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PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

A different perspective on pain

Are men difficult to engage in pain self management?

Oxycodone in children

Training on pain management for neonates, children & young people

ISSN 2050–4497

TASTER VERSION

The British Pain Society

THE BRITISH PAIN SOCIETY
An alliance of professionals advancing the understanding and management of pain for the benefit of patients

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THE BRITISH PAIN SOCIETY
PAIN NEWS

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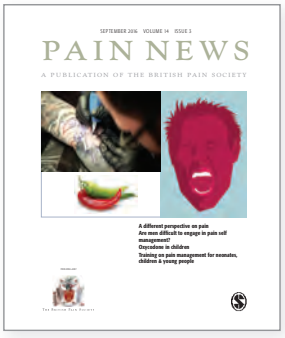

The Editor welcomes contributions including letters, short clinical reports and news of interest to members, including notice of meetings.
Next submission deadline : 30th September

Material should be sent to:

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https://www.britishpainsociety.org/for-members/pain-news/

Regulars

News

Professional perspectives - Margaret Dunham, Associate Editor

Informing practice - Christina Liossi, Associate Editor

End stuff

British Pain Society Calendar of Events

To attend any of the below events, simply book online at:
www.britishpainsociety.org/mediacentre/events/

2016

Patient Liaison Committee Annual Seminar
3rd November 2016
Churchill House, London

Headache SIG Annual Meeting
16th November 2016
Churchill House, London

2017

50th Anniversary Annual Scientific Meeting
Wednesday 3rd – Friday 5th May 2017
Birmingham

Put the dates in your diary now for this flagship event – the 50th Anniversary Annual Scientific Meeting of the BPS. We are putting together an exciting and stimulating programme and will be announcing plenary speakers and parallel session topics in the near future. The ASM is a great opportunity to:

- Network with colleagues
- Keep up to date with the latest cutting edge research and developments relevant to pain
- Raise questions, partake in debates and discuss outcome
- Meet with poster exhibitors and discuss their research

For regular updates please visit: https://www.britishpainsociety.org/2017-asm-birmingham/

Philosophy & Ethics SIG Annual Meeting
26th to 29th June 2017
Rydall Hall, Cumbria

This meeting promises to be a most stimulating conference considering the power of the human mind in pain. It will be held at Rydal Hall near Ambleside in the Lake District and during the conference there will be time to explore the gardens and grounds of the hall as well as the beautiful surrounding lakes and hills.

Further details for all our meetings can be found on our events listing page:
www.britishpainsociety.org/mediacentre/events/

Editorial

THE BRITISH PAIN SOCIETY

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SAGE

Dr Arasu Rayen *Editor*

pns.rayen@gmail.com

I hope you have had wonderful summer. it has been an eventful one in this ever changing dynamic world. One week it was sweltering heat up to 36°. The very next day the temperature plummeted to 14°. We had the European Union (EU) membership referendum which led to a change in Prime Minister. Hillary Clinton and Donald Trump were nominated as candidates for Presidential election in the United States. We had our own event as well - the 2016 Annual Scientific Meeting (ASM) in Harrogate, which was a great success. There are written and photographic evidence in this issue of *Pain News*. Both the academic and social programmes were wonderful. Brock Bastian, one of the plenary speakers, has kindly written on 'different perspectives on pain'. This was the topic of his talk. As specialist in pain management, we rarely think about the 'different aspects of pain'. Brock talks about positive effect of pain, about people who seek out pain for reward. He asks us to think about people who get pleasure from pain – people who have tatoos and body piercing. He has written this article on the same topic. Please read it; you won't be disappointed.

We all have the experiences of dealing with different patients – demanding, unreasonable, with unrealistic expectations, angry and frustrated. In this issue, Sandeep Kapur has written an article titled 'Game Theory in Pain Clinic'. It examines the science of conflict or cooperation between rational individuals. He explains the theory and helps us to understand how it applies to us in pain clinic. It is thought-provoking.

Next year, 2017, is the 50th year of Annual Scientific Meeting. To mark the anniversary, *Pain News* is planning make the March 2017 issue a special edition focusing on the ASM. Leading up to this, from next issue onwards, we are planning to publish more articles and photographs on yesteryears of BPS and ASM. May I request all of you to send me any information or photographs of previous years' ASMs. The 2017 ASM is going to be a huge success in Birmingham. Please book your study leave for this meeting.

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Feedback from the Annual Scientific Meeting 2016

Kate Seers *Chair of the Scientific Programme Committee*

First of all, before I go on to the actual feedback from 2016 Annual Scientific Meeting (ASM), I would like to inform you that the Scientific Programme Committee (SPC) is starting to work on the ASM programme for 2017, *our 50th ASM*, so really something to celebrate together.

We will welcome your poster abstracts for that meeting. We really want to accept as many as we can, so please follow the poster abstract submission guidance to give you the best chance of being accepted (https://www.britishpainsociety.org/2017-asm-birmingham/poster-exhibition/.) The online submission will open in September and close on Monday 12th December 2016.

2016 ASM at Harrogate was a resounding success. I'd like to summarise the very helpful feedback that was provided on the ASM 2016. Thank you to the over 350 people who submitted feedback; we had 71 pages of feedback, all of which I have read with care.

First, I would like to thank all our plenary speakers, those who ran and spoke at workshops and those who presented their posters for their contributions. Most comments about the meeting were very positive.

Plenary sessions: It was encouraging that on a 1–5 scale from poor to excellent, all of the plenaries were rated on average around 4 or above. However, it is also interesting to note the spread of responses, with most plenaries attracting the full range of scores from 1–5.

I am really pleased to report just some of the positive comments made about the whole range of plenary speakers: *well set out and contemporary; fantastic overview; really helpful for my clinical practice; relevant and informative; visionary and thought provoking; extremely relevant; fascinating insights; stunning delivery and content; this was a wonderful session; appealed to a variety of levels, excellent; engaging speakers and interesting topic; clear and concise, a good demonstration of how to give a lecture; made a complex subject easy to understand; fabulous broad ranging insights*.

If you didn't make it last year, then I hope this feedback on the ASM will encourage you to come in 2017!

As in previous years, the student/trainee oral presentations were very well received: *really good quality of presentations and good to hear from emerging experts; the quality of the talks was phenomenal; excellent session an absolute must keep*.

Parallel sessions were mostly well rated averaging around 4, but again often a diverse range of views from 1–5 (poor to excellent): *a good sleeves rolled up practical session; made me want to rush back to work and start something; this actually felt like CPD and I'd love more of this at the ASM*.

There was feedback around wanting more interactive parallel sessions where there was plenty of time for discussion, and we will be emphasising this even more strongly to our parallel session presenters again for next year's ASM. There were also requests for more clinical sessions, which we will take into account as we plan for 2017.

A new initiative in 2016

We started oral presentation of the top-rated poster abstracts from those who are not trainees or students in response to your feedback for the first time. These were very well received with 95% who attended these sessions wanting this to continue.

General feedback

In all, 40% felt there were enough clinical sessions and 47% would like more. Most (85%) felt the poster viewing time is about right.

At times feedback was conflicting: *too much science; not enough science; make it more multidisciplinary – heavily focused on medics this year; needs of physicians are being submerged in an attempt to satisfy the non-medical group; talks better for a multidisciplinary audience this year*.

It was fed back that some speakers forgot the audience was largely not research based. We will re-emphasise to all speakers that the clinical implications are crucial to consider in all presentations.

Encouragingly, 86% felt something they'd learnt at the ASM would change their practice and many people talked about how they valued the networking opportunities.

People were very complimentary about the organisation of the meeting. Thank you to all in the Secretariat for all your hard work to make the meeting run smoothly.

Views on food this year ranged from good food to dreadful food, but most

people thought the food was better this year.

There was a strong theme of wanting a less expensive meeting, and a small proportion of people would prefer a 2-day meeting or end at lunchtime on the last day. Most people valued the social gathering, but felt it had been somewhat crowded on this occasion.

Having presentations online was requested, and a feedback survey that could be saved as you went along was requested. Overall, 97% would recommend the ASM to a colleague, which was very encouraging.

There were many good suggestions for the 50th ASM 2017, and the SPC will be working hard to consider these suggestions.

Thank you to the 2016 SPC for all your hard work on behalf of the British Pain Society, and I look forward to developing the 50th Anniversary ASM with our Committee for 2017.

Congratulations to all the prize winners at the 2016 ASM

Student/trainee prize paper presentations

These were the highest scored abstracts from all those submitted by students/trainees:

1st Prize – Rhiannon Edwards
2nd Prize – Katelynn E. Boerner
3rd Prize – Muna Adan
Runners up – Kristy Themelis and Hannah Durand

Thanks to the judging panel for these prizes who were Professor Nick Allcock (chair), Dr Heather Cameron, Dr Gillian Chumbley and Professor David Walsh.

The People's Choice award went to Fiona Owen (poster 98).

Non-student/trainee prize paper presentations

These were the top-rated poster abstracts submitted by those who are not students/trainees, and the prizes were awarded (in no particular order) to Janet Bultitude, Richard Harrison, Alison Llewellyn and Candy McCabe. Thanks to the judging panel for these prizes who were Dr Lesley Colvin, Dr Gillian Chumbley, Professor Kate Seers (chair) and Professor David Walsh.

I look forward to seeing you at the 50th ASM in Birmingham in 2017.

Have your say and contribute to *Pain News* today

Pain News is the Members newsletter and as such we encourage and welcome 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
December 2016	30 September 2016
March 2017	2nd January 2017
June 2017	31st March 2017
September 2017	30th June 2017

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Poster abstract submission – 2017 Annual Scientific Meeting

Dear Colleagues,

You are invited to submit poster abstracts for exhibition at the 50th Anniversary Annual Scientific Meeting (ASM), 3–5 May 2017 in Birmingham.

We really want to accept your abstract! We would like to accept as many high-quality posters as we can for the ASM. Many delegates really value the discussions that take place and new contacts they make when viewing the posters. Make sure your poster is one of the ones on display. All types of high-quality research relevant to pain are welcome. To view the simple tips for writing a good abstract, please visit the following link: https://www.britishpainsociety.org/static/uploads/resources/files/Tips_for_writing_a_good_poster_submission_for_the_ASM_Kate_Seers_PN.pdf

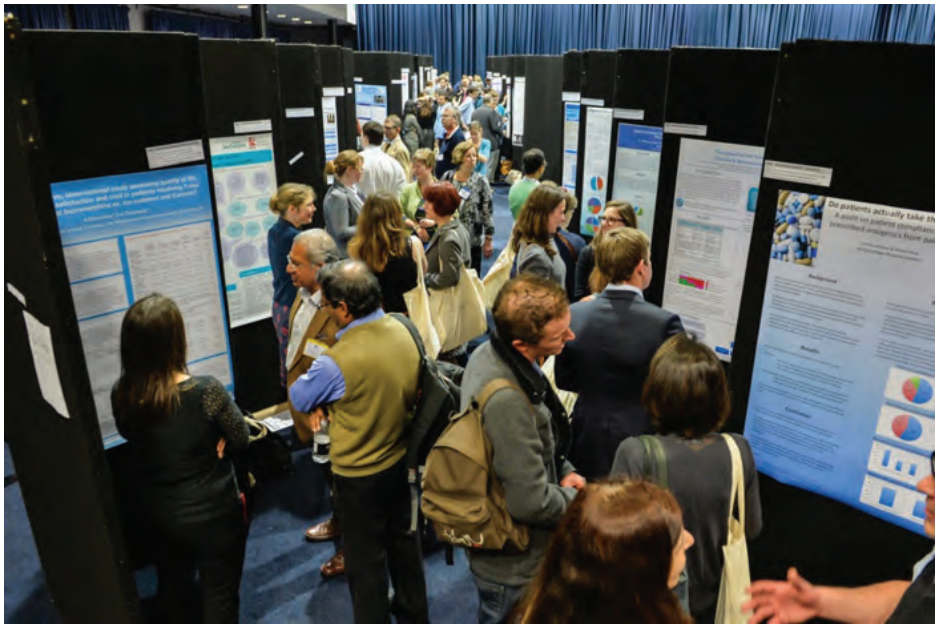
All abstracts will be reviewed by the Scientific Programme Committee subject to review; those accepted will be invited to exhibit throughout the meeting and will be published as a supplement to the *British Journal of Pain*, which will be available as a hard copy in the conference pack and electronically for members to download from the website at the conclusion of the ASM.

The most highly rated poster abstracts will be invited to present their work orally at the ASM.

The deadline for submission is Monday 12th December 2016 at midday (12:00).

To submit an abstract and to view the poster submission guidelines, please go to our website: https://www.britishpainsociety.org/2017-asm-birmingham/poster-exhibition/

Again, this year, we will have prizes for best poster prize presentations by trainees/students, People's choice award and the best oral poster presentations. For further information, please visit the following link: https://www.britishpainsociety.org/2017-asm-birmingham/poster-exhibition/



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Are men more difficult to engage in Pain Self-Management? A two-part study looking into the gender split among people attending the Pain Self-Management Service in Gloucestershire and Herefordshire

Emelie Hasselgren *Psychology Placement Student, Gloucestershire and Herefordshire Pain Management Service, Gloucestershire Hospitals NHS Trust; BSc Psychology Student, Aston University*

Katie Parker *Psychology Placement Student, Gloucestershire and Herefordshire Pain Management Service, Gloucestershire Hospitals NHS Trust; BSc Psychology Student, Cardiff University*

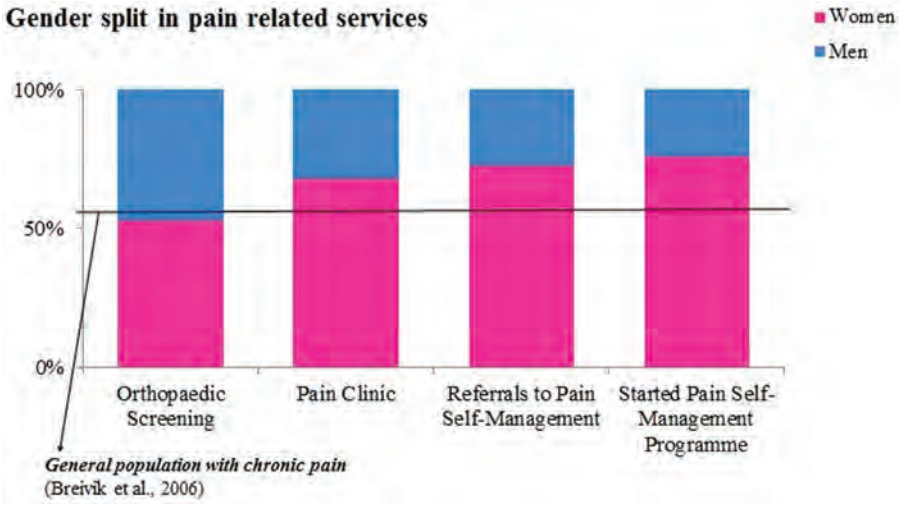
Polly Ashworth *Consultant Clinical Psychologist, Gloucestershire and Herefordshire Pain Management Service, Gloucestershire Hospitals NHS Trust*

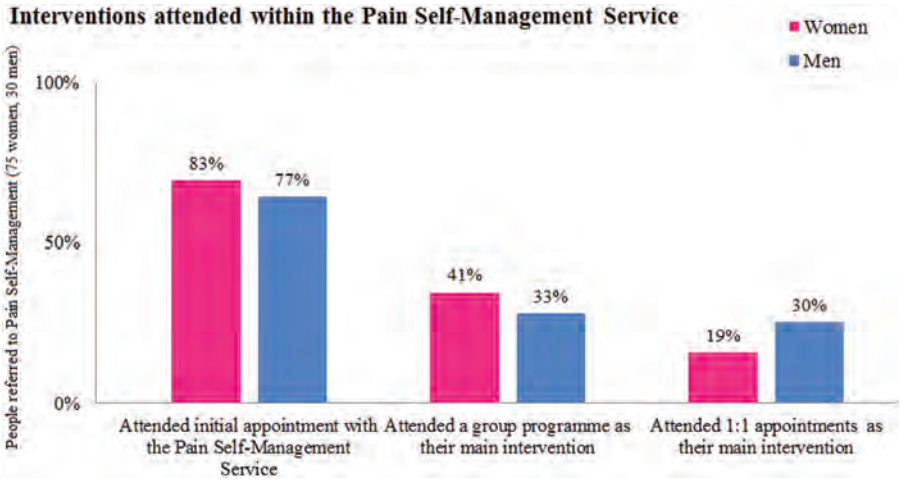
The prevalence of chronic pain in the general population is estimated as 44% men and 56% women.[1] At the Gloucestershire and Herefordshire Pain Self-Management Service, we noted that people attending our group programmes were predominantly women and we had no information about the gender split among people who chose to attend on a 1:1 basis. Pain self-management improves quality of life for people with chronic pain,[2] and it is important that men and women are equally able to access the service, even though men have been described as 'hard to reach' when it comes to engaging them in self-management support.[3] Masculine ideals and socio-cultural expectations may influence men's health behaviours.[4] We were concerned that we were being less successful in engaging men in our service. We conducted a two-part study trying to investigate why we did not see as many men as women in our Pain Self-Management Programmes.

Method

In order to get an overview of the gender split in a number of pain services, we first used a cross-sectional study to look at activity at Orthopaedic screening (n = 1,109), activity at Pain Clinic (n = 2,057), referrals to the Gloucestershire and Herefordshire Pain Self-Management Service (n = 1,016) and people starting Pain Self-Management Programmes in Gloucestershire and Herefordshire (n = 266), during the financial year 2014–2015.

Second, a cohort study followed every third patient referred to the Gloucestershire and Herefordshire Pain Self-Management Service between August and October 2014. We mapped the treatment pathways of a total of 105 people (75 women and 30 men). The





treatment pathways consisted of initial referral, interventions attended, completion of main treatment intervention and discharge from service. This enabled us to compare the uptake of different interventions available in the service between men and women.

Results

We found a fairly equal gender split in patients attending Orthopaedic Screening (47% men and 53% women), and this was near to the general population estimate. However, a larger gender split was found among people attending Pain Clinic (32% men and 68% women), referrals to Pain Management (27% men and 73% women) and attendance at our Pain Self-Management group programmes (23% men and 77% women). Thus, the gender split seen in Orthopaedic Screening and the general population estimate is not reflected in the gender split in people attending Pain Self-Management group programmes.

Looking at our cohort of 105 people, referred between August and October 2014, a similar gender split of the referrals to Pain Self-Management was confirmed, that is, 29% men and 71% women. This means that our Pain Self-Management Service receives over twice as many referrals for women than men. The level of service uptake was equivalent between men and women, indicating that once referred, men and women are equally likely to engage in an intervention (77% men and 83% women attend their initial appointment with the service, that is, introduction session or assessment appointment). When looking at the different treatment interventions, 33% of men and 41% of women referred to our service decided to start a group programme. Also, 30% of men and 19% of women attended 1:1 appointments as their main course of intervention. Even though the proportion of men and women are similar, we can see that women are slightly more inclined to attend a programme, whereas men are more likely to attend 1:1 appointments. This, alongside with the big gender split in referrals may explain why we see fewer men on our programmes.

Conclusion

Our investigation shows that fewer men are attending our Pain Self-Management Programmes mainly because of the high gender split in referrals to the service (29% men and 71% women). Although fewer men attend programmes than expected from general population estimates, we found that once people are referred to our Pain Self-Management Service, men and women are equally likely to attend an intervention, which is reassuring given that it is recognised that men can be more difficult to engage.[3] Analysis of the treatment pathways through the service revealed a slightly higher percentage of women attend a programme as their main course of intervention, and a slightly higher percentage of men attend 1:1 appointments. No particular approach of self-management support has been identified as most effective for engaging men.[4] It would be useful to have a better understanding of the factors underlying

these preferences to why women and men prefer different types of interventions.

The gender split in Pain Self-Management referrals reflects the population attending Pain Clinic, but interestingly not for the orthopaedic screening service which, for some, is earlier in the treatment pathway. The next step would be to investigate the influences on referral patterns which result in fewer men attending the Pain Clinic which is a key source of referrals to the Pain Self-Management Service. This would identify ways in which we could ensure that Pain Self-Management is equally accessible to both men and women.

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Applying Game Theory in the pain clinic

The British Pain Society

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SAGE

Sandeep Kapuur *Consultant in Pain Management, Queen Elizabeth Hospital, Birmingham*

Game Theory is a term used to study the science of conflict or cooperation between rational individuals. A classic Game Theory scenario, the prisoners' dilemma, plays out as follows:

The police arrest two men (A and B) on suspicion of armed robbery, though they lack enough evidence to convict them in court. The men are taken to separate cells for questioning and have no means to contact each other. The police then individually offer prisoner A and prisoner B the following deal:

- The prisoner who turns informer and cooperates with the police walks free, while the one who stays silent and refuses to cooperate gets 10 years in prison.
- Both prisoners confess to their crime and get 5 years each in jail.
- Both men stay silent and get 1 year imprisonment apiece on a less serious charge.

On the face of it, the prisoners' choice appears straightforward enough: they both keep their lips sealed and walk free after 1 year in prison. However, lack of mutual trust invokes the 'prisoners' dilemma': unable to communicate with one another, each prisoner fears that if he keeps quiet and the other confesses, then he will spend 10 years in prison and the other will walk free. This then pushes them to separately choose the 'least bad' option: both confess to their crimes and get handed 5 year sentences. The prisoners' dilemma therefore represents an aspect of Game Theory in which the 'players' fail to cooperate with each other (non-cooperative gameplay) and end up getting a relatively worse deal than if they had cooperated to achieve a better outcome for both parties.

While Game Theory has wide-ranging applications in mathematics, economics, computers and many other fields, it has increasingly been recognised as having value in understanding the complex dynamics underpinning doctor–patient interactions as well:

> *I know I'm addicted to (opioids), and it's the doctors' fault because they prescribed them.*
>
> *But I'll sue them if they leave me in pain.*[1]

The current healthcare zeitgeist of 'all pain is treatable' pushes the patient to seek and the clinician to prescribe opioids. The fear of being at the receiving end of a patient's complaint reduces the clinician's motivation to confront the patient's opioid-seeking behaviour; the patient in turn uses this fear to his or her advantage to achieve his or her goal. Moreover, prescribing is quicker and relatively easier than a prolonged, difficult consultation focused on patient education and counselling. A lack of trust in each other means that both patient and doctor end up as losers in this zero-sum game.[1]

In their recent paper 'Modern Health Care as a Game Theory Problem', Djulbegovic et al. describe how the conflicting demands of healthcare provision (limited resources and time) and patient needs (rising healthcare costs and expectations) collide to create the 'perfect storm'. They state, '*In times of financial and overall societal uncertainty, all stakeholders are struggling to exploit healthcare systems to serve their own interests best*'.[2] In other words, both play the strategy most suited to their interest and chose the 'least bad' option, much like the prisoners' dilemma scenario described above. This outcome is termed the

'Nash equilibrium', named after the Nobel laureate John Nash, played by Russell Crowe in the Oscar-winning film 'A Beautiful Mind'.

So, how then do we escape the prisoners' dilemma in doctor–patient relationships? The answer lies in building trust between patients and doctors: trust leads to collaboration and better outcomes for both parties, resulting in greater satisfaction for both the patient and the doctor. As Tarrant et al.[3] state in their paper 'Models of the Medical Consultation: Opportunities and Limitations of a Game Theory Perspective',

> *In the context of the consultation, mutual cooperation becomes a more attractive prospect if future interactions are anticipated. There are incentives for the doctor to spend time finding an appropriate management approach: consultations with the same patient in the future are likely to take up less time and the doctor will have the satisfaction of carrying a management plan through to completion. The patient is likely to follow through with the treatment if there is an expectation that the doctor will monitor his progress in the future. Both the doctor and the patient can anticipate future payoffs from this mutual cooperation, and this model implies that higher quality of care can be achieved when the patient sees the same GP repeatedly.*

All this makes eminent sense of course, but runs contrary to the NHS-wide push to reduce follow-ups. 'See, treat and discharge' within 18 weeks is the new mantra. In my view, the 18-week 'referral-to-treatment' model is therefore uniquely unsuited to the complex circumstances of the pain clinic; while this strategy may help reduce waiting times, it does not allow time to build trust between the patient and the clinician, which is vital to working collaboratively and escaping the prisoners' dilemma.

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