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PAIN NEWS

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NICE and Pain Medicine: not so nice?

Pain: a neurological viewpoint

Women in Pain Medicine

Self Management of chronic pain in a time of Covid

Virtual medical consultations

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PAIN NEWS MARCH 2021

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Editorial

- 2 Treating pain nicely, part 1: the unique nature of perception and towards effective utilitarianism

In this issue

- 5 In this issue – Jenny Nicholas

From the President

- 6 President's message – Arun Bhaskar

Articles

- 8 Self-management – abandonment or empowerment
11 Women in neuromodulation UK [WINMOD UK] report
17 A snapshot of patient satisfaction with virtual consultations in community pain in East London

Perspective

- 20 Remote pain clinics consultations from patient and carer perspectives
21 Post-traumatic pain: a neurological perspective

Response

- 36 The end of pain medicine as a professional specialty? A response to NICE and its managerialist attitude

Commentary

- 38 The NICE guideline on chronic pain – the NICE guideline we didn't need but which is OK
43 NICE? The National Institute for Health and Care Excellence (NICE) guideline [NG59]

Article

- 45 Relationships, self-management of long-term health conditions and a new normal in a post-Covid-19 world

End stuff

- 49 Book review – Jenny Jessop
50 Book review – Jenny Jessop
51 Book review – Rajesh Munglani

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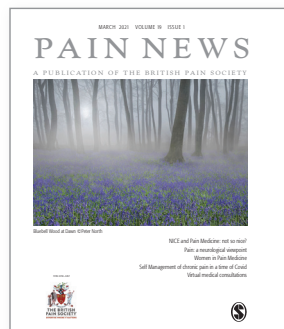
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Treating pain nicely, part 1: the unique nature of perception and towards effective utilitarianism

Rajesh Munglani* and Paul Wilkinson*



Our view of the world is determined only by what we are able to see, hear and how we interpret those sensations.¹

There is an allegory where Socrates describes a group of people who have lived their whole lives chained to the wall of a cave facing a blank wall. The people watch shadows projected on the wall from objects passing in front of a fire behind them and they give names to these shadows. The prisoners cannot see any of what is happening behind them, they are only able to see the shadows cast upon the cave wall in front of them. The sounds of the people talking echo off the walls, and the prisoners believe these sounds come from the shadows. The shadows and the sounds are the prisoners' reality but are not accurate representations of the real world.

Socrates goes on to explain how we can be like a prisoner who is freed from the cave and comes to understand that the shadows on the wall are not reality at all. Like this one freed prisoner, our aim is to be free and understand and perceive the higher levels of reality.

However, there are the other inmates of the cave who do not even desire to leave their prison, for they know no better life and will never know it. The freed prisoner would think that the world outside the cave was superior to the world he experienced in the cave and will attempt to share this with the prisoners remaining in the cave. The returning prisoner, whose eyes have

become accustomed to the sunlight, would be blind when he re-enters the cave, just as he was when he was first exposed to the sun. The prisoners, according to Plato, would infer from the returning man's blindness that the journey out of the cave had harmed him and that they should not undertake a similar journey. Plato concludes that the prisoners, if they were able, would therefore reach out and kill anyone who attempted to drag them out of the cave. The allegory contains many forms of symbolism and is used to instruct on the nature of perception.²

The journey we have been on, and what we have perceived, not only changes what is truth for us but also divides us from our compatriots who have not shared the same journey and therefore cannot share the reality that is manifest to us.

A natural inference is to understand that others may hold a truth diametrically opposite to our own and yet neither of us may be wrong. Thus, in Socrates' example, phenomena do not have objective reality understandable by one observer but the true nature or meaning can only be constructed from multiple perspectives. Given the biopsychosocial nature of pain and multidisciplinary assessment, arguably we work in a world of collaborative, co-constructed reality. This has very significant implications for how we should approach evidence.

For the past 70 years, patient care has been dominated by evidence-based medicine (EBM) with its emphasis on randomised controlled trials (RCTs) and clinical guidelines to standardise medical decision-making. This population-based approach relies on results averaged or otherwise derived from RCTs. These have served medicine well. We are unlikely to fall into the trap of a type 1 error (a false positive) though probably more likely to end up with a type II error (a false negative).¹

Intuitively, type I errors can be thought of as *errors of commission*, that is, the researcher concludes that something is factually true when it isn't. For instance, consider a study where researchers compare a drug with a placebo. If the patients who are given the drug get better than the patients given the placebo by chance, it may appear that the drug is effective, but in fact the conclusion is incorrect in the population as a whole. Conversely, type II errors can be thought of as *errors of omission*. In the

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Treating pain nicely, part 1: the unique nature of perception and towards effective utilitarianism

example above, if the patients who got the drug did not get better at a higher rate than the ones who received the placebo, but this was a fluke untrue in the wider population, that would be a type II error. The consequence of a type II error depends on the size and direction of the missed determination and the circumstances.³ Treatments that are effective in proportionately fewer patients or only in subgroups are more likely to be viewed as ineffective. So, should society be concerned about the omission of a treatment that helps for example only 1 in 10 individuals? Perhaps not on the surface, but this should depend strictly on context. If 10 similar treatments were omitted by this process and they were the only treatments available, outcomes could be devastating as all 10 patients could potentially have been otherwise helped.

The forthcoming National Institute for Health and Care Excellence (NICE) guidelines may conclude that drugs or treatments are not effective and yet in our clinical experience, we may conclude that they collectively help a substantial minority of individuals. Crucially, we cannot currently predict which drugs may help an individual person, many clearly do not respond and yet some respond markedly. The normalisation effect of RCTs and thus the ignoring of individual responses mean that the opportunity for people who may well benefit from a treatment may be lost. Temporary pain relief to enable engagement with rehabilitation is also not an outcome that would be measured or easily valued using this experimental approach, nor would the value of treatments of low efficacy that prevent progression to more efficacious but much more expensive treatments be a statistical outcome. Important questions clearly exist:

- Should individuals miss out on what may be a life-transforming pain-relieving treatment because the outcome is not good enough for the group in general?
- Do we completely ignore the suffering of an individual so that the greatest good can be done for the greatest number of people for the least amount of money, as money is limited?
- How do we develop strategies to minimise the impact of placebo effects if we do decide to treat?
- Importantly, NICE do emphasise the importance of decision-making in individual patients. In other words, one size does not necessarily fit all.

Let's now take a step back on these issues, philosophically.

So far, our analysis is centred around outcomes of experimental trials and potential errors. But what if, like in Socrates' allegory, we do not know the limits of what we can see through our experimental lens? In other words, to what extent can we rely on experimentally derived statistical evidence in pain medicine? There are some compelling philosophical issues that suggest, unlike many other specialities, we cannot rely on this approach.

The paradigm underpinning experimental methodology for the past several centuries is derived from Positivism. This was developed by the French philosopher Auguste Comte⁴ and refined by other groups. Key positivist principles that underlie experimental research are as follows:

1. A belief in objective reality.
2. Knowledge of the subject can be usefully and strictly acquired from data that is directly experienced/measured by independent observers.
3. Observation of phenomena is subject to natural laws and applied logic.
4. Empirical testing in trials can be undertaken; the environment can be controlled, subjects 'matched' between experimental groups, and relationships among variables analysed by mathematical means.
5. Finally, using inductive and deductive hypotheses derived from a body of scientific theory, the findings can be extrapolated to other groups in the wider population.

So, what about pain? Generally speaking, the more complex and unpredictable a phenomenon, the less likely these conditions will apply. There are over 30 psychological variables that may contribute to the pain experience, multiple influencing cognitive factors, highly variable presentations of disability and multiple potential neurophysiological mechanisms, not to mention the impact of variable secondary pain conditions. We also could quote solicitous or confrontational family behaviours and a variety of social issues. Arguably, 50% of the variance in outcome of pain after back surgery can be determined by one, just one, variable, namely catastrophisation, that is a factor which is almost never controlled. The authors argue that it is doubtful that any of these positivist principles actually ever truly, fully apply! Curiously, a Court viewing such evidence might simply rule it too uncertain or flawed and treat it as inadmissible!

To move forward, we need to switch towards a constructivist view of the reality of pain. We need to use and strive for the acceptance of research methodologies that match this co-constructed reality. We need to think about triangulation of evidential sources, audit trails to improve accountability, acceptance of, and strategies to use and enable trust in immersed (not independent) observers: that is, us as healthcare workers. Ultimately, our professional judgements need to be evidence-based in no less rigorous a way but using more appropriate, new frameworks of assessment.

We suggest that utilitarianism may offer a useful philosophical framework. It is close to our subject of pain as the consideration of the dimensions of pain, suffering and pleasure underpins this philosophy.

Utilitarianism is seen as a powerful and persuasive approach to ethics in the history of philosophy. It encourages actions that

Treating pain nicely, part 1: the unique nature of perception and towards effective utilitarianism

maximise happiness and well-being for the group of relevant individuals. The basic idea is to maximise *utility*, defined as *well-being*. Jeremy Bentham described *utility* as ‘that property in any object, whereby it tends to produce benefit, advantage, pleasure, good, or happiness ... [or] to prevent the happening of mischief, pain, evil, or unhappiness to the party whose interest is considered’. A related concept is of consequentialism, that results of any action are the only standard to judge right and wrong.⁵

Utilitarianism is generally held to be the view that the morally right action is the action that produces the most good.

The Classical Utilitarians like Jeremy Bentham and John Stuart Mill identified the good with pleasure, so, like the Greek philosopher Epicurus, they were hedonists about value. They asserted we ought to maximise the good, by promoting ‘the greatest amount of good for the greatest number’.⁶

How might the principles of utilitarianism apply to the current discussion? On one hand, we could say that if we’re going to maximise the benefit for a relevant group of people then all treatments need to be tried, and to discard the ones that do not help, thereby not missing out on some individuals benefitting from treatment. In this way, one could argue that the imperative to achieve maximum good or relief of suffering has been achieved. Another is to look at patient pathways rather than the ethics of no treatment or treatment and furthermore explore how we measure a meaningful patient outcome.

On the other hand, one could say that by offering only limited likely effective treatments, there is overall more money for effective treatments to go around, and also if the proposed treatments were to have any negative side effects, then we are minimising the chances of those.

The question then arises, ‘How do we weigh up these competing factors?’ We must ask the following questions, but fundamentally it boils down to a point of view:

- How limited is the pot of money? Are we underspending on the NHS or on pain services?
- How many people are we missing out on if we limit the availability of treatments? How many people are we causing to suffer either intentionally or unintentionally by simply withholding treatments because there is a prohibition, for example, on providing Lidoderm patches, opioids, gabapentin or spinal injections?
- How many people are saved from suffering by not offering treatments that are only likely to be beneficial to a few but have significant and/or long-term side effects? (e.g. medicinal cannabis, long-term opioids or brain stimulation for neuropathic pain).

Conclusion

Over the next two editorials we will be exploring these issues further and discussing the urgent need for a paradigm shift. There is a significant danger of patients with chronic pain or indeed ourselves as healthcare professionals being imprisoned in a Socratic cave. Patients may end up having little or no treatment because the complex phenomenon of pain and required treatment approaches are not perceived correctly.



Plato's allegory of the cave by Jan Saenredam, according to Cornelis van Haarlem, 1604, Albertina, Vienna Public domain Wikipedia

Note

- i. Type I and type II errors are derived from statistics: a type I error is the rejection of a true null hypothesis (also known as a ‘false positive’ finding or conclusion; example: ‘an innocent person is convicted’), while a type II error is the non-rejection of a false null hypothesis (also known as a ‘false negative’ finding or conclusion; example: ‘a guilty person is not convicted’). Much statistical theory revolves around the minimisation of one or both of these errors, *though the complete elimination of either error is a statistical impossibility*. By selecting a low threshold (cut-off) value and modifying the alpha (p) level, the quality of the hypothesis test can be increased.

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Jenny Nicholas



Here we are, the first issue of Pain News in 2021!

In this issue, we once again take some time to consider the impact of COVID-19 on pain services and our patients, with articles focusing on the patients experience of virtual consultations, attending pain clinics during these times and the role of self-management.

- Chris Bridgford: Self-management. Abandonment or empowerment
- Shreya Mehta: A snapshot of patient satisfaction with virtual consultations in community pain in East London
- Jim Blake: Remote pain clinics consultations from a patient and carer's perspectives

With the forthcoming publication of the new National Institute for Health and Care Excellence (NICE) Guidelines for Chronic Pain, this issue also includes articles which look at the processes NICE used in their development of these guidelines, as well as some personal experiences of being involved in developing other NICE guidelines, with articles as follows:

- The end of Pain Medicine as a professional specialty? A response to NICE and its managerialist attitude, Dr Mike Platt
- The NICE guideline on Chronic Pain – The NICE guideline we didn't need but which is ok, Dr Truro Nurmiko

- The NICE Guideline NG59. Low back pain and sciatica in over 16's: assessment and management. A personal view of my involvement by Dr Chris Wells.

And we finally round up the issue with a few Book Reviews for your interest.

- Innovative approaches to chronic pain. Understanding the experience of suffering and pain and the role of healing.
- The pain free mind-set

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

What's new for 2021?

Going forward into 2021, we are looking to develop some themed issues of *Pain News*, and the Editor and I will therefore be putting out calls for articles on various topics that we would very much welcome your contributions on.

The first two topics that we are requesting articles on are; **'sex and pain'**; this might encompass desire for sexual intimacy while in pain, body image issues in pain and how it can affect sex life, linking of sexual desire to the basic human need for communication, **and 'self-management of pain'**; this might encompass, what resources do patients find helpful on the Internet?, peer support in self-management, to name a couple of examples.

If you would like to contribute an article on this topic, please contact us in the first instance at: newsletter@britishpainsociety.org with the proposed premise of the piece and we will review before you submit your full article.

President's message

Arun Bhaskar



Dear Friends

I trust this finds you well.

The crisp clear mornings are progressing on to sunny days and Spring is upon us as evidenced by the crocuses and daffodils adding colour to the birdsongs providing the right ambience. As I sit down to write my first President's message for 2021, after a long months covering most of last year when we were all busy dealing with the pandemic, there is now an air of optimism and good

reason to feel like that. The R-numbers are heading in the right direction with a decreasing number of hospital admissions and deaths due to Covid-19. The Government have already announced the plans for a phased easing of the current lockdown restrictions. Most of our colleagues who had been redeployed to assist in Covid wards and intensive care are now back in their departments. On a personal note, some of my friends and colleagues who had been personally affected by Covid, directly and indirectly, are very much on the mend. Hopefully, in the coming months we hope to see more of each other and I look forward to those times.

First of all, let me start with some good news. I had written in my last piece the circumstances under which we had to postpone the 2020 ASM and due to the onset of the second peak, we were unable to have any meetings last year. We were hopeful that we may be able to hold a face-to-face meeting later in the year, but the advice of the Council and the Scientific Programme Committee was to have a 3-day virtual meeting earlier in this year. I am sure most of you have heard by now that we are holding our ASM on 27-29 April and it will be on a virtual platform. Dr Stephen Ward and the Scientific Programme Committee have put together a very exciting programme. My thanks go to them and all the speakers who have kindly agreed to continue their support to the British Pain Society ASM. I would encourage all of you to register for the ASM and

continue to support the Society and I am sure this will be a great educational and networking event. The AGM that would be normally held during the ASM will now be held at a later date and it is also very likely to be a virtual AGM as we had in September.

There are some major issues that will impact on pain clinics and how we will have to adapt our working environment in the future and also on how we engage with our patients and colleagues in primary care and other specialities.

Most of the pain services around the country have been hugely affected by redeployment of staff and non-allocation of clinic space and theatres. This issue may continue for some time as most surgical specialities will be competing for these limited resources once services are resumed. Currently, we have been managing patients through virtual clinics and direct patient contact was limited to emergencies and one-stop assess and treat clinics. The vast majority of our patients who had been waiting for several months will need to be prioritised and this will likely strain already overstretched hospital services and also primary care services.

We should also be preparing to adapt our clinics for managing symptoms of Long Covid. The National Institute for Health and Care Excellence (NICE) guidance on Chronic Primary Pain is scheduled to be released during the first half of April and the consultation process of the draft guidance had raised some concerns. It will be a priority to ensure that this guidance is interpreted correctly by various CCGs and we will work alongside our primary care colleagues to minimise any disruption to the treatments of our patients.

I had mentioned in previous communications that we are in the process of setting up a virtual educational platform that could impart knowledge and training for not only BPS members and other multidisciplinary colleagues involved in pain management, but also to other specialities, healthcare professionals in the primary care as well as patient groups. The Education Committee and the Education SIG along with some very dedicated Council members have put in a lot of effort get this going. We will be having further discussions on these important topics in the coming weeks on how we support each other and this project.

On the topic of collaborative working, there are a couple of initiatives I would like to bring to your attention. There is a Joint Meeting with the RCGP on 'One Day Essentials of Pain Management' on 23 April 2021. I would like to thank Prof. Sam Ahmedzai and Dr Martin Johnson for putting together a fantastic programme and would request you to support the meeting. Prof. Richard Langford and I are leading on a project looking at pathways and best practice for interdisciplinary MDT working in the management of osteoarthritis. This project which is going to be divided into three phases is being led by Dr Amelia Swift and consists of experts from the field of Pain

Management, Orthopaedics, MSK, Physiotherapy, Psychology, Nursing and Rheumatology. We shall update you about the developments in the coming months.

There are several challenges ahead of us to deal with the aftermath of the pandemic and it is important that we look after ourselves and each other. We need to ensure that we come through this stronger to look after our patients who need our help and support in this trying times. We look positively towards the future in arranging face to face meetings and events as we used to do before, and I am sure those days are not far away.

Bluebell Wood at Dawn by Peter North

(Front Cover photo)

Trying to get a good photograph in a forest or wood is usually very difficult because the scene is often very cluttered with so many trees and the image usually lacks any sense of depth or interest. In this image, the mist and fog transform the scene by obscuring a lot of busy detail and, more importantly, render the tree trunks into various shades of grey as they recede into the distance. The presence of the rising sun back-lights the scene nicely, adding a focal point and giving the image both a sense of mood and calm. I was keen to make sure that individual bluebells could be seen in the foreground so I made sure that the low camera position and depth of field captured them clearly while those in the distance merged into a gentle blue haze broken by patches of green.

<http://melbournphotoclub.com>