features Dr Andreas Goebel, a Consultant in Pain Medicine, one of the many who makes up the MDT membership of the Society.

As always, we update you on other recent events organised by the Society and introduce you to more of the key people who make up our Committee's, who work together to achieve our mission to 'enable best pain management for all'.

If any of this content has inspired your thinking, we are always looking to hear from our Members. Perhaps you'd like to contribute your own article or feature as our 'Spotlight' in the future? Please do let us know by emailing us at newsletter@britishpainsociety.org.



Pain News
2018, Vol 16(2) 46
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Guest-editing this edition has given me new insight into different aspects of producing *Pain News*. Dr Arasu Rayen has held the reins for nearly 5 years and sadly, the March issue was his last. I want to take this opportunity to thank Arasu for the marvellous job he has done over the past few years, including the improvements he has made in both style and content of *Pain News*. I hope the content he has compiled over the years has challenged your point of view and provided you with useful information. We have appointed a new Editor, Rajesh Munglani who writes his first editorial for *Pain News* in this issue.

I would also like to thank our Associate Editors, Margaret Dunham, Christina Lioffi and Sandeep Kapur, who also worked closely with Arasu to ensure your quarterly newsletter is interesting and informative – in short, a 'must read'.

I hope you enjoy reading this issue of *Pain News* as much as I/We have enjoyed pulling it together for you!

From the new Editor

Rajesh Munglani



Pain News
2018, Vol 16(2) 47–48
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SAGE

THIS IS US

... or why we need a multidisciplinary pain society so as not to miss the gorilla in the room.

'Many of the truths we cling to
Depend greatly on our point of view'

Obi-Wan Kenobi

Having reached the age of 55, I now realise that I have very likely lived more than half my life. This could be depressing news but in fact my maturing, like a fine wine, has been accompanied by a number of effects. I have found both the strength of my opinions and the tone of my bodily structures are now both very much less firm (or indeed, in the case of my body, now really quite saggy in parts). In fact, the majority of my previously longstanding and rigidly-held medical opinions have altered, sometimes in dramatic moments.

But I'm in good company with others: it is well known that the opinions of most scientific studies are eventually proved to be wrong. Richard Smith, former Editor of the BMJ, stated provocatively "*scientists are [more] interested in funding and careers rather than truth*". Indeed, Ioannidis' paper on '*Why Most Research Findings Are Wrong*' is one of the most cited papers in PLoS¹⁻³. Professor Ioannidis states that [with time] it is more likely that research claims will prove to be false rather than true, but also that for many current scientific fields, claimed research findings may often be *simply accurate measures of the prevailing [scientific, medical] bias*.

Other studies show how easily the most well-intentioned and careful scientists and medics can be misled or misperceive. This is perfectly illustrated



An early summer wild flower meadow, Cambridgeshire - or is it an MDT discussion in progress?

by the phenomenon of *inattentional bias* or *selective looking*.

How not to miss the gorilla

Simons and Chabris conducted a set of experiments in which observers watched a video of two teams of basketball players, one clad in white shirts and the other in black shirts, passing basketballs amongst themselves. The observers were instructed to count the number of passes made, either by the white team or the black team. Part way through the task, either a woman with an umbrella or a person dressed in a gorilla costume unexpectedly walks through the centre of the action, remaining clearly visible for about five seconds before exiting. *35% of the observers failed to notice the woman with the umbrella and 56% failed to notice the gorilla*⁴.

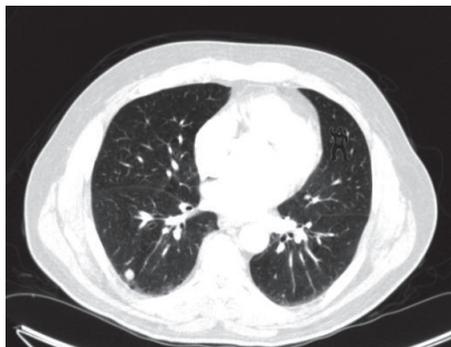
But surely, the training of expert observers would allow them to perform better? In 2013, a team of psychologists

asked 24 radiologists to perform a familiar lung nodule detection task. A gorilla 48 times larger than the average nodule was inserted in the last case. *83% of radiologists did not see the gorilla on the x-ray*. Eye tracking revealed that the majority of those who missed the gorilla looked directly at the location of the gorilla, (Drew et al (2013))⁵.

It would seem that even trained observers operating in their domain of expertise are vulnerable to inattentional blindness, and indeed may be more prone to it.

Further studies have suggested that if an image is expected in a particular area of a screen, then placing that same image further away from the usual area reduced the absolute chance of seeing it⁶. All of this is worrying, and suggests that in fact experts may be rather *too biased, and have too narrow a field of view*. One might also conclude that specialists in a field are always in danger

Rajesh Munglani



Can you spot the gorilla? By kind permission of Professor Trafton Drew, *Psychological Science*, 2013;24 :1848-1853

of becoming too blinkered in their approach, particularly if their usual patient group is already highly selected.

This is where there is strength in a multi-disciplinary team. Different perspectives allow one to approach the same problem with different biases and priorities and, as such, a combined MDT with their multiple viewpoints allows a shift of focus from our own specialist perspective to a more (and probably more useful) patient focussed approach.

The Faculty of Pain Medicine core standard document states that complex patients need a multi-disciplinary approach, simply because the presentation (and causation) of such pain is likely to be multi-factorial in any individual complex pain patient⁷. There are likely to be many such patients indeed, as demonstrated by Fayaz et al in 2016⁸, who found that moderate to severe disabling chronic pain probably was experienced by 10% to 14% of the population. Those patients severely affected by chronic pain are more likely than not to have significant associated (and multiple) medical, psychiatric and psychological co-morbidities and will likely need more help than one single specialist could possibly hope to provide⁹⁻¹¹.

The need for such a multi-disciplinary approach is supported by Turk et al.¹², who reviewed the efficacy of pain

treatments. Based upon their analysis, we can conclude it is *unlikely* that any single pain treatment method (physical, pharmacological, psychological, interventional etc) is likely to work when applied to an unselected population of patients severely affected by pain.

Thus, whilst it is necessarily right that most patients with chronic symptoms either self-manage or are assessed and treated in primary care and in community-based pain clinics, large numbers may well still benefit from MDT-based secondary and tertiary pain services.

It is clear that we have to work together, otherwise we may miss spotting the gorilla.

The purpose of Pain News

We have research papers in journals (*and we now know whose findings are unlikely to be enduring with the passage of time and the progress of knowledge*) and also an endless 24-hour (transient) news cycle in terms of Twitter, Facebook and the internet. Is there a niche for the British Pain Society Newsletter in this endless media stream?

As I take over editorship of this newsletter, my vision is to encourage the acknowledgement of alternative viewpoints by the potent mix of new ideas in medical and scientific findings, multi-disciplinary perspective *and* combined with (priceless) individual clinical experience and opinion. I think this is best described as *taking the long view*.

We can now see that the answer to a particular problem may change with time, that a treatment that was considered acceptable in the past now is no longer so (such as hemi-glossectomy for stuttering¹). The answers may change but the questions are often eternal, such as the question of what exactly pain is, and how it is linked to the human condition.

So, I would encourage you all to submit articles for consideration of publication to this Pain News (or in a

bygone age this journal might have been called '*The Proceedings of the BPS*' to reflect this more reflective approach). I would welcome contemplative pieces that intertwine both personal observation and opinion, whilst acknowledging collective MDT peer experience set in the landscape of prevailing scientific knowledge with the ultimate aim of further promoting a holistic and person-centred approach for those who are in pain and are suffering. I look forward to hearing from you.

Note

1. As an additional tangent I would state that a thoughtful examination of past observations may prove useful, e.g. the ancient Egyptians, reportedly using mouldy bread to disinfect wounds, were clearly foreshadowing Sir Alexander Fleming, who discovered on 28 September 1928 that Penicillin mould inhibited staphylococci colonies in a petri dish.

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Dr Andrew Baranowski



All change ...

Whereas the Society is its members, the backbone is the Secretariat. We are very pleased to be able to announce that Ken Obbard has realised one of his

dreams and he will be moving on to work at the Zoological Society of London (ZSL).

Ken has been responsible for membership and many of the committees for the past 10 years. He introduced and supported many changes over the past few years, facilitating membership applications, collecting of membership dues, redesigning the website, supporting SIG events and much more. Recently, he has been at the forefront of our membership review and has provided his significant wealth of experience in supporting that. The Chairs of the SIGs change but for many years Ken has been there to ensure that there is consistency and good communication. We wish him all the best:

At this year's AGM we also said goodbye to outgoing Vice Presidents; Martin Johnson and Paul Wilkinson, and Paul Cameron, Elected Council Member, as their terms of office came to an end. They have all been a huge support to the Society and their contributions over the years have been invaluable.

Editor of *Pain News* ...

Arasu Rayen has decided to step down from the important task of *Pain News*

Editor. He has carried this responsibility with great professionalism. However, his photograph brightening up our day also needs to be mentioned! This important position for the Society will be taken on by Rajesh Munglani.

Life never stands still ...

In my last *Pain News* commentary, I informed you that Anthony Chuter had stepped down as Chair of the Patient Liaison Committee (PLC) and that Margaret and Kevin were now joint chairs bringing their unique experiences to the PLC. The PLC has now met on several occasions and at the last meeting they started to prioritise their plans. Two things that I have picked up on are that the PLC wishes to review the role of the Patient Reference Group, how that Group interacts with the Society and how the Society works with them. Building up our relations with this group could potentially result in major gains for pain medicine. Currently there are 400+ patients and carers in that group. Another exciting development for the PLC will be the production of short information videos on understanding pain for patients. Don't be surprised if you are approached to take part.

Work, work and more work ...

Reviewing the reports from the various SIGs and Committees for Council, I was impressed by the dedication of the few members engaged in activities on behalf of all members and the Society (and of course you can also volunteer!). Below are a few examples of the sort of things going on. I can only mention a few and I hope that those not mentioned understand that I have a limit to how much I include.

The Communication Committee (written by Arun Bhaskar)

Notable Activity (since AGM in May 2017):

- Expansion of Communications Committee with Sam Ahmedzai, Stephen Humble and Pete Moore actively promoting the British Pain Society (BPS) on various social media platforms.
- Significant increase in regional and national networks and print media with BPS representation for comments and opinions – thank you Sam Ahmedzai, Roger Knaggs and Casey Freeman.
- Increased presence on Twitter and Facebook – thank you Stephen Humble and Sam Ahmedzai.
- Wikipage on the BPS.
- Sam Ahmedzai as webmaster with support from the Secretariat.
- GDG set up for Cancer Pain, Neuromodulation and PMP publications.
- Publications completed – document on position statement on epidural steroids along with FPM.

The Education Committee (written by Sam Ahmedzai)

Notable Activity (since AGM in May 2017):

Short-term changes

1. We have sent out a survey to all members asking for their suggestions for future study days in 2018 and 2019. We offered specific days available to us at Churchill House, but also opened the possibility of other venues around the country. We will follow this up with other surveys

Dr Andrew Baranowski

targeted at specific disciplines, and consumers.

2. Through the website, emails and social media, we will ask the membership and wider 'followers' of BPS for their views of future educational activities. Specifically, we will seek the level of interest in
 - (a) Regional events – in the North (e.g. Manchester) and South (e.g. Bath)
 - (b) Joint meetings with other related organisations (e.g. Royal Colleges, FPM, APM, RoyalPharmSoc, British Psychological Society, and Association for Palliative Medicine)

Long-term strategic plan

I am keen to gauge the interest of Council and the wider membership of moving to a more online platform for educational (and possibly SIG) events:

- (a) Pilot-testing of e-learning via Pain Community website (Zoey Malpus has done a lot of background work here and we need to agree with Executive a budget and plan for implementation with a pilot set of modules by summer 2018).
- (b) Online educational events – using Facebook, LinkedIn, webinars and other bespoke platforms.

Acute Pain Special Interest Group (written by Ruth Day)

The membership of the SIG has grown by over 15% this year – an indication of

the continuing interest in acute and inpatient pain management. This interest was made clear from the attendance at the Persistent Post-Surgical Pain: Challenges and Approaches day prior to the 2017 ASM which APSIG ran with BPS support. It celebrated the IASP global year against pain after surgery. Thank you to Felicia Cox and Jane Quinlan who, with the APSIG committee, ensured the success of this day. Stephan Schug introduced the day and many attendees were delighted to meet him. (He continued to work hard for Acute Pain during the following ASM.)

Pain Education Special Interest Group (written by Emma Briggs and Alison Twycross)

Every 2 years, the committee meet at the BPS to devise a 2-year strategy, key priorities that are aligned with the SIG aims and are achievable in the time and resources available. The 2017–2019 priorities are as follows:

- Launch the undergraduate document and plan an evaluation of its impact;
- Support and promote the IASP Global Year of Excellence in Pain Education;
- Educational practice: plan ASM workshops and a SIG study day;
- Educational research and innovation: activities that stimulate, engage in or disseminate research and innovation;
- Develop resources for healthcare professionals to enhance patient education skills;

- Communication: continue our communication with members and use social media to promote pain education;
- Networking: within the BPS, with partner organisations and internationally with IASP SIGs.

The above illustrates a very small part of the significant activity by members. What I would like to do is to acknowledge the activities of our members outside of the Society as well.

I would be interested in seeing whether our membership would also like to acknowledge their colleagues.

My proposal is that members write to me at presidentawards@britishpainsociety.org naming an individual or Team and highlighting such achievements. Depending on the number, we receive we will publish those that show outstanding dedication to

1. Patient-centred approach;
2. The MDT;
3. Innovation.

The proposal needs to come from two colleagues and have a 100 word maximum citation. Proposals may be submitted at any time, and details of recipients will be published in *Pain News* and on our website.

May I wish you all the best for a great Summer.

Professor Roger Knaggs



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One of the issues with writing a column several months prior to publication is that it can be very difficult to predict what is going to be topical and relevant. By the time you read this, we

will have met in Brighton for our 51st Annual Scientific Meeting (ASM).

Election results

Some may say that elections have become a bit of theme to my columns over recent issues. However, this year there have been requests for nominations for a number of key positions in the Society and the results of these elections were announced at the Annual General Meeting in Brighton.

President elect

There was only one nomination for President elect. According to the regulations, there is no requirement for a voting process, and hence, Dr Arun Bhaskar has been appointed President elect this year and will become President from 2019 for a 3-year period.

Many congratulations to Arun, who becomes our new President elect.

Honorary Treasurer elect and Honorary Secretary elect

These positions are elected by current Council members. It gives me great pleasure in announcing that Dr Glyn Williams from Great Ormond Street Hospital has been appointed Honorary

Treasurer elect and Dr Ayman Eissa has been appointed as Honorary Secretary elect. We are very grateful to Glyn and Ayman for accepting to take on these important roles for the Society.

With three incoming executives being current Council members, it meant that there were vacancies for seven Council members. It was pleasing that there was significant interest and as we had eight nominations you will have been aware of the need for an election. The results of the ballot are reported below:

Thus, Sam Ahmedzai, Peter Brook, Neil Collighan, Ashish Gulve, Ramanarayanan Krishnamoorthy, Sarah Love-Jones and David Pang are our new elected Council members. Many thanks to all candidates for putting their names forward.

The Society relies on the commitment and dedication of members in order to ensure the smooth running on a daily basis. As I enter my last year as Honorary Secretary, I am slightly disappointed that there were no nominations from other professions. The British Pain Society is the only multidisciplinary society for pain professionals in the United Kingdom, so when nominations for elected Council members are announced next do think about whether you have the time and vision to contribute to the further vision and development of the Society.

Honorary membership

Honorary membership is one of the few ways that the Society can recognise the achievements of people who go beyond the course of 'doing the day job' in support of the British Pain Society or pain management more widely. At the Annual General Meeting, Professor Kate Seers and Mrs Vidyamala Burch were awarded honorary membership. Citations provided by Emma Briggs,

Gillian Chumbley and Amanda Williams will be included in the September issue of *Pain News*.

Special Interest Groups (SIGs)

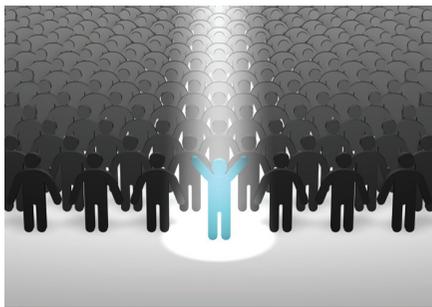
We held a meeting recently that was attended by the Chairs of some of the 14 Special Interest Groups (SIGs) of the Society together with Chairs of some of the key committees and current executives. One of the recurring themes during the meeting was that of engagement; engagement both between Council and the SIGs, and between SIGs and their members. Some may consider SIGs are the lifeblood of the Society as they offer the opportunity to discuss and interact with colleagues throughout the country interested in one of the many varied aspects of pain medicine that they cover. Reviewing membership applications, it often surprises me the number of people who request membership of numerous SIGs. While there is nothing wrong with this, I doubt it is possible to contribute to all SIGs in the same way. So do think about those SIGs that you wish to make an active contribution to and do so on a regular basis.

52nd Annual Scientific Meeting

So, coming full circle to where I began this column. Planning has already begun for the 2019 ASM to be held in Belfast. One of the first priorities is to identify plenary speakers and there will be the opportunity for members to submit proposals for topical workshops. Please do consider nominating a good or engaging speaker that you have heard at other conferences or contributing to a workshop proposal to make the ASM programme next year as good as this year.

Spotlight – Andreas Goebel

Andreas Goebel *Liverpool and Bristol*



The width and breadth of BPS membership is testimony to the diversity within the organisation and in the pain world. The Editorial Board would like to acknowledge this richness by shining a spotlight on some of our members. In this edition, we speak to Andreas Goebel.



1. What first brought you in contact with the BPS?

The BPS is my professional organisation as a doctor in pain medicine. When we moved to the United Kingdom in 2001 I joined soon after.

2. What was your role in the BPS? What excited you about this role?

My role so far has been as a member of the BPS Science & Research Committee. In that role, I have also convened a recent workshop on UK pain research (see elsewhere in this edition) – I found it very exciting to bring people from a large variety of research backgrounds together under the BPS umbrella, united in their wish to seek better solutions for people suffering from chronic pain from different angles.

3. What are you best known for professionally?

I have set up a successful regional CRPS clinic in Northern England; my chairing of the UK CRPS Guidelines, and that I conduct research into the autoimmune causes of non-destructive

chronic pains and immune-treatments for these conditions.

4. How do you think the BPS has changed from when you first became a member to now?

Perhaps there is now a more conscious focus to improve members' experiences and participation. When reading the *Pain News*, there appears to have been a risk to the very existence of the BPS recently, which I don't recall from when I first joined.

5. If you were President of the BPS for a day, what would you do?

Hmm – I suspect it might be quite limited what a President can do – nevertheless, if there are no hidden treasures which I could perhaps look at during that day which only a president may see, then I would love to get a group of philosophers together and ask them to come up with an answer to the question of why in Pain Medicine we are still in Stone-Age with regard to pain relieving treatments, whereas the remainder of Medicine has moved on – there's got to be a cultural reason underpinning our insufficient research progress.

6. Where can we find you in your spare time? What is your favourite way to spend a weekend or a Sunday afternoon?

I like hiking, biking, swimming, reading and holidaying, but we spend most of our weekends closely aligned with our children's schedules!

Currently I am campaigning for a popular vote on the final deal from negotiations which became necessary following a large referendum recently held in the United Kingdom.

7. What would be impossible for you to give up?

It'd be really hard to give up good food.

8. Any life achievements you are particularly proud of?

Our two daughters.

9. Anything else you'd like to tell people about yourself?

I am member of a socially engaged lay Buddhist group (SGI-UK); I miss opportunities for forest walks and German food!

I would like to thank the Editors for inviting me.

Have your say and contribute to *Pain News* today

Pain News is the newsletter for members of the British Pain Society and we welcome member and non-member contributions to share your news with the wider membership and beyond.

Do you have a news item to share?

Perhaps a professional perspective, or informing practice piece?

Maybe you would you like to feature as our 'Spotlight' member?

We'd love to hear from you so drop the Editor an email today at: pns.rayen@gmail.com

Upcoming submission deadlines:

Issue	Copy deadline
September 2018	29 th June 2018
December 2018	28 th September 2018



Pain in military veterans study day

Amanda C de C Williams *University College London*

The needs of military veterans with pain, and torture survivors with pain, made up the two halves of February's BPS Education Day. Both were excellent, with speakers from research, policy and clinical settings, and the questions and discussions showed there were experienced clinicians in the audience too. All of us will come across these groups in our clinical work, whether we recognise them/they disclose their origins or not, and it was a pity that the day was not better attended.

Pain in military veterans

The first speaker was Emily Mayhew of the Imperial College Centre for Blast Injuries, who is a historian currently studying the medical records of amputees from World War I, although here she spoke mainly about her work on Afghanistan. She described the 'unequivocal saves' there from providing trauma units in the field rather than distant from the likely point of injury, but the emerging understanding of profound and widespread damage from blast injury, from astroglial scarring in the brain to delaying healing, with no treatment at present. Many blast injuries in Afghanistan are to children.

She was followed by Andrew Baranowski, describing a charity-run pain management programme for UK military veterans with chronic pain, in which as a doctor he has quite an active role not only in assessment but also in explaining pain and addressing other medical problems of the veteran population. Three of his colleagues from the programme then spoke: Jannie Van Der Merwe (clinical psychologist), Claire Fear

(specialist nurse) and Suzanne Brook (specialist physiotherapist). The veterans, from various wars, often have not only multiple physical problems but also fragmented lives: for many, the army provided stability, a community, a purpose and a valued identity, and the loss of these when discharged can make huge demands on adjustment, and they may feel abandoned and purposeless. Their internalised military culture tends to make for attempts to 'push through the pain', to prove themselves by feats of strength and endurance, such as in the Paralympics or Invictus Games, but these are usually followed by collapse and a sense of defeat, as well as considerably increased pain. The pain management programme draws on those with which we are all familiar, but avoiding guided imagery because of flashbacks; trying not to overtax concentration and memory affected by traumatic brain injury (TBI), blast and posttraumatic stress disorder (PTSD); and of course, the emphasis is on careful planning of physical activity rather than 'going for it'. Initial results are good, despite the very severe psychological and social problems of some of the veterans.

The last speaker was Walter Busuttill, a psychiatrist who described the effects of combat and of torture, reviewing models of PTSD and the notion of moral injury, when the individual's moral framework is shattered. He returned to the earlier concern with minimal TBI after blast exposure, differentiating it from post-concussion syndrome and presenting with symptoms in common with PTSD. He alerted the audience to the problems of reading the American research

literature, where diagnosis of PTSD and TBI is partly driven by its qualifying veterans (and their families) for VA healthcare, worth many thousands of dollars. On a positive note, he observed that veterans are now seeking help sooner, a mean of 2 years after service in Afghanistan and 3.3 years after service in Iraq, compared to 13 years after serving in Northern Ireland and 15 years after the Falklands War.

Pain in torture survivors and refugees

The afternoon was introduced by Amanda Williams, who emphasised the very high rates of chronic pain in torture survivors and the very poor evidence on effective treatment. A recent systematic review and meta-analysis (Baird, Hearn & Williams 2017, Cochrane Database of Systematic Reviews) found only three randomised controlled trials (RCTs) of pain treatment for torture survivors. One was from Korea and involved hands-on physical manipulation; the other two were from Europe and involved cognitive-behavioural treatment with biofeedback. Results for pain and distress were no change or no change of clinical significance, while the Korean physical treatment claimed efficacy for reducing disability. None assessed quality of life or changes in healthcare use. So, the picture overall is dismal. We just do not know whether torture survivors' pain is even harder to treat than equivalent pain in our clinical populations. RCTs are difficult and expensive to run, and torture survivors are a very heterogeneous group, so rather than proceed with group trials, it was recommended to do

Pain in military veterans study day

N-of-one studies, to share data and to benchmark against standard treatment outcomes. Stephen Morley's book on single-case methods has just been published by Routledge and makes N-of-one studies straightforward and meaningful. Finally, we were reminded that rehabilitation is a human right for torture survivors, alongside asylum and reparation, and that treatment needs to proceed with an understanding of the human rights context.

The first speaker in the afternoon was Jennie Corbett, a policy and advocacy officer from Doctors of the World UK branch, describing entitlement – and non-entitlement – to healthcare for undocumented migrants, a group that includes those who have not claimed asylum and those who have been refused asylum, among them many survivors of torture. Of this group, 89% are not registered with a general medical practitioner (GP), and although primary care is an entitlement, about 40% have been refused when they tried to register. She also outlined the complex arrangements around secondary care, where all but certain exempt services (A&E, communicable diseases, family planning) are charged at 150% of the normal rate, to undocumented migrants. Refugees and asylum seekers, and those in detention, are also officially exempt, but the complexity of the rules means that many are wrongly refused care or are told they will be charged. She noted that many hospitals put far more resource into recovering these costs than they do into identifying the vulnerable individuals who have a right to exemption and those who cannot pay are reported to the Home Office for debt. Because the National Health Service (NHS) also shares patient records with the Home Office and with immigration authorities, this is often the beginning of deportation for vulnerable torture survivors and other refugees. In 2016, 2,000 people were apprehended on the basis of this sharing of information: the 'hostile environment'

intended by the 2014 Immigration Act in action.

She suggested several courses of action. One is always to ask patients about violence, since this could well identify them as a member of an exempt group when they seek secondary care; this requires access to interpreting, rather than trying to manage without. All decisions about care should be recorded in writing, particularly about urgent care. We should ask our Trusts about their policies on decision-making around identifying exempt groups – is it clear? Is the information where it is needed? – and about charging.

The next speaker was Juliet Cohen, who has worked for many years writing medicolegal reports for torture survivors as well as doing research. She started with definitions of torture and some recent prevalence studies: up to 50% of Syrian refugees may have been tortured. She gave a moving account of the difficulties of disclosing torture by those who have lost all trust in authority and had their beliefs in a just and reasonable world destroyed; they are also ashamed and avoidant of describing some torture, particularly when it is sexual or cultural, or breaks taboos, and she advised always asking for details and exploring euphemisms. For instance, we should ask a survivor who says 'I was beaten' where s/he was beaten, with what, where, with restraint as well and so on. She reminded us that many blunt force trauma injuries heal without scars, as does much sexual torture, and that creates particular problems for medicolegal reporting. She also reminded us of cultural differences in narrative and expression of emotion: lack of eye contact, because of shame, or respect or gender norms, is commonly misunderstood as evasiveness. And she advised her audience to be careful of accepting a 'friend' or family member as an interpreter: he or she may not be a friend and may be controlling the patient and what she/he says.

The last presentation was by Susan Childs (clinical psychologist) and Bianca Kuehler (pain consultant) from Chelsea and Westminster hospital, where they regularly run a pain management group for torture survivors, addressing the question of whether their one-stop pain clinic specifically for survivors of torture was the right decision. The patients they see are a mix of those whose torture has already been clearly identified as the cause of pain, and those who develop chronic pain later in life and have a history of torture. Their pathway through pain and other services, before the pain clinic was set up around their needs, was often distressing and even retraumatising, without identifiable benefits in pain relief or rehabilitation. Re-routing patients had proved cost-neutral, and their assessment, any investigations and treatments proceeded with careful discussion of what they involved and whether that was acceptable. It also provides a safe environment in which people's accounts are believed, and they can describe their history at a pace that suits them. Comparison with a local fibromyalgia patient group established similar levels of depression, but many symptoms of PTSD and anxiety, and far greater intake of psychotropic and psychoactive drugs by survivors of torture. This justified separate treatment, and the low rate of attrition strongly suggests that it suits patients well.

The whole day showcased considerable and diverse expertise in the pain community and wider and the practical ways in which pain treatment and rehabilitation could be improved for both military veterans and survivors of torture. If you wish you'd been there, why not set up an education day or half day nearer you? 2019 will be the International Association for the Study of Pain (IASP) year for pain in vulnerable populations, among which are torture survivors, and resources including fact sheets and slide sets will become available.

Focus on pain research day

Andreas Goebel *Liverpool and Bristol*

Antony Jones, a Manchester rheumatologist and researcher who investigates pain-induced brain activation patterns, raised the idea in 2016 – we should have a day where UK pain researchers come together. In 2017, the BPS Science & Research Committee chaired by Sam Eldabe discussed and confirmed a desire to reach out to other UK pain research communities. Ultimately, we may wish to thank the Arthritis Research UK (ARUK) charity for acutely fashioning our vision towards a joined-up approach to achieve more and better pain research. ARUK had asked people with musculoskeletal conditions about their priorities – responders put ‘sorting out pain’ first. And when ARUK analysed search terms that had led people to the ARUK website, again pain came on top – ARUK consequently decided to put 20% of their overall budget over the next 5 years into supporting pure pain research in musculoskeletal conditions. I reviewed submissions as member of their grant committee, and it stuck me that there is a whole world of research out there, which we don’t often see at BPS meetings; researchers originally interested in the biology underpinning joint inflammation in rheumatic conditions have now started to focus on chronic pain in a wide range of musculoskeletal conditions. They bring a wealth of methodologies and approaches which can enrich our collaborations.

So, we dreamed up and devised the ‘Focus on Pain Research’ day to harness the potential for collaboration dormant in our different pain research fields. The convening team included Sam Eldabe,

Nick Shenker – the Chair of the special interest group on chronic pain within the British Society for Rheumatology (BSR) – and I. Following encouraging discussions with Heather Cameron, the BPS Treasurer, the BPS agreed to underwrite the event and provide administrative support, but we were also successful in obtaining external funding from the Pain Relief Foundation in Liverpool, the neuromodulation society (NKUSI), a research fund held by Dr Shenker, NIHRCRN and ARUK.

We invited active UK pain researchers from a wide range of fields such as epidemiology, community-based pain research, molecular pain research, clinical trials, pain-psychology, psychophysics pain research, brain imaging, genetics and others. Human pain conditions included neuropathic pain, but also musculoskeletal pains such as back pain and fibromyalgia, which affect such a large percentage of patients in our clinics. Our funding allowed arranging an invitation-only event, free of charge, and indeed with almost full recompense of all travel expenses. We invited 95 UK participants – the maximum which our space would comfortably hold. Hayley McCullough, the Research Administrator at the Liverpool Pain Research Institute, expertly led communication with participants, in close contact with Ken Obbard at the BPS. We asked participants whether they would like to present their work in short oral presentations, or as posters, and we selected 13 speakers from among those interested. The idea was to have simple presentations which would primarily

allow others to see the type of research being done, fostering crosstalk and collaborations. All participants were equally important to the meeting’s success; everyone was encouraged to submit e-posters, and all participants received the same funding support.

We were extremely pleased that the event was oversubscribed. The Focus on Pain Research day was held on 7 March 2018 at the Royal College of Anaesthetists in London and was in my view a roaring success. Researchers from many different pain fields including MSc and PhD students in pain research gathered, chatted, listened and made plans. Martin Johnson welcomed participants on behalf of the BPS. Colin Wilkinson, a patient suffering from a rheumatic disorder outlined how it is in fact his pain that impacts on his quality of life, pain which cannot be sufficiently relieved by the various biological drugs successfully applied to keep his rheumatic disorder biologically at check. Although his joints are preserved more than it has ever been possible in the history of rheumatic disorders, the largely unknown factors responsible for his pain are not tackled by these same biological drugs. We then had major funders presenting their visions for supporting UK pain research, including Wellcome Trust, MRC, NIHR, NIAA, Pain Relief Foundation and ARUK, and we listened to an example of excellence in joined up thinking between funders and researchers presented by Lesley Colvyn from the Scottish Pain Research network. We are very grateful for this massive presence of UK funders; it became clear that some funders are

more obviously up to speed on pain research than others – I am hoping that the truly outstanding presentations from some prominent funders might also entice other funders to further up their game – after all we are talking about a very large proportion of the population affected by this health problem; given the wide and huge impact of chronic pain, research into these conditions, their causes, prevention and treatment proportionally still receive relatively little funding.

A total of 13 speakers highlighted expertise across our wide field of UK pain research. They largely succeeded in presenting such that feedback indicated the audience gained an understanding – which is wonderful – we largely avoided unnecessary jargon. It also became clear that there was not half enough time for chatting, despite a long lunch break and good time keeping. Taking this forward, we may wish to do it again in the future, perhaps as a 2-day event.

I am aware that it was not possible to be fully inclusive, in part due to our limited space. If you are a UK pain researcher interested to be invited in the future, please would you write to Hayley.

The contents of presented e-posters and also a video recording of the whole day are available at: <https://www.britishpainsociety.org/mediacentre/events/focus-on-pain-research-meeting/>. For further information, please contact: hayley.mccullough@liverpool.ac.uk

Psychology for Pain Medicine Study Day 6th June 2018, Royal College of Anaesthetists, London

An informative and interactive study day on Psychology for Pain Medicine. The day will include lectures and workshops with Clinical Psychologists and Pain Medicine Consultants.

Topics covered will include psychological interventions, pain clinic consultation and interview skills, and the nuts and bolts of psychology for pain medicine.

<https://www.rcoa.ac.uk/education-and-events/psychology-pain-medicine-study-day>

Patients' voices at the heart of the Society

Margaret Whitehead and Kevin Bowers *Co-Chairs of the Patient Liaison Committee, of the British Pain Society*

Margaret Whitehead introduces the new co-Chairs of the Patient Liaison Committee (PLC).

Every patient is different and their pain unique; so how can patient involvement in the British Pain Society (BPS) seek to effectively represent the patient voice and make a meaningful difference? This is the challenge faced by the new co-chairs of the PLC. Working with eight other lay members and four professional members, I co-chair this standing committee with Kevin Bowers (who introduces himself below). Together, we are responsible for ensuring there is a patient voice throughout the BPS.

The PLC advises on service improvement, patient liaison and education while raising the profile of pain within the public, professional and public realms. The role is surprisingly onerous; it is not just about sitting on committees but voluntarily working alongside council members to ensure the BPS is truly multidisciplinary by involving patients as partners in every facet of the Society's work. Recruitment to the committee can prove difficult because volunteer members have work and family commitments while also living with persistent, and often extremely debilitating, pain.

My background in policy development and running a health networking organisation makes me acutely aware of the difficulties of putting fine words and great ideas into practice. Too many times over the past quarter of a century, I have seen organisations and professionals pay lip-service to public and patient involvement, without really 'getting it'. Likewise, I have met lay-members who,

sadly, see clinicians and politicians as part of the problem rather than partners in finding solutions. Thankfully, attitudes are improving.

As co-chairs, our combined experience has focused our minds on steering the PLC to achieve realistic improvements. We have therefore set ourselves two key priorities for our first year. The first is embedding the work of the PLC in every workstream of the BPS; part of this includes raising the profile of the patient voice within the BPS and across the wider community.

The second priority is developing the Society's patient reference group. Because pain is so personal, the PLC cannot hope to have a meaningful impact without seeking to try to represent the diversity of people living with pain across Britain. This is no mean feat. The patient reference group was set up under the leadership of the previous PLC chair, Antony Chuter, and we aim to extend its contribution to further support the work of the Society and its members.

I am very excited to be working with Kevin, members of the PLC and pain clinicians across the country on issues I care about. We stand on the shoulders of lay members who have volunteered their time, energy and expertise over many years. If you know a person living with pain who might like to get involved, encourage them to get in touch via this link <http://eepurl.com/Zalkv>.

Kevin Bowers

Following my appointment as co-chair of the Patient Liaison Committee, I thought I would introduce myself. My name is

Kevin Bowers and until June 2014 I was gainfully employed as a manager for a large food retailer; I loved my job as it gave me an opportunity to engage with customers and colleagues on a daily basis. It taught me how to listen and recognise how important it is to hear the thoughts and opinions of others and that by listening you can improve. I discovered how the knowledge and experiences of the people working in and the users of an environment can lead to better ways of doing things and improve the experience for everyone.

My journey with pain began in January 2009. My wife Karen was pregnant with my second daughter Bethany and my eldest daughter Lauren was 7; I woke up in severe pain in my lower right abdomen. I thought it was a stomach bug, but after a day it was unbearable and I saw my general practitioner (GP). The initial thought was appendicitis so I was sent to A&E and later admitted to hospital. After a few days, having given consent for an appendectomy, which did not happen, I was discharged. The pain persisted and after many more doctors' appointments and a few more possible diagnoses, I was told that I had epididymitis and prescribed antibiotics. The infection cleared but the pain didn't; I'd now been off work for a couple of months and was starting to get desperate. My GP referred me to an urologist, but the appointment was a few months away, so I made a private appointment. Following the initial consultation and a local anaesthetic injection, which stopped the pain, I had an elective orchiectomy. My pain was nearly gone with just occasional flare-ups

and I returned to work. A year later, though I was back to my GP again in agony, this time I was referred to the local pain team, but once again the wait time was too long so I went private. I was introduced to the concept of chronic pain and that like my diabetes it wouldn't be taken away but that it could be managed. I was prescribed gabapentin, solpadol and nortriptyline and advised to try acupuncture. The medication lowered the pain to a manageable level and I found the acupuncture helped too; I'm not sure whether it was the needles or the discussion I was having with the practitioners and possible psychological benefits it gave me. I was back to work albeit with some changes and was almost living the way I had.

The acupuncture team led me to a local pain support group they had helped form a few years earlier. Keeping pace with pain in Southampton has now been going for 13 years; it meets three times a month, a coffee morning, a craft session and the main meeting usually with a guest speaker. My attendance initially was sporadic, I'd go if I could get away from work but I found it helped me. They have no membership fees or commitments, just a small donation for tea and coffee or towards the cost of the craft supplies; it is an environment where people with a shared issue, chronic pain, can meet, chat and share if they want their experiences of pain. They have

people of all ages and all backgrounds with varied and different conditions that have left them with chronic pain and they can be themselves, no pretending to be well, no putting on a face, no worrying if they need to move around or they can't attend just a haven.

In 2014, I was back in the hospital, my pain which had progressively worsened was now unbearable. Again appendicitis was a possibility but quickly ruled out, I saw the pain consultant while in the hospital and my medication was changed to morphine from codeine and I was discharged to be treated in the community. I saw a psychologist, an occupational therapist and a consultant; I was placed on the Pain Management Program (PMP) and personally sought out a mindfulness course through Breathworks. I didn't return to work and eventually retired through ill health, a tough thing at 42, you don't get to prepare, to plan the things you'll be doing with your new found free time, you're home alone with lots of time to think. I had dark times, once asking my wife whether it would be better if I wasn't around anymore? I don't think I meant it but I felt I had to ask the question. Things were tough both emotionally and financially, with the latter also massively impacting the former. I could no longer tolerate the acupuncture, even the first needle was too much; I was struggling with what to do, who I was and where I was going? I eventually started to go to all of the support group meetings,

and I started speaking up more. I put things from the PMP into practice and eventually began to accept my pain and the limitations it places on me; I allowed myself to live again; I went back to drama, a hobby that had been a passion for me; I had, of course, had to adapt my involvement, smaller parts, move into directing and so on, but I could still do it! I began to want to do more, I started by talking to PMP patients about the support group, then I was asked to be a volunteer as a peer supporter in a follow-on program to PMP, I speak to medical students to give them a patient perspective on chronic pain and now I'm here.

With my pension, our finances began to improve and with that we could fall into a routine that worked for us as a family; PIP and other benefits meant we could get a car adapted for me to drive meaning. I could help out more and not have to rely on others. Emotionally things improved for me and my family; things still get stained, but generally we've all accepted that our lives have changed. It's not all bad, I've made some real friendships, people who help me and I hope I've made a difference to people. There are three legs to how I cope with my pain outside of the medication and mindfulness: family and friends, drama and support, the support I get from others and I hope the support I can give. It's looking at the doors that have opened in front of me and not at the ones that have closed behind.

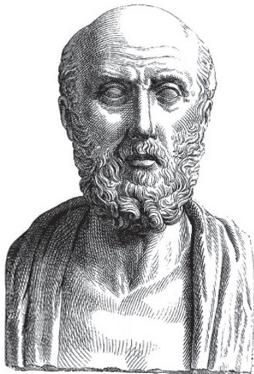
Consent in pain medicine: law and implications for practice

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Part 1: medical paternalism versus patient autonomy



I swear by Apollo the Healer, by Asclepius, by Hygieia, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out, according

to my ability and judgment, this oath and this indenture.

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing.¹ (Hippocrates, 460–370 BC) (in italics)¹

Every human being of adult years and sound mind has a right to determine what should be done with his body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. (Schloendorff v Society of New York Hospital 103 NE 92 (1914) at 93–94, per Cardozo J)

Without a consent, either written or oral, no surgery may be performed. This is not a mere formality; it is an important individual right to have

control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done, when it will be done and by whom it will be done. (Linden J Allan v. New Mount Sinai Hospital (1980) 28 OR356)

Due to the restrictions of space, there are obvious limitations to this article in the number and details of cases that can be cited. The aim is to present in as concise a fashion as possible ... 'to the man on the Clapham omnibus' our view of the implications of the current position of medical consent in English law upon medical practice with special reference to pain medicine following the groundbreaking decision of the Supreme Court in the case of Montgomery 2015.^{3,4}

The decline of medical paternalism

Medical paternalism has held sway over medicine since the beginnings of a doctor/patient relationship. Such paternalism is assumed in ancient systems of medical practice such as ayurvedic medicine.⁵

The Hippocratic oath, while holding the physician to account over his actions, implicitly assumes the agreement of the patient and/or the relatives to whatever course of action the physician decides. However, there was also evidence of obtaining patient's consent in ancient times.⁵

Plato is quoted as saying, 'free-born doctors who mainly treated free-born patients, describe to (their patients) the nature of the illness, *often not revealing the whole truth regarding the condition or its prognosis* and then prescribing medicine to them only after obtaining their consent'. Sometimes, a person trained in speaking to the public or doctors trained to persuade were called in to help obtain consent. Interestingly, no such consent was required of doctors treating slaves.⁶

The idea that the status of the patient would determine the level of consent required is also mentioned elsewhere. Critobulus, an eminent Physician was only persuaded to operate on Alexander the Great, after Alexander openly declared prior to the operation that his condition was incurable. Other powerful patients such as kings would offer a sword to the physician before an operation, symbolising that they consented to be operated. This way, it was also stated, if God willed the healing, then the physician would boast and if not, then the latter would not be blamed.⁵

Dalla-Vorgia⁷ notes that from ancient times, physicians have, at least on occasion, been driven to seek consent of their patients either because of respect for their patient's autonomy or from fear of the consequences of a failure.

Sutherland in her recent (*and excellent*) book on *A Guide to Consent in Clinical Negligence, Post-Montgomery*⁸ states

that in terms of consent, medical law has been significantly behind medical guidelines in this country.

To understand why this was and how the recent Supreme Court ruling of *Montgomery (2015)* has profoundly changed this, one needs to understand the different roles of a doctor:

- (a) On one hand, *diagnosis and treatment and on the other*;
- (b) a separate but equally vital area of disclosure of information to obtain consent.

The fundamental issue has been that until recently the test of legal consent used in the UK courts was based on the case of *Bolam*.⁹

Bolam was a case about clinical negligence, and deciding whether a particular course of medical action would be considered professionally responsible by a body of the doctor's colleagues.

The judge in the case, *McNair J*, looking at a case of possible clinical negligence, said the following:

*A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art Putting it the other way around, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.*¹⁰

Therefore, the decision in *Bolam* (applied and accepted in many subsequent cases including the important case of *Bolitho* in 1996^{11,12}) was essentially about how to judge a doctor in performing *the duty of a doctor in areas of diagnosis and treatment*. However, the *Bolam/Bolitho* tests were also being applied to (and certainly not distinguished from) another equally important area of a doctor's duty, that of *the disclosure of information to patients*

in the process of obtaining consent to treatment.

Many Courts outside the UK common law jurisdictions had already recognised that obtaining consent through the provision of sufficient information was a vital part of a doctor's duty, for not to do so could well constitute a case of battery or assault.

Laying the ground work for consent and the rise of patient autonomy

While some would argue that patients can only make decisions based on what doctors tell them about the options for treatment, it is recognised that patients make decisions about such matters not always for medical reasons alone, that is, there are individual non-medical, patient-specific factors which influence a patient's consent.

In the *Montgomery 2015* case, which will be described in more detail later, the Claimant's legal team, *Lauren Sutherland QC* then junior counsel with *James Badenoch QC*, argued that a doctor has a duty of care in the performance of treatment and the making of a diagnosis but that there is a separate moral or ethical duty which relates to information disclosure.

The provision of that information permits patients to make choices about what risks they are prepared to run, and these (ultimately medical) *choices of the patient* depend on factors that may transcend professional medical training and knowledge. Many studies suggest that non-medical factors and patient-specific factors are important. *Sutherland* quotes in her book, the *Fadum and Beachamps* study, that 88% of subjects made decisions based on factors external to the (medical) information given.

To put it simply, the decisions of *Bolam*, *Bolitho* and other previous decisions of the Court essentially rested on the premise that the person who would best decide what a doctor should

tell a patient about the various possible courses of treatment would be another (peer) group of doctors.

However, the problem with using the *Bolam* test (which was actually about the standard of medical practice and clinical negligence) in the area of information disclosure is that this test is more concerned about professional consensus and standards than with the rights, concerns and priorities of the patient. The peculiarities of a particular patient are not considered and non-medical considerations are irrelevant under the *Bolam* test.

Issue of consent prior to Montgomery

The case of *Sidaway* in 1985 tried to challenge the right of doctors to decide what to tell patients. In this case, the Claimant suffered from pain in the neck, right shoulder and arms. Her neurosurgeon took consent for a cervical cord decompression but did not include in his explanation the fact that in less than 1% of cases the decompression caused paraplegia. Unfortunately, she developed paraplegia after the spinal operation.¹³

The Court *rejected* her claim for damages, stating that as the law then stood consent did not require an elaborate explanation of remote side effects.

However, Lord *Scarman* provided a dissenting judgment and said the *Bolam* test should not apply to the issue of informed consent and the doctor should have a duty to tell the patient of inherent and material risks of treatment proposed. Clearly, though the claim was rejected, this was not a unanimous endorsement of the *Bolam* principles but despite Lord *Scarman's* dissent, Lord *Diplock* stated that *it was up to a doctor to decide what were the risks the existence of which a patient should voluntarily be warned of* and this should be just as much an exercise of professional skill and

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judgment as any other part of a doctor's comprehensive duty of care to the individual patient.

Lord Scarman, on the contrary, asserted the duty of providing information was distinct from the duty to take care and treatment. He stated, in 885–886 of the judgment, that the doctor's concern is with health and the relief of pain. These are medical objectives *but a patient may well have in mind circumstances, objectives and values which may lead him to a difference decision from that suggested by purely medical opinion.*

A further case, *Pearce v United Bristol Healthcare Trust 1999*,¹⁴ also looked at what information was appropriate to disclose. The case concerned an expectant mother whose baby had gone to term. The consultant obstetrician took the view that she should wait and have a normal delivery rather than proceed to caesarean section at an earlier date. The mother was not warned of the risk the baby could die in utero (with a known risk of 0.1%–0.2%) which is in fact what happened. The question was whether she should have been warned of that risk to assist in selection of the option of delivery.

The issue came down to what was considered a significant risk that should be disclosed and Lord Woolf reluctantly focused on a 10% risk that would trigger a duty to disclose. He held that at a 0.1%–0.2% risk it was not considered to fall within the category of significant risk⁸ (p. 93).

The importance, as mentioned again by Sutherland, *is whether one decides a risk is relevant to an imaginary reasonable patient or whether one should consider the subjective position of the particular patient.*

This leads to the point of what is known as therapeutic privilege of filtering information. It was argued in *Montgomery* that the medical profession should not be permitted to filter information or substitute their own best

medical judgments for the informed decision of the patient.

The duty to provide the patient with information should not be defined by the amount of information the doctor thinks the patient should know, but by the information the patient needs to enable them to make an autonomous choice (Sutherland, 2015: 30).

A further notable progression occurred in the case of *Chester v Afshar*.¹⁵ Miss Chester was referred to Mr Afshar, a neurosurgeon, for lower back pain. He told her that surgery was a solution, but (the judge found at first instance) he did not inform her of the 1%–2% risk of the operation going wrong, even in the best hands. She suffered a complication, called cauda equina syndrome. The judge found that there was a causal connection between the failure to inform and Miss Chester's injuries – and if she had been informed, she would have sought further advice or alternatives. There was no question that the surgery was performed other than to a good standard. The issue was of the failure to provide the information to obtain valid consent *at the time*, that is, if she had been told she would have hesitated *at the time and not had surgery on that occasion.*

The important part to understand in this judgment is that the Claimant accepted she would have probably had the operation *at some point in the future*. The Court accepted her testimony that if she had been told about the risks, she would not have had the operation *at the time*, but instead she would have gone away and thought about the risk and (most likely) gone ahead with the operation on another date. Since the chances of the operation going wrong on any occasion was 1%–2%, if she had gone away and thought about it and come back and had the operation on another the date then the chance was only of 1%–2% again, therefore she would not have suffered a cauda equina on a subsequent occasion with a 98%–

99% certainty, and therefore with a much greater certainty than required for proof on the balance of probabilities she would have suffered no adverse consequence.

This roll of the dice approach to considering likely clinical outcome in this judgment caused natural consternation among clinicians, but it had a profound effect on the consenting issues in that a risk of 1%–2% was now considered by the Court something that a responsible group (i.e. Bolam's 'responsible body') of clinicians would consider a complication to have to tell a patient about as it may change the clinical course regardless of the standard of surgery (which was never an issue).

The case of *Montgomery v Lanarkshire Health Board 2015: the death of medical paternalism*

The *Montgomery* case has been cited many times, but a short description of its facts is both profoundly disturbing and helpful to understand why the Supreme Court has changed the law in this country. The Medical Protection Society has also given a good summary of this case.^{16–18}

In 1999, Nadine Montgomery gave birth by vaginal delivery. The birth was complicated by shoulder dystocia and during the 12-minute delay, Sam, her baby was deprived of oxygen and subsequently diagnosed with cerebral palsy with ongoing lifelong consequences.

Mrs Montgomery was diabetic and small in stature and the risk of shoulder dystocia was thought to be 9%–10%. Despite her expressing concern to her consultant about whether she would be able to deliver her baby vaginally, the doctor failed to warn Mrs Montgomery of the risk of serious injury from shoulder dystocia or offer her the alternative possibility of an elective caesarean section.

Mrs Montgomery brought a claim, alleging that had she been advised of the 9%–10% risk of shoulder dystocia

associated with vaginal delivery (notwithstanding the risk of a grave outcome was small, less than 0.1% risk of cerebral palsy), then she would have opted for delivery by caesarean section and that this would have prevented her child's injury.

All the medical experts, and indeed the (defendant) treating obstetrician at the time, when asked what they would likely have wanted had they been in Mrs Montgomery's position, agreed they would have wanted a caesarean section too but the Defendants in the case maintained their position that a reasonable body of obstetricians would not have informed Mrs Montgomery of the risk. That is, they stated it was the treating doctor's right to choose what to tell the patient and that a reasonable body of responsible peer doctors would not have advised of the risk.

The Supreme Court rejected the Defendant health board's argument and ruled that the Bolam test was no longer suitable as a test for deciding what information should be provided in order to obtain valid consent. The Supreme Court decided that the discussion of risks with patients, and the extent to which a doctor may be inclined to discuss risks with patients, should not be determined by what was established medical practice:

A doctor is under a duty to take reasonable care to ensure that a patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor was or should reasonably be aware that the particular patient would be likely to attach significance to it.

The Supreme Court ruled that Mrs Montgomery should have been informed

of the risk of shoulder dystocia and given the option of a caesarean section. Mrs Montgomery was awarded £5.25 million in damages for the injury sustained by her child.

But we were here all along: the role of GMC in Montgomery

As stated by Lord Brodie,¹⁹ what Montgomery did was radically to rethink just what should be understood by the notion of consent to treatment and to endorse (as the GMC had been stating for many years) a model of a therapeutic relationship in which, when it comes to deciding treatment, *the focus is turned upon the patient and the patient's rights and responsibilities.*

Under this model, first it is for the doctor to fully explain the options to the patient, setting out the potential benefits and risks of each option, including that of having no treatment, taking into account matters which would be expected to be significant to that patient or which, on discussion are found to be significant.

Second, it is for the patient, who has been properly informed, to weigh up what they have been told about potential benefits and risks and then to decide upon what option is best for them, taking into account both clinical and non-clinical considerations important to them.

It is the patient not the doctor who is taken to be the person best able to make the necessary choices, once they have been equipped to do so by the doctor explaining in a way the patient can understand what the available choices may involve.

As Sutherland points out the GMC was represented at the hearing of the Supreme Court although it had not been represented at previous hearings. The Supreme Court was provided with the GMC position on patient consent as already in 'Consent: patients and doctors making decision together' GMC 2008'.²⁰ (Note: The consent guidance is separate from Good Medical Practice.)

In fact, the medical authorities had been arguing for some time for a less paternalistic role; the BMA handbook on medical ethics in 1984 (*31 years before the Supreme Court Judgment in Montgomery*) stated that a patient's trust that (their) consent to treatment should not be misused is an essential part of the relationship with (their) doctor. For a doctor even to touch a patient without consent may constitute as assault.

Implications of Montgomery

The emphasis is now on the individual's right of autonomy or self-determination. Patients are now recognised as having the right to make choices about their own health once they are properly informed of risks and benefits, and the law now recognises they may have individual (non-medical) factors which influence the choices they make.

As the result of Montgomery, the test now recognises the right of the individual patient to receive full information and to participate in decisions about their own health⁸ (p. 16ff).

An immediate difficulty arises if a patient were to ask for treatment the doctor considers is not of benefit to them. The GMC state in their 2008 guidance that the doctor should discuss the issues with the patient, explore their reasons for the request and if after discussion the doctor still considers treatment will not be of overall benefit, they do not have to provide the treatment but they should explain their reason to the patient and explain any other options that are available, including the option to seek a second opinion.

Principles of consent post-Montgomery

The GMC has provided a framework for consent which all medical practitioners are expected to be familiar with ('Consent: patients and doctors making decision together' GMC 2008). Briefly, the principles include the following:

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- (a) Listen to patients and respect their views about their health;
- (b) Discuss with patients what their diagnosis, prognosis, treatment and care involve;
- (c) Share with patients the information they want or need in order to make decisions;
- (d) Maximise patients' opportunities, and their ability, to make decisions for themselves;
- (e) Respect patients' decisions.

There is recognition of the complexity and uncertainty in medical information and practice and the difficulty in applying appropriate information to a specific individual.

In relation to consenting a patient and warning of the risks of treatment, the Supreme Court ruling of *Montgomery* (2015) has retrospectively superseded the older tests (in *Bolam*, *Bolitho*, *Sidaway*, *Pearce*, *Afshar*, etc.) by imposing on a doctor the duty to take

reasonable care to ensure that a patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

A risk is material if a reasonable person in the patient's position would be likely to attach significance to the risk, or if the doctor was or should reasonably have been aware that the particular patient would be likely to attach significance to it.

So, doctors must now ask themselves three questions:²¹

1. Does this patient know about the material risks of the treatment I am proposing?
2. Does this patient know about reasonable alternatives to this treatment?
3. Have I taken reasonable care to ensure that this patient knows this?

It is not the purpose of this article to provide a definitive or approved medical course of action but the following practices need to be demonstrated to have been performed:

1. A provision of information which will allow for the understanding of this particular patient. The complexity of information and issues that needs to be considered means that in practice the prior provision and consideration of written information (e.g. a patient information leaflet or similar and a copy of the clinic letter) followed by a subsequent discussion is most likely to achieve this. This consenting process will take time and usually require more than one occasion and should not be rushed. The fact that it has taken place and the key points discussed must be recorded.
2. A discussion of those particular factors that are likely to matter to this particular patient. Risks or complications which may not concern another patient may be very important to this one.
3. That care has been taken to ensure that this patient understands what are the implications of any treatment which is being suggested, what alternative or variant treatments exist together with their implications and the implications of not going ahead with the proposed or any active treatment.

Consent and who does the procedure?

It should also be noted that a patient who has consented to treatment by Doctor A but on the day of the procedure is presented with Doctor B may have grounds for complaint should there be an adverse consequence to the procedure if the choice of doctor was material to the process of consent.

Therefore, where there is such a change of personnel, it is important that

the patient is again consented and the further consent and process clearly documented prior to the procedure.

In *Jones versus Royal Devon and Exeter NHS Foundation Trust 2015*, Mrs Kathleen Jones had been added to the waiting list to have surgery performed at the Royal Devon & Exeter Hospital by a highly respected and well-known consultant spinal surgeon of her choice, only to discover, on the morning of the operation, that it had never been intended that he was to perform it.

Instead, it was to be carried out by a more junior and much less experienced spinal Fellow at the hospital. Unfortunately, the operation went badly and Mrs Jones was left with serious and permanent injuries as a result.

The Claimant's evidence was accepted that she was not told in advance who was in fact to operate, and the evidence of the spinal fellow who said that she had been told during the consenting procedure some days before was rejected. The court further found that the Claimant would not have agreed to have the operation performed by a replacement, had she been told in advance, and ruled that it was too late for her to be expected to exercise informed choice when, moments before the operation, she was eventually told by a theatre nurse that her surgeon of choice was not available:

*... although there was no breach of duty to warn the claimant of the risks of the operation, it was an infringement of her right 'to make an informed choice as to whether, and if so when, and by whom to be operated on'. Unless a remedy is provided in the present case that right would be a hollow one.*²²

In our view, the full implications of this judgment on NHS practice have not yet been fully appreciated.

Implications for clinical practice in pain medicine

We have deliberately concentrated on the changes in the legal basis for the consenting processes and the law's new emphasis on the autonomy of the individual to override the knowledge and expertise of the doctor in choosing the ultimate course of action. It is clear and understood now that assessing whether a risk is material is not a matter for experts, but, for a well-informed patient.

There are a number of areas where this will come into play in pain medicine and in particular may give rise to issues with regard to consent to treatment and the provision of information to the patient. The basic principles are as follows:

1. That the natural history of the pain condition needs to be considered, that is pains may get better, or worse, but usually they are persistent regardless of treatment.
2. That there is very little evidence that any treatment in pain medicine will reliably make a long-term difference to the condition of a patient.
3. That certain treatments may produce long-term change but may also be associated with (potentially catastrophic) risks.
4. That certain treatments may or may not be more efficacious than other treatments, but do carry greater risks. This is particularly relevant in the case of particulate steroids for neuraxial use. The choice about the composition of the injectate now lies with the patient who should be informed of the current medical range of opinion in the matter.
5. That patients need to be given adequate time to consider the proposed treatment and particularly where invasive treatments may be associated with serious complication and with no clear benefits in terms of long-term outcome are recommended. These issues need to be discussed

fully and the patient needs to be given adequate time as needed to reflect and consider whether to accept them. Currently, patients are often given little or no time just before surgery, for which they have been carefully consented, to consider the use of invasive regional anaesthesia (e.g. brachial plexus block, spinal other, regional block) and their effects on short- and long-term outcome and the possible serious (but fortunately rare) complications.

6. That consent of a patient for a procedure by a particular individual, say a consultant in pain medicine, does not automatically give any other person the right to perform the same procedure without further discussion and further consent. This may well mean that the consent is not automatically extendable or valid for a junior doctor or indeed an extended scope physiotherapist to perform the same procedure. Where the patient has given a highly specific consent and the seniority, training and skill of the individual performing the procedure may be important to that particular patient, the original consent may no longer be valid. The procedure might even then be considered to amount to an assault. One further implication arises where a patient turns up to a pain clinic to be seen by a *specialist in chronic pain* who in fact is not a doctor. The practitioner should make it very clear who it is who is actually examining the patient, whether it is a senior or a junior doctor, a physiotherapist or another healthcare professional and their medical background. The patient may be expecting to be seen and examined by a (senior) doctor but instead be examined by somebody else than a (senior) doctor. To misrepresent oneself and examine a patient could be seen as an assault.
7. It should be remembered that consent can be withdrawn at any time.

It is therefore important that care is always taken to ensure that consent is appropriate, fully informed and transparent.

In part 2 of this article, we will discuss the further judgments that have taken place subsequent to Montgomery and give thought on how to develop consent forms and process which account for the implications of Montgomery.

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Social and cultural influences on pain, pain behaviour and treatment

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Introduction

Chronic pain is a complex phenomenon that encompasses various biological, psychological and social aspects. There are social and cultural factors which influence patients' understanding and behaviour towards pain. This can vary depending on the context, situation and environment ranging from being stoic or emotive. Stoic patients tend to less express pain outwardly, and if the pain impacts on their social interactions might contribute towards their social isolation. Emotive patients externalise their pain and prefer to verbalise it to people around them and expect their empathy to validate their pain and suffering. Often people coming from Mediterranean, Hispanic and Middle Eastern backgrounds are good examples of emotive (expressive) patients, while people from Northern European and Asian cultures are examples of stoic patients. However, these cultural stereotypes could misinterpret individuals' pain and distress, which in turn can lead to serious errors of judgement. Despite that, broad generalisations of human behaviour and culture could be considered within a framework that directs human experience of pain, but individuals within cultures are not confined to the same set of expected beliefs. Still, the individual person's experience of pain could manifest itself in behavioural and emotional responses

Figure 1. Top right image, bottom middle image and bottom right image are published under CC BY-SA 3.0 licenses.⁹⁻¹¹



depending on their perception of the pain problem and unique personality. An understanding of the impact of culture on the pain perception and expression was identified in the early work of the anthropologist, Mark Zborowski, who suggested that the expression of pain and suffering is socially learned and has cultural significance.

Individuals within cultures Western culture and stoicism

Stoicism was a school of thought and philosophy that flourished among ancient Romans and Greeks. It was popularised by the writings of Marcus Aurelius, Seneca and Epictetus and to this day it is considered as one of the most sublime philosophies of Western civilisation.

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There is a long history of stoicism in Western culture in which the bearing of the pain and suffering, discomfort or hardship without complaint or any display of feeling or emotion. Healthcare professionals are now aware and understand the effect of culture in these attitudes; some of the elderly patients may hold back about their pain. However, the new generation has moved from being stoic to being more expressive within the context of their culture and beliefs. This awareness could establish a basis for comparison that allows seeing where beliefs and attitudes are likely to impact on human behaviour towards pain.

Asian culture and stoicism

Patients from Asian cultures are other examples of stoicism, which links directly to the strong cultural values about self-behaviour. In Asian societies, behaving in a dignified manner is crucial with some behaviours and attitudes like complaining frequently or drawing attention in a negative way considered as indicative of poor social skills. In many Asian traditions, maintaining harmony in interactions with others in a positive way is important, so an individual who may be feeling pain, discomfort or sadness might hide their true feelings, as expressing their distress because it is not considered as 'accepted behaviour'. Moreover, in Asian societies, people are treated as per their social ranking, which are based on variables such as education, age, sex and occupation. Healthcare professionals are often considered as a person of high status, so some patients feel that they should not be bothered with their complaints about pain and suffering.

Middle Eastern and Mediterranean culture

Middle Eastern and Mediterranean people are more likely to verbalise both physical and emotional pain as part of their emotive behaviour. Most of the time

the patients attribute their pain to predestination, supernatural spirits such as evil eyes and in accordance to God's will. The concept of 'Pain as the Will of God' provides an opportunity to atone for their worldly sins and earns greater reward in the afterlife.

Evil eye

Evil eye is a curse believed to harm anyone who had been praised excessively for his or her success or received admiration beyond what they truly deserved. People who believe in the evil eye also believe that this curse has the ability to cause physical and mental illnesses. The belief in the evil eye was common to European, Middle Eastern and North African cultures as well as tribes all over Asia. In Islam, the evil eye is a common assumption and it is believed that individuals have the power to look at people or objects to cause them ill feeling and harm. Belief in the evil eye is based upon the statement of Prophet Muhammad 'The influence of an evil eye is a fact ...' (Sahih Muslim, Book 26, No. 5,427).

Attempts to ward off the harms of the evil eye in different cultures have resulted in a number of amulets, talismans and lucky charms to turn away harm or evil influences and/or to bring good fortune to the possessor (see attached figure). Discs or orbs, consisting of concentric blue and white circles representing an evil eye, are common talismans in West Asia. Nazar is another attractive blue-eye charms; its name deriving from Phoenician word meaning *sight*, *surveillance* or *attention*. It is a common belief among Muslims in the Middle East and Mediterranean that the talismanic power of a nazar will be able to defend against the envious looks containing the destructive power of the evil eye. This charm is frequently seen in Turkey in the houses, cars or worn as beads around the neck. It is now popular among tourists to buy it as souvenir on a visit to Turkey.

Another common practice among Muslims is invoking God's blessing upon the person or object that is being admired by directly expressing appreciation with name of ALLAH. In Arabic it is customary to say *Masha'Allah*, which means 'God has willed it'. Reciting from the Holy Qur'an three times per day, it is also used as a means of personal protection against the evil eye.

The Hamsa Hand found in West Asian cultures is a hand-shaped talisman with a blue or green eye and it represents the five fingers of the hand; it is an apotropaic against the evil eye. In some Muslim cultures, it is called the 'Hand of Fatima', and in some Jewish cultural practice, the Hamsa is also referred to as the 'Hand of Miriam'.

African culture

The Tswana and Afrikaans cultures of Southern Africa did not believe in the evil eye like most of other cultures. Tswana culture believes in the 'power of the ancestors' as the cause of their illness or pain. In their rituals, for protection, they try to connect spiritually with their ancestors, which could be their deceased parents, grandparents or other elders, as it is believed that the souls of their ancestors will protect them most of the time. In the Afrikaans culture, pain is a private matter; it is believed that pain should not be expressed to others and no treatments sought for it if possible.

Expression of pain on the background of social and ethnic beliefs

The relationship between pain perception, ethnic identity and socioeconomic status made an attractive subject for many anthropological studies. For example, studies carried out to evaluate the aetiology and prevalence of back pain in Native Aboriginal communities revealed that more than half

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of the adults in this community experienced chronic back pain, but had never sought any medical advice or visit healthcare professionals for treatment because of their cultural beliefs.

Healthcare professionals should be aware of the dichotomy between cultural or personal beliefs and professional clinical opinion about the causes of pain. The cultural background determines how pain (physical and emotional) is experienced by the individual and communicated to others and may not represent the medical explanation. In developing countries, people, especially those with limited education, tend to express and explain their pain based on their religion, spiritual views and the role of supernatural powers. This may be in contrast to the logical or scientific explanations, which is more common in Western and industrialised countries. Ramer and colleagues have highlighted that it is critical to know pain has both personal and cultural meanings; hence, the feelings of the patient may be understood by those within the same culture but may not be appreciated by those outside that culture.

Pain and cultural beliefs

Pain is a qualitative phenomenon and experience, and despite incorporating quantitative assessment of pain to the overall evaluation, there is still no accurate way of measuring how much pain a person is experiencing. The currently available pain measurement tools do not work equally across different cultures. For example, one scale uses smiling and frowning faces to signify their pain where a smiling face suggests no pain and frowning suggests maximum pain (e.g. Wong-Baker scale); but smiling does not suggest feeling good in many cultures. In some Asian cultures, people tend to smile when they are embarrassed or even angry. Another popular measurement tool is the Numerical Rating Scale (NRS) from 1 to

10 where pain could be rated as mild (1–4), moderate (5–6), and severe (7–10). However, people in some cultures attach great superstition to particular numbers. Another cultural obstacle for the expression of pain is the limitation of language to convey pain experiences; different cultures describe pain and pain experiences differently. In Western culture, words such as ‘sharp, throbbing, stabbing or aching’ are used to describe the nature of pain, and these descriptions are well understood and accepted by patients there. Those words are not necessarily used or have the same significance for patients from other cultures. In tribal cultures, telling stories or using symbols from the natural world like lightning, trees with deep spreading roots, spider webs, bee stings or the tones of drums and flutes are very influential in relating one’s feeling of pain. Another group of symbols used are those of evil spirits or jinhs that are believed to be the cause of illness and pain in which patients usually talk about their suffering as punishment for previous sins.

Cultural perceptions of pain treatments

In the discussion on cultural values about the treatment for pain, we will come across a lot of difference in the attitudes and stigma across many cultures. Some cultures believe that injections are more effective than pills, while in other cultures, people believe that the larger pills work better than the smaller ones or the bitter medicine is stronger and more effective than the medicine that tastes better. Most cultures still stigmatise the use of opioid medications. In some cultures, intravenous pain medication would be preferred to oral opioid analgesics even if the tablets or capsules were proven to be highly effective. Patients from other Asian societies such as the Filipino, Indian or Afrikaans reject pain medications because of their undesirable

and perceived harmful effects such as sedation and the risk of potential addiction. The Tswana does use some herbal preparations with a narcotic effect, but can still refuse to take opioid medications. The reluctance to use opioids is also prevalent in Western culture, but with better patient education, most people find its use acceptable for pain relief under medical supervision.

Religious and spiritual aspects of pain

The use of religion for comforting the sick through spiritual healing or faith-based remedies is consistent within cultures that are grounded in religion, such as Islam and the Christian faith. This exploits the beliefs of the individual and their family that the illness, injury and pain are caused by a higher power. The acceptance and tolerance of pain are demonstrating and validating a person’s faith and staunch belief in their religion. Devout Muslims offer their pain to Allah as thanks for his goodwill for allowing being worthy of the treatment. The Catholic faith teaches that the will of the Almighty gave them pain and would give the strength to bear it similar to how Jesus Christ suffered for them. Buddhists believe in accepting the suffering as a form of spiritual growth in itself. Native Americans thought that the blessing of medications by the tribal medicine man makes the medicine ‘stronger and more potent’ which puts the patient’s mind at rest.

Experiences from a pain clinic in Saudi Arabia

The patient and their family

The people of the Kingdom of Saudi Arabia share the common cultural aspects with Arabs and Muslims worldwide. Health beliefs in the Saudi culture has its own considerations, some of it is in common with other Arabs and Muslim cultures, while others are very

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unique to Saudi culture. One of the commonest beliefs that Saudis share with other Muslim cultures is that of predestination. They attribute that the occurrence of disease is already predestined as the will of Allah in which they do not perceive illness as a form of punishment; some cope well with the diagnosis of a terminal illness in terms of acceptance and may not even seek medical treatment. Breaking bad news can be very challenging to the healthcare provider because the authority of the patients' family overrules the individual's autonomy. This is one of the unique features of the Saudi culture in which decisions taken by the patient could often be rejected and reshaped according to the will and wishes of the family. It is expected that the bad news are intimated and discussed with the family first rather than to the patient; the family would then decide on how, when and whether this is to be communicated to the patients. Often, the patients are kept in the dark about their prognosis. Healthcare professionals often have to deal with the conflicting interests between ethical obligations towards the patient and the family's appeal for withholding vital information from the patient.

Traditional medicine

Traditional medicine is still one of the accepted modalities of treatment among Saudis in both rural and urban areas in varying degrees. Traditional treatments include herbal medicine, cauterisation, chiropractic manipulation, fracture reduction by traditional bonesetters, cupping and dietary treatment. Interestingly, most traditional healers are illiterate people who inherit the job from their close family members and have no formal training in any field of medicine. However, they treat the whole spectrum of diseases with varying degree of severity ranging from the common cold to fractures and even cancers. They often charge the patients large sums of

money for their services or ask for donations.

Spiritual healing is also widely practised by Saudis which is of particular concern; this is employed in conditions that have a poor prognosis or for which there is no existing curative medical treatment. The principal modality spiritual treatment is the recitation of verses of the Noble Qur'an and specific sayings of the Prophet Muhammad (peace be upon him). Holy water (*Zamzam*), which is obtained from the Holy Mosque in Makkah (Mecca), and food supplements like honey and black cumin (nigella seeds) are considered as healing agents. In contrast to other Islamic beliefs, the use of amulets is seen as an unacceptable behaviour in Saudi culture. Healthcare professionals would be advised to show respect towards spiritual or traditional practices and this is more likely to foster a good relationship with the patients and their families.

Challenges in delivering treatment

The worship rites in Saudi Arabia have a lot of implications on the delivery of healthcare. Being Muslims, praying regularly five times a day, fasting for Ramadan and pilgrimage to Makkah are very important to the devout individual. Patients who are limited by their illness or pain will suffer a lot from the feeling of guilt if they couldn't do it at all or do it with a degree of autonomy; some people would request assistance from a family member to do pilgrimage and prayers on their behalf. The rituals of the prayer involve certain specific movements such as standing, bowing, prostrating sitting and kneeling which for some patients could be a very painful experience. Fasting during the Holy month of Ramadan could be a challenging task for patients who are unwell, but some prefer to continue fasting against medical advice; this is despite common knowledge that according to the scriptures, they are exempted by Allah from this mandate due to their ill health. It is therefore

recommended that the choices shall be left to the patients and their families after fully informing them about the associated risks and potential complications. Pilgrimage to Makkah (Hajj) is obligatory for the adult Muslim who is physically, mentally and financially able to do it. The Hajj is an exhausting journey that takes about 4–5 days during which one will have to do certain rituals visiting different Holy places. This is often associated with some health risks such as trauma due to congestion and overcrowding, heat exhaustion and heat strokes.

Another important healthcare challenge is the gender-specific consideration. In Saudi culture, a male member leads the family in which he is the ultimate, but not absolute, decision maker. However, the female family members have their own influences on the ultimate decision before it is made. It is highly recommended for healthcare provider who is interviewing patients of the opposite gender to have one of the family members present or a nurse to act as a chaperone. Some of the male patients would not want to be examined by a female doctor or nurse and even if they agree may request that the doctor wear gloves before touching them as skin contact with a male who is not a close relative is considered 'haraam' by some conservative Muslims. Even taking a history could be a challenge particularly when you need to assess the impact of pain or illness in their social life; information about sexual health and behaviour, drug dependency or alcohol consumption, mental health depression, aggressive behaviour, irritation and stress are to be obtained in a sensitive and discreet manner. It may be best to approach this during a subsequent visit after establishing a good rapport with the patient, and the family has a more trustful relationship with the healthcare providers.

Conclusion

The critical influence of cultural and social factors on pain, pain behaviour, and pain

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management should always be taken into consideration when evaluating patients from different cultures. As healthcare professionals, it is our role and duty to help and advocate on behalf of the patients for what is appropriate and acceptable for them within their cultural context. We should learn to anticipate a patient's needs with respect to their pain management and to initiate important discussions based on their cultural, social and religious background. It is important to explain the rationale behind the use of specific medications and give the patients the choice of deciding which

type of medication is preferred or accepted in their culture.

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The British Pain Society is nothing without you, its members, and we appreciate your continuing involvement and support. We recognise that, for many members, in recent years, the decision to pay the membership fee for a non-compulsory professional society has been more challenging so we will continue to look closely at our fees and we will take care to limit any increases. We hope that you will continue to encourage your colleagues to join us.

May we also remind you that The British Pain Society is a registered charity and we welcome funds received from legacies and through sponsorship. As we know from the numbers who have joined fun runs at previous ASMs, many of our members are actively engaged in sporting activities. So, if you are signing up for any marathons, half-marathons, triathlons, swims or tiddlywinks contests, please consider nominating The Society as your chosen charity.

Thank you for supporting the BPS!

Applying clinical audit to support educational package to improve compliance of performing observations for patient-controlled analgesia and epidural analgesia

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Introduction

Surgery continues to play an important role in the treatment and management of patients with cancer with surgical resection being used for both primary tumour resection and as an intervention in the management of complications.¹ The exact incidence of surgical resection in the cancer population varies significantly depending on the location, type and extent of disease. For example, 80% of people with breast cancer will have surgical resection compared with 6% of people with liver cancer.²

Pain is the most common symptom reported by patients in the post-operative setting. It is estimated that 80% of patients will report pain in the general post-operative setting with around 75% of these describing it as moderate to severe.³ Despite advances in pain management patients continue to report moderate to severe pain that is poorly controlled.⁴ Uncontrolled pain can be detrimental to patient recovery (see Box 1) and there is evidence to suggest that prolonged periods of uncontrolled pain can suppress immune function which, in turn, can have an impact on prevention of further tumour growth.⁵

The most common methods of post-operative pain control are patient-controlled analgesia (PCA) (see Box 2) and epidural analgesia (see Box 3).¹²

Box 1.

1. Impact of uncontrolled pain⁵⁻⁷

Risk of developing into chronic pain

Increased risk of atelectasis or respiratory infection due to inability to deep breath and cough

Increased cardiovascular stress (tachycardia, hypertension) which increases stress on the body and wound breakdown

Reduced mobility increasing risk of DVT

Increased anxiety and stress

Impact on endocrine, gastrointestinal and immune system.

Delayed discharge

Box 2.

Patient-controlled analgesia (PCA)

PCA is the method by which the patient can self-administer a pre-set dose of IV opioid through use of a medical device.⁸ This bolus function can also be combined with a continuous background infusion of opioid via the same device with the aim of improving pain control. This results in a patient receiving a continuous supply of IV opioid plus potential additional boluses as requested by the self-demand button. There is large variability across the literature as to what the ideal PCA protocol is; it is advisable that this should be tailored to individual patient's needs.⁹

The use of continuous opioid infusion alongside PCA bolus significantly increases the risk of developing respiratory depression due to the continuous infusion of the opioid regardless of the patient's respiratory rate or sedation level.¹⁰ If a patient's respiratory rate falls below 10 breaths per minute, this would result in a respiratory depression. In these circumstances, it is recommended that the opioid is stopped and high-flow oxygen is administered to the patient. It may be necessary to reverse the opioid if the symptoms are severe using an opioid antagonist (naloxone).

These methods are inherently safe; however, there is a significant risk of adverse effects and as a result both methods require an increased level of observation.

Due to the inherent risks of using both PCA and epidural analgesia, it was decided to undertake an evaluation of practice. Clinical audit was used to evaluate compliance in completing PCA and epidural-specific observations against trust policies. Clinical audit was chosen over service evaluation as it is an effective way to establish if healthcare is being provided in line with agreed and accepted standards. It allows care providers and patients to know whether their service is doing well and identifies where improvements could be made.¹³

Audit standards

Although it is acknowledged that frequent observations are required to identify adverse events in patients receiving PCA or epidural analgesia,¹⁰ there is no national standard as to how often these observations should be performed. Therefore, in line with trust policies, the following standards were utilised:

- All patients with continuous opioid infusion via PCA must have respiratory rate and sedation level observations performed every hour and documented on observation chart.
- All patients with epidural analgesia must have dermatome sensory level and motor power checked once per shift or every 8 hours and continued for 48 hours following removal of epidural catheter.

Given the risk to patient safety if the complications described earlier were to go unnoticed, and according to trust policy, it was expected that 100% of patients would have these observations fully performed and documented.

Box 3.

Epidural analgesia

The epidural space is located between the dura mater and the vertebral wall of the spine. Nerves entering and leaving the spinal cord pass through the epidural space. Epidural analgesia involves a continuous infusion of local anaesthetic and/or opioid into the epidural space to provide pain relief.

This is a more effective method of controlling pain in the post-operative setting when compared with parenteral opioid administration.¹¹

Due to the location of the epidural space, there is risk of adverse events such as formation of an epidural haematoma. This can occur when there is trauma to epidural blood vessels resulting in bleeding in the epidural space. The risk of this occurring is greatest at insertion and removal of the epidural catheter.⁹

However, the risk of developing a haematoma is low and estimated at 1 in 100,000.¹⁰ It is essential to continue sensory and motor block observations for a period of time after the epidural catheter is removed.¹¹ This is to identify the presenting symptoms of a haematoma that can take the form of sensory loss, loss in motor power or back pain.⁹ If the haematoma is identified and treated with surgical intervention within 8 hours of presenting symptoms, the chances of a partial or good recovery are significantly increased; however, if this is not identified and treated within 8 hours, can result in permanent neurological damage.¹⁰

Methodology

The audit was undertaken in three phases along with educational interventions in order to improve compliance.

It is important to note that study took place in a specialist cancer centre with 92 beds meaning that the number of patients receiving these types of analgesia is relatively small compared to a large teaching hospital.

Educational interventions

Informal feedback from staff involved in the care of these patients identified that there was a lack of knowledge with regard to what observations were need. Following each phase of the audit, the pain clinical nurse specialist implemented educational interventions with the aim of improving knowledge and awareness. Three sets of interventions were implemented.

Phase 1	Phase 2	Phase 3
Initial baseline audit performed in July 2015 (retrospective analysis of approximately 60 patient notes that were identified from the acute pain ward round handover list)	Retrospective audit in February 2016	Phase 3 final spot check audit in August 2016
Spot check audit of five observation charts in August 2015	Spot check of five charts in April 2016	

Intervention phase 1 (for a 6-month period following phase 1) July 2015

- Ward-based teaching over a period of 6 months during staff handover times to highlight importance and frequency of observations (see Box 4).
- Redesign of 'in-house' epidural study day with more emphasis placed on observations and safety, including a new session on PCA that highlighted safety aspects and the need for close observations (see Box 5).
- Discussion of audit results at monthly ward sisters' and matrons' meeting to highlight patient safety risk.
- Design of a Pain Team 'Road Show'; this took the form an information board that was rotated through all clinical areas that outlines requirements for observations along with other pain topics. The information board was left in a visible area in the clinical environment with a pain clinical nurse specialists being available to answer any related questions during handover times (see Box 4).

Intervention phase 2 over 1 month (following repeat audit February 2016 phase 2)

- Repeat of ward-based teaching over a period of 1 month during staff handover times to highlight importance and frequency of observations.
- Results were discussed at monthly ward sisters' and matrons' meeting to highlight patient safety risk and need for increased observations.
- Pain clinical nurse specialist worked alongside nursing staff in the clinical areas with a focus on patients with PCA and epidural analgesia where there was no improvement following first round of interventions.

Intervention phase 3 over 2 months (following spot check audit in April 2016 phase 3)

- Further round of ward-based teaching over 2 months;
- Increased engagement with pain link nurses to model best practice in

Box 4.

Ward-based teaching

The Pain Clinical Nurse Specialist attended each ward at pre-arranged times (normally handover times) and engaged in informal teaching with the staff highlighting importance of the following:

1. Performing observations;
2. Potential complication;
3. Frequency of observations;
4. General Q&A discussing specific concerns.

Pain Team 'Road Show'

Information board was taken round all wards with three panels each focusing on an aspect of pain management.

Panel 1:

Trust pain assessment tools and information on how to perform accurate bedside pain assessment.

Panel 2:

PCA and epidural care with a focus on care and management with additional emphasis on observations and safety.

Panel 3:

Opioid prescribing and administration focusing on different formulation of immediate release and modified release opioids.

Box 5.

In-house epidural study day:

The study day is mandatory for all staff caring for patients with epidural analgesia and must be completed every 2 years. This is run by the pain clinical nurse specialists and includes support from anaesthetic registrars, critical care outreach nurses and a medical device trainer from a device company. A multiple choice test consisting of 20 questions on content covered during the day is mandatory at the end with an expected pass mark of 100%.

Programme

Anatomy, physiology and pharmacology of epidural analgesia;

Management of epidural complications;

Care and removal of epidural analgesia;

Epidural infusion pump training;

Care and management of PCA;

Simulation centre in managing complications;

Knowledge test.

Applying clinical audit to support educational package to improve compliance of performing observations for patient-controlled analgesia and epidural analgesia

Figure 1. Retrospective audit performed in July 2015 of 14 PCA observation charts

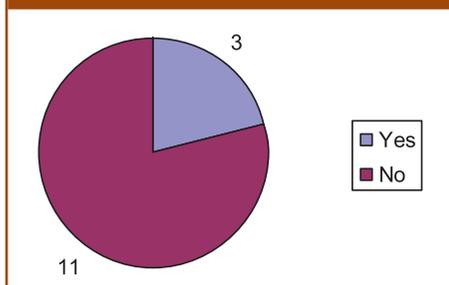
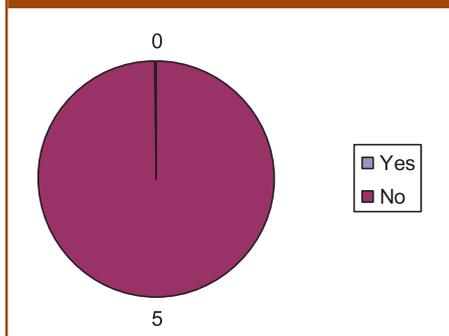


Figure 2. Prospective audit performed in August 2015 of five PCA observation charts



clinical areas. Some ward-based pain link nurses undertook local audits in their own areas to improve standards;

- Further engagement by pain clinical nurse specialist with ward sisters and matrons regarding improving compliance.

Audit timeline

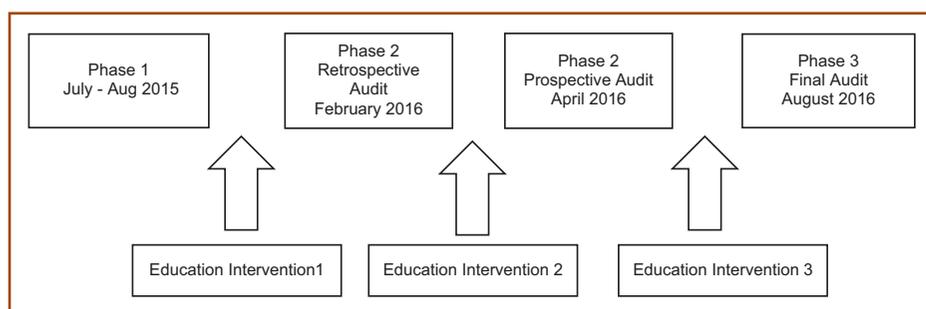
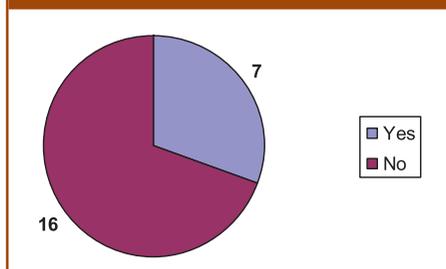


Figure 3. Retrospective audit performed in February 2016 of 23 PCA observation charts



Results

PCA observation results

Phase 1 (July 2015)

A total of 14 patients with continuous background infusion via PCA were identified in the retrospective audit in July 2015 (Figure 1). In 14 patients, 3 patients (21%) had hourly observations documented.

Prospective audit of five charts

No hourly observations were recorded on observation chart. Observations were being recorded 4 hourly (Figure 2).

Following these results, educational interventions phase 1 was introduced over a period of 6 months.

Phase 2 audits

Retrospective audit in February 2016

A total of 23 patients with continuous background infusion via PCA were identified (Figure 3). Of the 23 patients, 7 (30%) had hourly respiratory and sedation observations recorded on observation charts; this represents a negligible improvement of 9%.

Prospective audit in February 2016

Four out of five (80%) had observations recorded on the observation chart, which is a significant improvement from baseline spot check (Figure 4).

Phase 3 audit

Prospective audit August 2016

A total of 13 patients with continuous backgrounds via PCA were identified (Figure 5). Of the 13 patients, 8 (62%) had hourly observations documented on observation chart and 5 (38%) had 2-hourly observations documented.

Epidural observations' results

Phase 1

A total of 10 patients who had received epidural analgesia were identified during the retrospective audit (Figure 6). Of the 10 patients, 9 did not have sensory-level or motor power observations performed in the 48-hour period after removal. One patient was discounted as they were receiving palliative care and observations were not required.

Prospective audit

One out of five patients had sensory-level and motor power observations performed for 48 hours following removal (Figure 7).

Phase 2

Retrospective audit of eight patients

One out of eight (12.5%) patients had 48-hour observations completed, four (25%) had observations documented for 24 hours and five (62.5%) had no observations documented (Figure 8).

Prospective audit

One out of five (20%) patients had observations documented and four out of five (80%) had observations documented for 24 hours (Figure 9).

Phase 3

Prospective audit took place in August 2016

Of the 10 patients, 7 (70%) had epidural observations documented for 48 hours

Applying clinical audit to support educational package to improve compliance of performing observations for patient-controlled analgesia and epidural analgesia

Figure 4. Prospective audit performed in April 2016 of five PCA observation charts

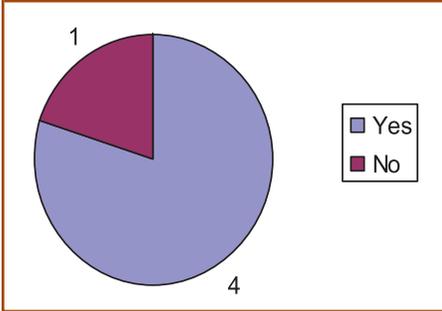


Figure 7. Prospective audit performed in August 2015 of five Epidural observation charts

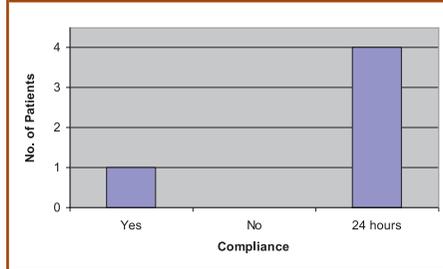


Figure 9. Spot check audit performed in April 2016 of five epidural observation chart



Figure 5. Prospective audit of 13 PCA observation charts performed in August 2016

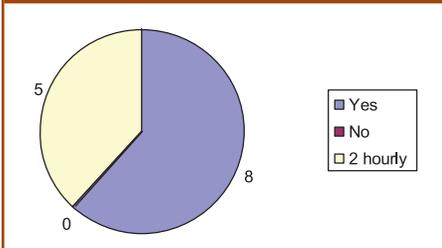


Figure 8. Retrospective audit performed in February 2016 of eight epidural observation charts.



Figure 10. Prospective audit performed in August 2016 of eight epidural observation charts

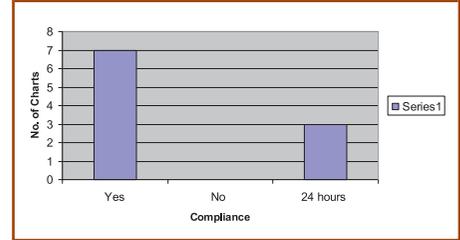
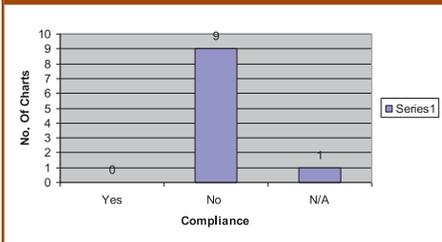


Figure 6. Retrospective audit performed. In July 2015 of 10 epidural observation charts



after removal and 3 (30%) had epidural observations documented for 24 hours (Figure 10).

Discussion

The results of phase 1 retrospective and prospective audits identified a cause for concern with regard to compliance in the completion of observations. The results from phase 1 audit generated discussion within the clinical areas and identified a

lack of knowledge and understanding by nursing staff surrounding the care of patients with these devices. From this, it was then clear that a series of educational interventions are needed in order to improve knowledge and clarify misconceptions and concerns surrounding the care of these patients.

Following phase 1 of educational interventions, the phase 2 audit of both PCA and epidural analgesia was undertaken. Unfortunately, the retrospective results did not show a significant increase in compliance so this was then followed by phase 2 educational intervention and by prospective audit as planned in the phase 2 audit pathway. There was a significant improvement in compliance during the prospective audit. There was a gap of 2 months between the retrospective and spot check audit, and during this period, a further 2 epidural study days were held with the updated content. This additional period of teaching could have contributed

to the increase in compliance during the spot check audit.

It is also interesting to note that with the epidural observations, we saw partial compliance, in that observations were being recorded for 24 hours and not the recommended 48 hours. This was encouraging as it shows greater awareness surrounding the need for these observations but further work was still needed. Therefore, following results from the prospective audit in April 2016, an educational intervention phase 3 was implemented followed by a phase 3 prospective audit in August 2016.

The result of the phase 3 audit showed a significant improvement from baseline. Although 100% compliance has not been achieved, there have been significant improvements at the phase 1 audit, where no device-specific observations were performed other than the standard 4-hourly observations, to the stage 3 audit where the majority of patients had the required level of observations performed.

At this stage, a small majority had either 2-hourly observations for respiratory rate or 24-hour epidural observations.

These audits demonstrate that an intense period of education and staff engagement resulted in a change in practice and attitude towards the care of these devices. This, in turn, may improve patient safety.

It is significant to note that there have not been any adverse events relating to patient safety with regard to PCA and epidural analgesia within the trust. This emphasises the importance of performing timely observations to ensure that adverse events do not occur. This in turn can allay complacency, which is a significant barrier in engaging staff to change practice.¹⁴

The combination of ward-based teaching, study days, engagement with ward-based pain link nurses and best practice role modelling has been demonstrated through audit because it is an effective strategy to improve practice and increase staff knowledge.^{15,16} It is also the recommended method of implementing a change in practice in the clinical environment.¹⁷ However, this was not easy to accomplish as pressures on nursing staff on the wards make it increasingly difficult to release staff from the ward environment to attend educational activities.¹⁸

For this reason, alternative methods of delivering education activities for ward staff to improve care standards are in development. This will take the form of e-learning package covering the main aspects of pain management and assessment. The use of e-learning modules allows clinical staff to undertake additional learning at any time and not impact on staffing levels on the clinical areas.¹⁸ Keefe and Wharrad¹⁹ found that

the use of e-learning in pain education had a significant benefit in improving knowledge and understanding surrounding pain assessment and management. The current e-learning system records each individual as they access the programme and they are unable to print off a certificate of completion until they have completed all the relevant knowledge questions throughout the learning package.

Conclusion

The use of clinical audit has allowed the identification of potential patient safety risks by an evaluation of current practice. Following a period of intervention and staff education, clinical audit has demonstrated a clear improvement in current practice and as a result has improved patient safety in relation to epidural analgesia and PCA by providing a continuing package of learning in the form of monthly study days, yearly pain update study days, e-learning packages and continued prospective audits of documentation to maintain and improve current practice in the care of patients with PCA and epidural analgesia.

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Audit on chronic pain duration – comparison to national audit data

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Thanthullu Vasu *Consultant and Head of Pain Management Services, University Hospitals of Leicester NHS Trust*

The Faculty of Pain Medicine (FPM), Royal College of Anaesthetists conducted a national audit on the duration of chronic pain in preparation for the Joint FPM / BPS Parliamentary reception in October 2017. The audit had four key questions on how long the patients suffered with chronic pain and how long they have waited in the system¹. This audit was done nationally in September 2017; our pain services at University Hospitals of Leicester NHS Trust (UHL) also had the opportunity to participate in this audit.

Having participated in this national audit, we wanted to compare our results with the national audit. To do this, we wanted to extrapolate and extend the audit to 30 patients. We obtained the permission from our Trust Audit department again and followed the local protocols.

Methodology

To compare with the results of the national audit, we wished to retain the same four questions in the original audit to avoid inference bias. The questions that were audited include the time duration between

- The onset of chronic pain *and* the first appointment at the Pain Clinic;
- Visiting the general practitioners (GP)/ doctor for the pain *and* the first appointment at the Pain Clinic;
- Getting referred to the pain clinic *and* the first appointment at the Pain Clinic.

The questionnaire asked four questions on when the pain started, when the patient visited GP, when the patient was referred to pain clinic and when the first pain clinic appointment happened. An illustration of questionnaire is shown below.

Methodology

Participant questionnaire

Please could you answer the following 4 questions?

- 1. When did you first notice that your pain was lasting a long time, and not going away?**
...../..... (Month/Year)
- 2. When did you first visit your GP about your pain problem?**
...../..... (Month/Year)
- 3. When did your doctor refer you to the pain clinic?**
...../..... (Month/Year)
- 4. When was your first appointment at this pain clinic?**
...../..... (Month/Year) (If today, please insert today's date)

Audit on chronic pain duration – comparison to national audit data

We prospectively collected the data anonymously for 30 patients between August and September 2017. This was done for patients who attended our chronic pain services and out-patient clinics.

Results

Our audit results showed that patients consulted GP at an average of 4.36 months after their pain started. An average of 57.4 months was taken before the GP or Specialists decided on referring them to our chronic pain service. After referral, the patients waited for average of 1.96 months before seen in our clinics.

The range of duration between identification of pain problem to getting advice from the GP/Specialist was 0–36 months. The range of duration between advice from GP/Specialist to referral to pain services was 0–284 months. The range of duration between referral for Pain Services to new patient appointment was 0–5 months.

The medians and the modes were calculated as follows:

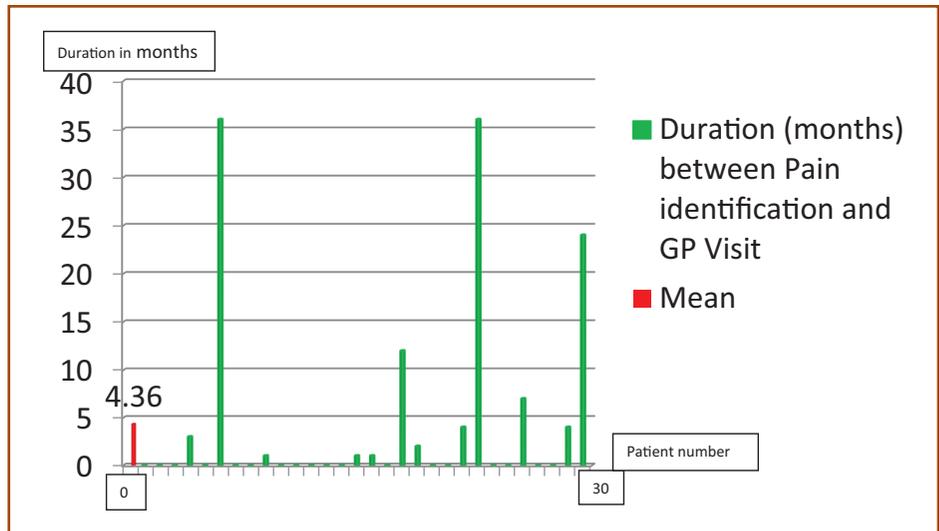
	Median (months)	Mode (months)
Identification of pain to advice from GP	0	0 months
Advice from GP/ Specialist to Pain services referral	27	(Multiple) N/A
Referral to new patient appointment	2	2 months

GP: general practitioners.

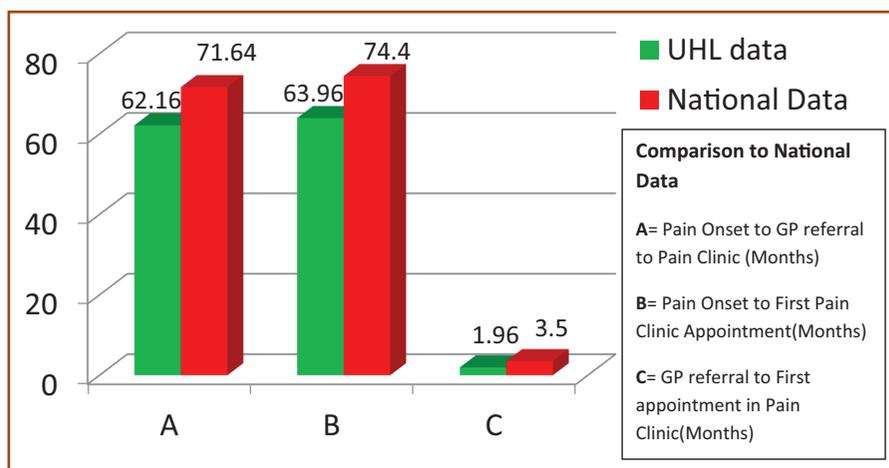
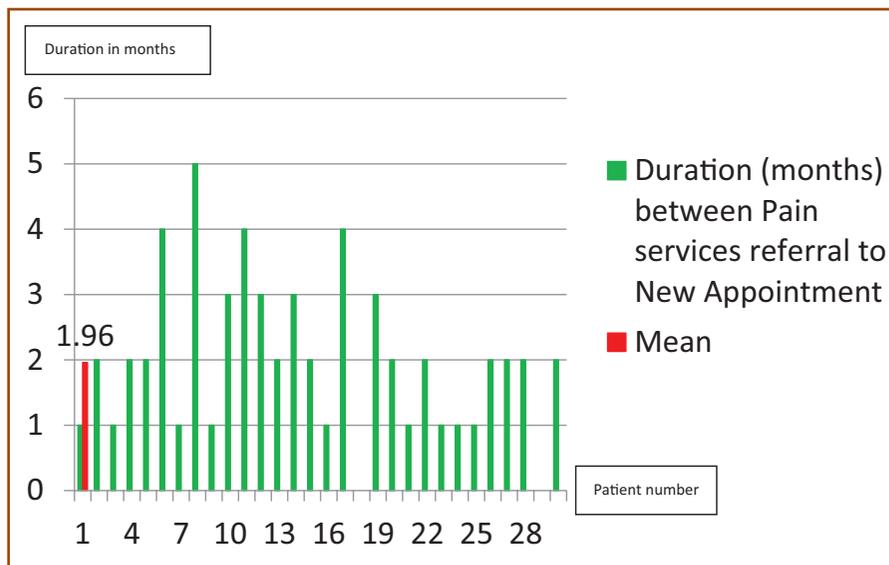
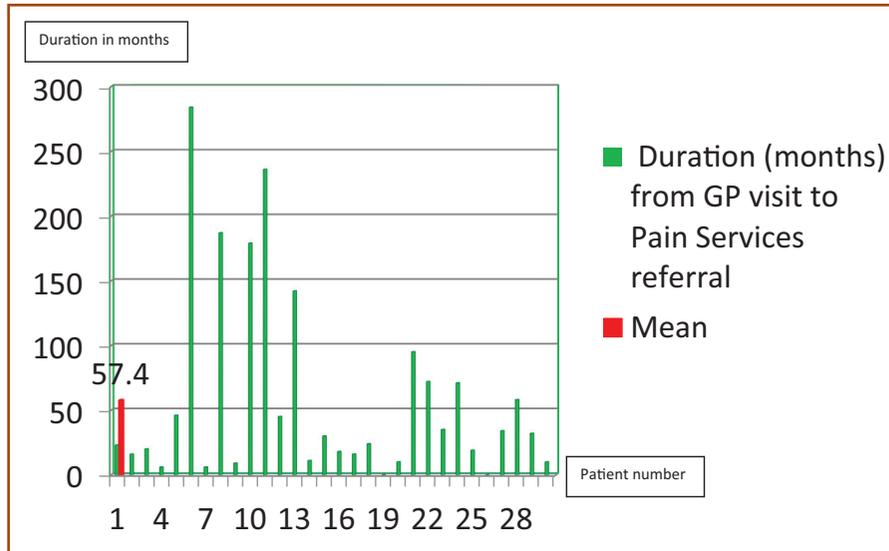
The mean duration from the initiation of pain problem to the first pain clinic appointment was 63.96 months, with a range of 5 months to 27 years.

Mean scores & Range

	Mean (Months)	Range
Identification of pain problem – advice from GP	4.36	0 months to 36 months
Advice from GP – referral to pain services	57.4	0 months to 284 months
Referral to pain services – new patient appointment at Pain clinic	1.96	0 months to 5 months
Identification of Pain Problem to Pain Clinic appointment	63.96	5 months to 27 years



Audit on chronic pain duration – comparison to national audit data



Audit on chronic pain duration – comparison to national audit data

Comparison with the National Data

	UHL Data	National Data
Pain Onset to GP referral to Pain Clinic	62.16 months (Range- 2 months- 26.66years)	5.97years- (71.64months) (Range- 1month-35 years)
Pain Onset to First Pain Clinic Appointment	63.96 months (Range- 5months-27 years)	6.2 years- (74.4 months) (Range- 1month-35years)
GP referral to First appointment in Pain Clinic	1.96 months	15 weeks (3.5months)

Discussion

Chronic pain affects 7.8 million people in our country and has a major impact on people's lives.² The 150th Chief Medical Officer's report (2009) illustrated the need for specialist pain clinics all over country and better coordination of services around patient's needs.² This document clearly stresses the need for early intervention to stop pain becoming a persistent problem.

Delay in access and treatment to pain can cause increase in frustration to patients, with a result of increased

healthcare resource consumption.³ The Faculty of Pain Medicine stresses the importance of early screening to minimise the burden of chronic pain.⁴

The aim of our audit was to compare our data with the national audit. Compared to the national data, the duration from pain onset to referral to pain clinic and pain onset to first pain clinic appointment was shorter by 9.44 and 10.44 months, respectively. We still feel that this waiting time is long for these suffering patients. It is unfortunate that patients have waited more than 5 years

since the pain started to be seen in the pain clinic (mean wait of 6 years in national data).

The time elapsed between the GP referral to the pain clinic appointment was 1.96 months in UHL, whereas it was 3.5 months in the national audit.

In summary, we feel that the referral time to pain clinic could be reduced by better awareness and utilisation of pain services. Our data were comparable and better than the national data, though there is room for further improvement. Early referral to pain services has a potential to reduce patients frustration, improve clinical outcome and minimise the overall costs involved in patient care.

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The launch of National Neuromodulation Registry – 2018

Simon Thomson *Consultant in Pain Medicine and Neuromodulation, Basildon and Thurrock University Hospitals NHS Foundation Trust*

The 1 February 2018 may be just a kick and a punch to you, but to all of us at Neuromodulation Society of UK and Ireland (NSUKI) it was the Kick Off of something important. After 10 years, with the collaboration of like-minded NSUKI colleagues, we finally launched the National Neuromodulation Registry (NNR). This has been collaboration between NSUKI and Northgate Public Services (NPS)

NNR is not only a long-term longitudinal observational data source but also a register of devices and patients who are implanted with spinal cord stimulator (SCS) (including dorsal root ganglion), peripheral nerve stimulator (PNS) or intrathecal drug delivery devices (ITDD).

Data fields have been honed to a bare minimum in order to reduce the burden of data collection commensurate with usefulness. It literally takes 5 minutes to input all the data required.

NHS number, demographic detail, diagnosis, severity (EuroQol five-dimensional descriptive system (EQ5D-5L)), occupational status, type of procedure, device model/serial number and anatomical target form the baseline data set with patient global impression of effect, EQ5D-5L and occupational status at follow up.

The governance board includes the following:

1. NSUKI board
2. Representatives from relevant Royal Colleges, Faculty of Pain Medicine, Society of British Neurological Surgeons - FPM and SBNS

3. National Institute of Health and Care Excellence - NICE
4. Medicines and Healthcare Products Regulatory Agency - MHRA
5. National Health Service of England - NHSE
6. Association of British Healthcare Industries - ABHI
7. Patient Representative

The research and publication group is in collaboration with Exeter University and Medical school.

NSUKI have commissioned NPS to provide the NNR system and technology services for the secure recording, storage and reporting of patient data. The NPS Service also captures electronic post-operative patient questionnaires, and this data is linked to the registry. Northgate PS manage many national registries including the National Joint Registry since 2006 and National Vascular Registry since 2014. The establishment of all of the NPS developed registries has involved NPS working closely with stakeholders, industry, the professions, and regulators to develop the process by which information is collected and disseminated. NPS work with external stakeholders to ensure compliance with the requirements of patient confidentiality and information governance.

The NNR is hosted with an NHS server and can only be accessed from NHS sites. NPS' Information Security Management System (ISMS) is ISO 27001:2005 compliant. NPS also operates an ISO9001 compliant Quality

Management System (QMS) providing a complete framework under which we deliver solutions

We live in times where information is essential to provide healthcare.

The aims of the NNR are:-

1. Protect Patients
2. Raise Quality Standards
3. Promote equitable access
4. Support Your Professional Development
5. Support Clinical Audit and Service Review
6. Support Clinical Research
7. Support Value based healthcare

This registry will

1. Track both patients and implants
2. Record activity and compare with NHS data
3. Compare relevant outcomes to baseline over a long time period
4. Provide information relevant to equity of access, diagnosis, device performance, refractory pain time
5. Be a resource for research, service review and clinical audit

Since launch in February 2018 we have 17 Trusts that have started data collecting. We estimate that there are 30–40 centres nationally so we are on the face of it doing well. The aim is to be 75% compliant within the first year. There are many centres that have not yet started to participate and we will be working hard to try to bring them on board.

The launch of National Neuromodulation Registry – 2018

The aim is to attract all centres to participate. We hope that this will be a natural part of your neuromodulation service. If you already collect data on your own databases then if the data are compliant and consent has been collected then bulk drops of data to NNR may be possible if the users want to avoid duplicating database entries.

Although there are other neuromodulation registries around the world, only the NNR is truly national

where the governance, funding and data outputs are secure.

Oge Swaby oge.swaby@northgateps.com is Northgate PS project leader and is your first point of contact in order to get your Super User Log In details. She can also provide necessary information for your Caldicott Guardian and your IT department.

The training video link is <https://www.youtube.com/playlist?list=PLvXZcD1R2ysUtEC98h3zzuCr56wUrgHDA>

The NSUKI NNR team includes Miss Stana Bojanic, Mr Roger Strachan, Dr Ganesan Baranidharan, Professor Sam Eldabe and Dr Simon Thomson.

Under the auspices of ABHI, we collaborated with four device manufacturers for funding grants and product listings – we thank Abbot, Boston Scientific, Medtronic, Nevro and all other stakeholders listed as the governance board.

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We will be sharing relevant information and updates from the Society.

Audit of Medial branch block 1-year outcomes 2010-Dec 2016



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SAGE

Janine Mendham *Pain Consultant Bristol*

Low back pain is responsible for considerable suffering across the world and is responsible for substantial costs in healthcare (1,2). 90% of adults experience low back pain at some time during their life, and if the pain persists more than 3 months it is frequently associated with anxiety and depression that has a huge impact on work and social functioning (3). Many treatments have been tried all with limited success and none with any lasting effect. The recent NICE guidance (4) suggests NSAIDs, codeine and rehabilitation should be recommended as part of a multidisciplinary approach, as this is likely to confer benefit in terms of reduced pain and disability that lasts more than 1 year (5). The current guidance also supports the use of medial branch denervation for people with chronic low back pain when:

- Non-surgical treatment has not worked for them **and**
- The main source of pain is thought to come from structures supplied by the medial branch nerve **and**
- They have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

Diagnostic medial branch blocks to try to make a diagnosis of facet joint-induced chronic low back pain are recommended by the current NICE guideline prior to undertaking radiofrequency denervation.

This paper describes an audit of outcome data of a single pain consultant over a 5-year period where 206 medial

branch diagnostic blocks were undertaken prior to subsequent denervation in 156 patients. A record of all procedures performed was kept and patients were followed up after at least 1 year either by letter or telephone.

Technique Clinical examination

There are no definitive ways of diagnosing pain arising from the facet joints. Criteria usually used are: pain on extension, pain on lateral flexion on the ipsilateral side, pain on rotation and/or pain on palpation over the facet joints. These are the criteria used for this audit. If the patient only had pain on one side they had unilateral blocks, if they had pain on movement in both sides they had a bilateral block. In most cases the medial branches at L3 and L4 were blocked if the patient had non-specific low back pain.

Diagnostic block procedure

An aseptic technique was used and C-arm fluoroscopy was used to confirm the position of the needle; 1% lidocaine was used to numb the skin and subcutaneous tissue and a 22G needle was then positioned. In most cases, L3 and L4 were selected for diagnostic blocks. Each branch was blocked with 1 mL 1% lidocaine. The patient was reviewed about 30 minutes after the procedure and any improvement documented. Improvement on 0–10 scale, 0 being no improvement and 10 being complete pain relief, was documented. A score of 5–10 was accepted as evidence of a positive

diagnostic block, but the majority of patients who had a positive block reported scores of 8/10 or better.

Denervation procedure

The patient was admitted on a separate occasion but usually within a month of the diagnostic block. An aseptic technique was used and C-arm fluoroscopy was used to confirm the position of the needle. 1% lidocaine was used to numb the skin and subcutaneous tissue. An 18G RFL needle was then inserted until contact with bone was made and then positioned between the supero-medial border of the transverse and superior articular processes, and the inferior portion of the lateral neck of the superior articular process at the and the nerve was stimulated at 100Hz and 2Hz. Successful positioning was confirmed when stimulation was felt at less than 0.5V and muscle contraction was seen but there was no leg movement. 1% lidocaine was used to numb the nerve and denervation was carried out for 120 seconds at 80°C. (Baylis RF Generator with Radiopaque radiofrequency cannula).

Results

206 patients had diagnostic medial branch blocks between 2010 and 2016. 156 went on to have denervation. These patients were sent a letter after 1 year to find out how many still had meaningful pain relief.

Of the 50 patients who did not proceed to denervation, 3 (6%) had sustained relief from the local anaesthetic

Audit of Medial branch block 1-year outcomes 2010-Dec 2016

alone and did not require denervation, 42 (84% demonstrated no improvement with LA and therefore did not proceed to denervation, and 5 (10%) did improve but declined or did not attend for denervation. 156 patients proceeded to denervation. Of these 64, (41%) showed no improvement at 6-week follow-up, 42 (27%) were still improved after 1 year, 25 (16%) did improve but the effect ranged from 2 weeks to 11 months with a mean duration of 5.74 months, 5 (3.2%) patients died and 20 (12.8%) could not be contacted.

Overall improvement for >1 year of all patients = 42/206 = 20.4%

Of those who improved <1 year, the mean duration of improvement was

5.74 months with a range of 2 weeks to 11 months.

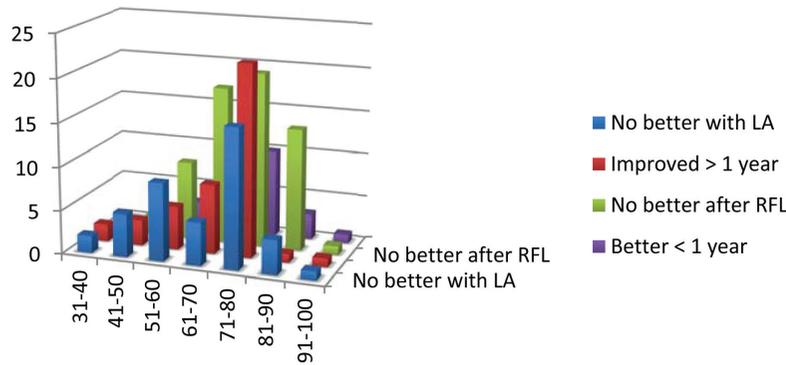
Duration of improvement	Numbers of patients
<1 month	1
1–3 months	4
4–6 months	12
7–9 months	5
10–12 months	3

Age (years)	Local only – no better (N = 42)	Improved >1 year (N = 42)	Improved <1 year (N = 25)	No better after RFL (N = 64)	No reply (N = 20)	Better with LA only (N = 3; no RFL needed)	DNA RFL (N = 5)	Died (N = 5)
31–40	2	2	0	0	0	0	0	0
41–50	5	3	2	2	3	0	0	0
51–60	9	5	3	9	3	0	1	0
61–70	5	8	6	18	5	0	2	0
71–80	16	22	10	20	3	3	1	4
81–90	4	1	3	14	6	0	1	1
91–100	1	1	1	1	0	0	0	0

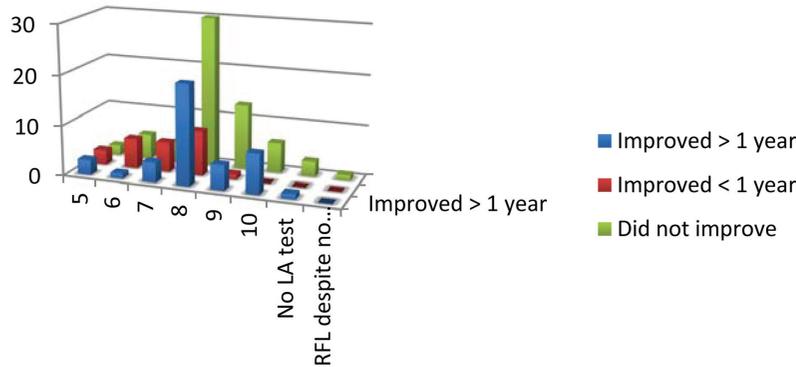
Site	Local only – no better (N = 42)	Improved >1 year (N = 42)	Improved <1 year (N = 25)	No better after RFL (N = 64)	No reply (N = 20)	Better with LA only N = 3 (no RFL needed)	DNA RFL (N = 5)	Died (N = 5)
Right	8	13	7	19	7	2	1	1
Left	8	14	6	14	0	0	2	2
Bilateral	26	15	25	31	13	1	2	2

Improvement after diagnostic block (%)	Improved >1 year after RFL	Improved <1 year after RFL	Did not improve
50	3	3	2
60	1	6	5
70	4	6	4
80	20	9	30
90	5	1	13
100	8	0	6
No local (warfarin)	1	0	3
Patient insisted on RFL despite no improvement with LA	0	0	1

Age of patients



RFL outcomes



Diagnosis of facet joint pain

Degenerative changes of zygapophyseal joints, more commonly known as the facet joints, are thought to account for 10-15% of patients with low back pain (6) There are no symptoms or clinical findings pathognomonic for facet joint pain. Pain referral patterns overlap considerably, and may radiate to the buttocks, thigh, groin and sometimes lower leg, hip and flank. There is poor correlation between MRI findings and response to diagnostic medial branch blocks and there are high false positive rates for diagnostic blocks. False positive blocks range from 25-41%

In 1971 W.S Rees (7) reported 2000 patients in whom he had severed the posterior rami supply of the facet articular

capsule for back pain, using a percutaneous scalpel technique. He reported a 99.8% 'success' rate, which encouraged C. Norman Shealy (8) to use the technique in 29 patients at the Pain Rehabilitation Centre Wisconsin in 1972. He found very striking relief in over half of his patients but 6 patients developed a huge haematoma prompting him to look at less invasive methods of producing the same outcome, denervation.

His management of early back pain was aggressive including electrical stimulation to the back, ice applications, analgesia, acupuncture and bupivacaine injections into the facet joints all taking place during the course of an inpatient stay. They were also encouraged to mobilise. If they had pain for a longer

duration and had become immobile they were given an aggressive therapeutic programme of exercise, biofeedback and autogenic training techniques at least 10 days prior to consideration of facet joint denervation. Facet denervation was not looked upon as a primary therapeutic approach and they felt the psychophysiological oriented programme was essential to accomplish any degree of pain relief. The technique they used was as follows:

A diagnostic block with a 19g spinal needle using 1.5mls 0.25% bupivacaine. A positive block was recorded if there was pain relief for 2-8 hours.

For the denervation they used 1% lidocaine, a 12G needle positioned at L3-4, L4-5, L5-S1 bilaterally. They used a pulse duration of 1 millisecond, at 25pulses/sec and 2-3 volts. Paraspinal muscle contraction was seen routinely. They made 3 lesions at 80-82°C for 50s lesion, first in a lateral central position repeated superiorly and caudally each for 50s.

They demonstrated a long-term benefit in 30-40% patients but commented that 'facet denervation alone is quite inadequate to get most patients rehabilitated and a more aggressive approach of physical exercise and psychophysiological rehabilitation is necessary.'

Radiofrequency denervation

Radiofrequency denervation prevents the conduction of nociceptive impulses through the use of electrical impulses. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves. This focused electrical energy heats and denatures the nerve. This may allow axons to regenerate with time, requiring the repetition of the radiofrequency procedure.

Although many such procedures are carried out in the UK by Pain clinicians and radiologists, there are a number of variations in technique and there is still no high quality evidence for its effectiveness and little information on duration of effect.

Audit of Medial branch block 1-year outcomes 2010-Dec 2016

The length of pain relief after radiofrequency denervation is uncertain. Data from randomised controlled trials suggest relief is at least 6 -12 months but no study has reported longer-term outcomes. Pain relief for more than 2 years would not be an unreasonable clinical expectation. The economic in the UK suggested that radiofrequency denervation is likely to be cost effective if pain relief is above 16 months (4). If radiofrequency denervation is repeated, we do not know whether the outcomes and duration of these outcomes are similar to the initial treatment. (2)

Although pain becomes increasingly more common with age, older people may respond less favourably to denervation. Brewer et al (10) reported of 45 patients (mean age 74 years) undergoing denervation, 57% patients initially reported a favourable outcome but only 23% showed benefit at 10 months. The mean duration of benefit was 3 months. There were no predictors of outcome and none improved after repeat procedure

Consistent with these findings, Juch et al (11) reported the results of 3 randomised clinical trials with chronic low back pain originating in the facet joints, sacroiliac joints, a combination of both, or intervertebral discs, compared with a standard exercise programme. No improvement was seen in the intervention groups above that achieved by the exercise programme after 3 months. Based on this study the authors felt this procedure should not be recommended and should only be used in a research setting. There remains a possibility that radiofrequency denervation could be beneficial in a subset of patients if selection methods could be improved.

The results in this audit show that a diagnostic block did not predict a successful outcome from denervation in this group of patients. A clinical diagnosis of facet joint pain made using current

suggested criteria only resulted in 20% of patients having pain relief for more than 1 year, and even after a positive diagnostic test this only increased to 27%. This finding is similar to that by Cohen et al who compared outcomes of patients with 0, 1, or 2 diagnostic blocks before denervation (9). The study demonstrated that 33% of patients had a successful outcome at 3 months if they had no diagnostic block. In contrast, the percentage success fell to 16% and 22% respectively after 1 or 2 diagnostic blocks. Cohen therefore recommended that it is more cost effective to undertake denervation without a diagnostic block first.

A recent series of papers in the Lancet discuss the major global challenge of low back pain, which is now the number one cause of disability globally (12). Cohen et al (13,14) present the evidence and challenges of prevention and treatment of low back pain and discuss the continued use of treatments without evidence throughout the world wasting health-care resources and subjecting patients to investigations and treatments that do not affect outcome. The NICE guidelines were published prior to the evidence subsequently presented from the MINT studies (11) that do not support the use of medial branch denervation. Treatments shown to be effective include graded exercise programmes to target improvements in function and prevent worsening disability. As low back pain is such a major problem and is getting worse because of the ageing and increasing world population, perhaps it is time to address widespread misconceptions in the population and among health professionals about causes, prognosis and effectiveness of different treatments for low back pain, and deal with fragmented and out-dated models of care (15).

In summary, the data presented here demonstrate that facet joint denervation alone does not appear to be beneficial in the long term for the majority of patients.

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‘A practical guide to incorporating pain education into pre-registration curricula for healthcare professionals in the United Kingdom’: the new BPS pain education free-to-access webbook

Sailesh Mishra *Chair, Pain Education Publication Working Party*

Dear Friends,
I am excited to inform you of the launch of the British Pain Society’s teaching document ‘A Practical Guide to Incorporating Pain Education into Pre-Registration Curricula for Healthcare Professionals in the United Kingdom’.

For those of you who attended the British Pain Society’s Annual Scientific Meeting (ASM) in Brighton last month, you may have noticed the fliers about this document’s launch event. This exciting new pain education document had its launch event at the general body meeting at the ASM. This document is aimed at serving as a reference point and as a useful resource for pain educators in their academic and clinical roles. This webbook contains several educational tools and techniques for teaching pain management to pre-registration healthcare professionals across different specialities, including doctors, nurses, physiotherapists, psychologists, pharmacists and other allied healthcare professionals.

This document has had an interesting journey. It was created from a pool of ideas from an educational task force of the BPS back in 2013. It progressed further under the umbrella of the Pain Education Special Interest Group (SIG) of the British Pain Society in 2013. Keeping with the changing times and the

changing focus of pain education in the past few years, this document was edited and updated further to keep it relevant in the current time. Allow me to stress that while this document is by no means a one stop handbook of pain education, it is a very useful resource and guidance tool for healthcare professionals across multiple specialities involved in various level of interdisciplinary pain education.

With this year 2018 being celebrated by the International Association for Study of Pain (IASP) as the Global Year for Excellence in Pain Education, the launch of this document at the BPS ASM is very timely. Following on from the earlier draft of this document, the British Pain Society’s Pain Education SIG constituted a working party that took on the responsibility of content editing, communication with the stakeholders, public consultation, content finalisation, seeking approval of the BPS Council and transfer to an easily readable free-to-use electronic format and the launch of this webbook at the general body meeting at the ASM. We changed the phrasing in the title of the document from ‘Undergraduate’ to ‘Preregistration’ to acknowledge that in certain professional curriculums, students completed their graduation and even post-graduation courses before proceeding with their

professional registration. When the content editing was completed, we wanted this document to be available to all healthcare professionals and educators in pain management in an easy readable format. We felt having it in an interactive webbook format would be the most preferred and cost-effective way. Our most sincere and heartfelt thanks to Dr Amelia Swift, Senior Lecturer in Nursing at University of Birmingham, her colleague Ms Marjorie Collaco and the University of Birmingham for supporting us with their valuable time and resources that made the creation of this interactive webbook possible.

I would request you to have a look at the interactive webbook and use it as a reference point for your day-to-day teaching in pain management. While its content is pitched at pre-registration students in general, its use can be extended to build initial concepts for teaching pain management to Healthcare Professionals at higher levels. This document has a useful list of suggested reading materials as well as references and external links that can help build up and reinforce key concepts in pain management education.

We have suggested a feedback process and we would be grateful to you if you could send us your feedback via the British Pain Society.

Phase 1: Original Working Party members

Nick Allcock (Chair), Neil Berry, Eloise Carr, Justin Durham, Alison Griffiths, Sarah Henderson, Roger Knaggs, Katherine Murphy, William Notcutt, Ian Power, Ian Semmons, Ann Taylor, Alison Twycross, Maggie Whittaker and Paul Wilkinson

Following changes in SIG Committee membership, a second working party edited the document and provided additional content:

Phase 2: Completion Working Party members

Sailesh Mishra (Chair), Emma Briggs, Joanne Etherton, Amelia Swift, Kate Thompson

The Pain Education Special Interest Group would also like to thank and acknowledge the contributions from Patricia Roche, Sharon Wood and members of both the SIG and BPS. We are grateful for the additional authors who shared their educational practice and experience:

Additional authors

Sally Curtis, Laura Dennison, Kathleen Kendall, Paul Kinnersley, Helen Makins, Elizabeth Metcalfe, Pete Moore, Mike O'Connor and Marcia Schofield

Terminology

The terms *undergraduate* and *pre-registration* are both used in this document to describe the formal programme of study for healthcare professionals that lead to entry onto a register with a regulatory body such as the Health & Care Professions Council and Nursing & Midwifery Council. Some disciplines also have a pre-registration programme at Master's (postgraduate) level, and the recommendations for this document equally apply.

Why this document is needed?

This curriculum set out to be interprofessional and was created by a multiprofessional group who share a keen interest in promoting effective and innovative pain education. This document provides a British perspective on a global pain management issues and makes use of a wide range of case studies to help promote engaging, enjoyable and, where possible, interprofessional pain education.

How to use this document?

This document is developed as a useful guide and reference source to pain educators who teach pre-registration healthcare professionals in multiple specialities within their clinical and academic roles. While this is by no mean an exhaustive textbook to pain education, it is aimed at providing educators with practical strategies to maximise the learning outcomes of their target participant groups, and there is a list of additional resources for further reading and continued professional education.

At the time of going to press for this edition of pain news, we were into the process of finalising the interactive webbook link in the British Pain Society Website. Please go to <https://www.britishpainsociety.org/> and search within 'preregistration education'.

Increasing access to psychological therapies and pain services

Zoey Malpus *Manchester University NHS Foundation Trust, Manchester, UK*

Amanda C de C Williams *University College London, London, UK*

Several British Psychological Society (BPS) members have raised concerns with Council regarding local developments where pain services were being offered by increasing access to psychological therapies (IAPT), competing at the commissioning level but providing a less than expert service and providing only psychological rehabilitation, with no medical or physiotherapeutic input. The two psychologists on Council, Zoey Malpus (elected) and Amanda Williams (co-opted), were asked to investigate and report back.

Before we describe what we found, and what is happening now, some readers will need a little background to IAPT. It stands for 'Increasing access to psychological therapies' and was an initiative by the last government to provide more accessible evidence-based help with anxiety and depression problems, with a shorter wait, from therapists trained for a year in cognitive-behavioural therapy techniques. Established in 2008, this has largely been successful, with good results and shorter waits to start treatment. The current *Five Years Forward View* for the National Health Service (NHS) includes the decision to extend the remit of IAPT services to the psychological needs associated with long-term conditions and 'medically unexplained symptoms', such as diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular problems, chronic fatigue

and chronic pain. In 2018/2019, all Clinical Commissioning Groups (CCGs) are being asked to recruit additional staff and commission Improving Access to Psychological Therapies–Long-Term Conditions (IAPT-LTC) services, with additional baseline funding from April 2018.

We are all aware of the huge gap between available pain management services that provide psychological help and the number of people with chronic pain who could possibly benefit, even if not requiring a full-scale pain management programme. So, in principle, this seemed a good way to extend pain provision, but *only* if patients are appropriately triaged according to need, through liaison with existing multidisciplinary team (MDT) pain services, and if IAPT workers were adequately trained in understanding pain (and other long-term conditions). The first and second waves of extension into long-term conditions were almost exclusively for diabetes, COPD and cardiovascular problems. The third wave is just beginning, expanding considerably the number of services that offer help with chronic pain.

However, the two 'ifs' above seem not to be met in all cases. In some areas, there is good liaison between existing MDT pain services and the IAPT service, resulting in appropriate allocation of patients to services, as envisaged in the Implementation Guidelines recently released (<http://www.rcpsych.ac.uk/>

workinpsychiatry/nccmh/mentalhealthcarepathways/improvingaccess.aspx), where there is considerable emphasis on working collaboratively with existing specialist MDT pain services. In other areas, despite concerted attempts by pain management centres, liaison with IAPT-LTC services has not proved possible. These were types of concerns raised by BPS members and Council have asked to be investigated further. Hannah Twiddy recently devised a BPS member survey, and this again highlighted examples of poor liaison with existing MDT pain services and in some cases direct competition, clearly at odds with national implementation guidance.

Recent discussion with the IAPT-LTC national development team confirms that they too are concerned and keen to know specific details about these difficulties in an effort to try to improve the situation.

More worryingly, the roll-out to LTCs envisaged a 10-day advanced training for IAPT workers which is not compulsory and so is not routinely used. It is not clear that this provides enough understanding of pain, and we were particularly concerned to see chronic pain labelled in the implementation guidelines above not as a long-term condition, but as 'medically unexplained'. This has been raised at the highest level in IAPT, where there is agreement that this is completely inappropriate, but there is a determined lobby behind the

Increasing access to psychological therapies (IAPT) and pain services

guidelines that refuses to engage with the last 50 years of pain science and continues to hold that anything not visible to the naked eye or radiography starts and ends in the head and can be safely diverted away from pain expertise: this includes all neuropathic pain, post-stroke pain, and many other problems that we routinely treat with all the resources of the pain clinic. In late March, we took part in a webinar for IAPT clinical leads keen to develop pain pathways, and we hope that we will be

able to contribute more to training over the next months or years. Our concern is not only that patients are poorly served, and often drop out of treatment early feeling (justifiably) that their pain is not understood, but also that it can inoculate them against future referral to and engagement in well-informed psychological intervention for pain management.

So, please let the BPS know if you are having difficulties locally with collaboration with IAPT-LTC services and

direct them to the implementation guidelines; also, do not hesitate to offer training and supervision on pain and to discuss what they are offering and where it may fall well short of the evidence base. We would strongly encourage you to make links with your local IAPT-LTC service. Only by engaging in such collaboration can we hope to identify the areas of unmet need and encourage them to use the additional funding to best model local services for the benefit of patients with persistent pain.

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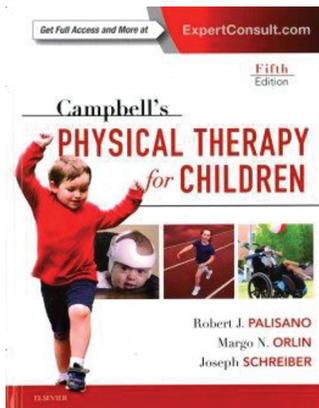


Please follow the Society on twitter **@BritishPainSoc**
We will be sharing relevant information and updates from the Society.

Book review



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Campbell's Physical Therapy for Children Expert Consult, 5th Edition.
Authors: Robert J. Palisano, Margo Orlin & Joseph Schreiber.
ISBN: 9780323390187

Reviewed by Ruth Bayliss,
Specialised Paediatric Physiotherapist

Campbell's Physical Therapy for Children, fifth edition, by Robert J. Palisano, Margo N. Orlin and Joseph Schreiber is an extensive textbook outlining and detailing the vast scope of paediatric physical therapy. The exhaustive list of conditions that can affect children from birth to adolescence makes producing a textbook that is as comprehensive and detailed as the 34 chapters of *Campbell's Physical Therapy for Children*, fifth edition, are, seem even more outstanding.

Upon reading the very first sentence of the Preface, my interest, as a practising clinician, was piqued. It became apparent that this textbook was written and edited with an intended purpose. The editors set out to produce a textbook with the aim of informing clinicians not only about the different

kinds of conditions they are likely to come across in paediatric physical therapy but also about the ways in which, as a clinician, one can apply this knowledge and evidence in the practical setting. The editors aim to take the core skills of a paediatric physical therapist such as clinical reasoning and decision making and guide the reader in the ways in which these core skills can be enhanced with greater knowledge. They aim to emphasise the importance of integrating evidence and research in day-to-day practice and how the information provided in the textbook can be used to further an individual's clinical practice.

The textbook is divided into five key sections; Section 1 Understanding Motor Performance in Children, Section 2 Management of Musculoskeletal Conditions, Section 3 Management of Neurological Conditions, Section 4 Management of Cardiopulmonary Conditions and Section 5, which is newly added in the Fifth Edition of Campbell's Physical Therapy for Children, Special Settings and Special Considerations. The first four sections beautifully explain the different specialities within paediatric physical therapy, whilst outlining the relevant conditions associated within these specialities. The fifth section is a fantastic addition to the textbook. It highlights key philosophies of treating children, encouraging the clinician to treat more holistically and see the child rather than the condition, taking into account all the biological, social, environmental factors that play a key role in the effectiveness of any paediatric physical therapy intervention.

Each section of the textbook is thorough in its explanation, but remains clear, logical and easy to interpret with

the assistance of visual learning aids, pictures, medical photography and diagrams. Whereas some textbooks can overwhelm and confuse the reader with large bodies of text and lengthy, academic sentences, *Campbell's Physical Therapy for Children*, fifth edition, is written in a factual, easy to read manner, giving the reader time to absorb the information and then allow this information to be consolidated further with the use of supporting diagrams or pictures. My one critique of this textbook is that the pictures and photographs used are at times unnecessarily dated, which in today's technologically advanced world can sometimes lose the desired effect. I think it may be something to consider updating for any further editions. It can be hard to achieve the editors' aim of translating knowledge to practice when faced with a black and white photograph of an infant from decades gone by.

The textbook itself is well structured and each of the five sections is clearly signposted. It is easy to pick out relevant areas of interest and turn to the correct page, making it a great point of reference for any clinician in need of a thorough yet concise explanation of a particular condition. This ease of finding information is further enhanced by the colour-coded sections providing an aesthetically appealing textbook while also proving helpful in finding a desired point of reference quickly and with ease.

The five sections are further organised into smaller chapters, each detailing different areas of interest and specialism within the section heading. The spacing of paragraphs, different font sizes and colours used within the

chapters make finding a particular topic or piece of information very easy. It is so well thought out and visually appealing that it does not lose the reader despite the level of detail within the text itself. It appears no corners were cut when writing and producing this textbook.

The thing I found most enjoyable about *Campbell's Physical Therapy for Children*, fifth edition, is the thought behind who the readers are. Most people reading this textbook will be physical therapists and experienced clinicians who have already worked as physical therapists prior to specialising in

paediatrics. The textbook authors have understood this fact and pitched it at exactly those clinicians. This makes it different from other physical therapy textbooks, because it describes and explains using clinical reasoning. It focuses on key skills such as decision making, service needs, goal and outcome-based interventions. The reasoning and evidence base for clinical decisions is used throughout the textbook. It is exactly this kind of ability to translate knowledge into practice that is required for clinicians and Campbell's textbook does exactly that with ease, accuracy and an understanding of the

modern day practice of paediatric physical therapy.

In summary, it is an outstanding textbook that fulfilled the intentions of the editors. It presents a detailed, accurate and up-to-date summary of paediatric physical therapy for the modern day physical therapist. A well thought out textbook that recognises its readers' existing skills and requirements and understands the need for all clinicians to be well-rounded professionals who know the importance of using a much-needed combination of knowledge, research, evidence and practical skill in the treatment of children.

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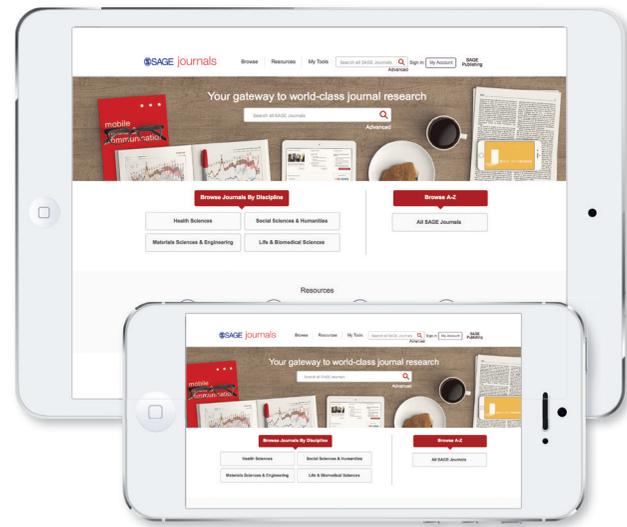
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