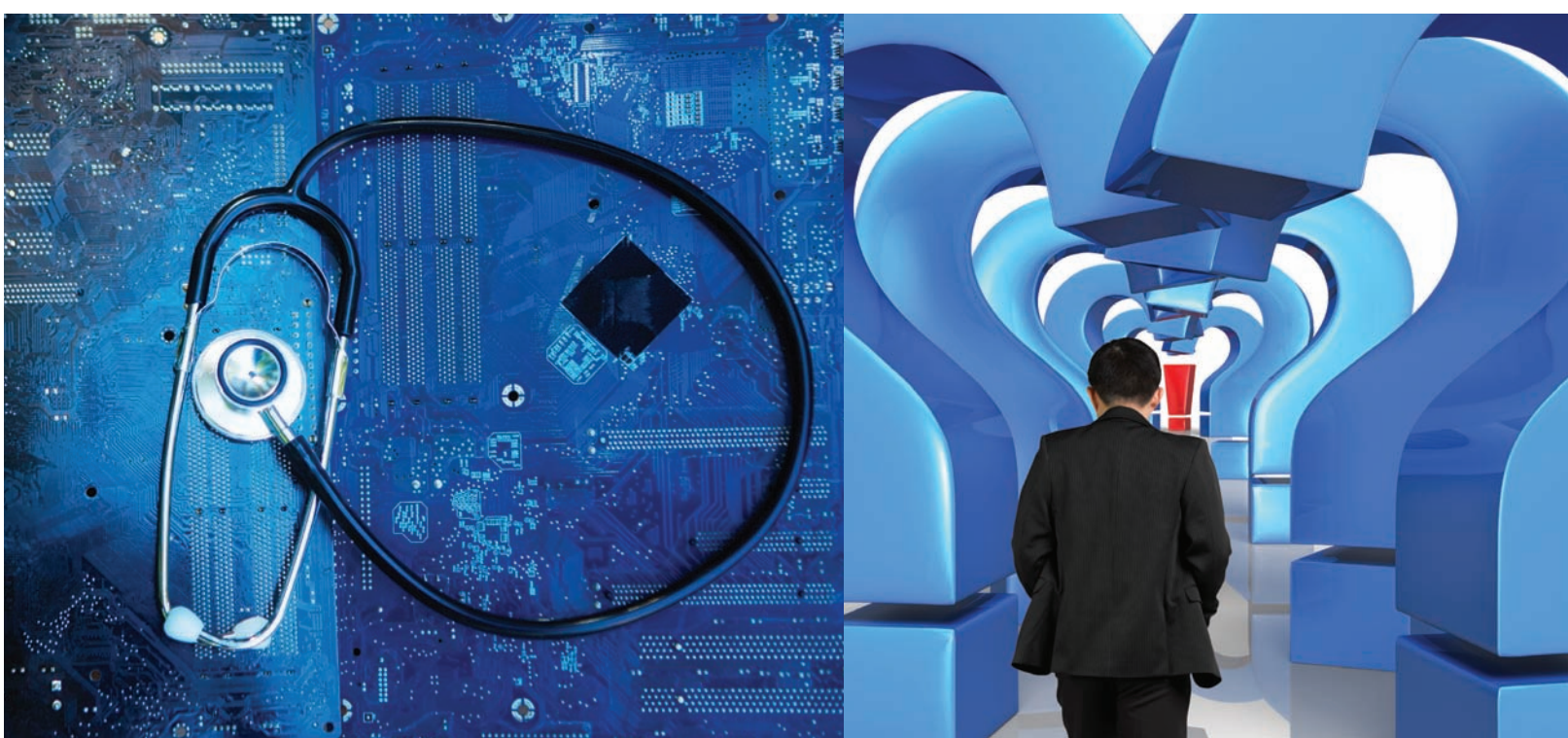


MARCH 2015 VOLUME 13 ISSUE 1

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



Attentional bias modification

Power of invalidation in consultation in chronic pain

Bad back and silverbacks

Reflection on pain experience



THE BRITISH PAIN SOCIETY

ISSN 2050-4497



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1. British National Formulary, Oxycontin® list price. Available at: <http://www.evidence.nhs.uk/formulary/bnf/current>. Accessed on 17th November 2014.

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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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PAIN NEWS MARCH 2015

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news of interest to members, including
notice of meetings.
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10th April 2015**

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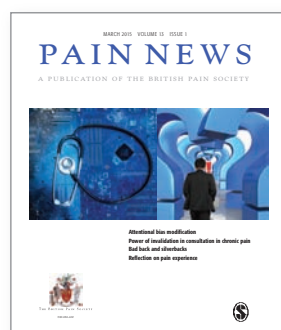
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<https://www.britishpainsociety.org/for-members/pain-news/>

Calendar of Events

2015

Cancer Pain (34th Study Day)

Friday 13th February

Churchill House, London

Annual Scientific Meeting

Tuesday 21st April – Thursday 23rd April

Glasgow

Study Day – Topic TBC (35th Study Day)

Friday 12th June

Churchill House, London

The Tyranny of Diagnosis

Philosophy & Ethics Special Interest Group Annual Meeting

Monday 29th June – Thursday 2nd July

Launde Abbey, Leicestershire

Pain Management Programmes 15th National Conference

Pain Management Programmes Special Interest Group

Thursday 17th & Friday 18th September

Manchester

Study Day – Topic TBC (36th Study Day)

September

Churchill House, London

Study Day – Topic TBC (37th Study Day)

Monday 23rd November

Churchill House, London

Headache Special Interest Group Inaugural Meeting

Wednesday 25th November

Churchill House, London

Further details can be found on our events listing page

<https://www.britishpainsociety.org/mediacentre/events/>

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SAGE



Recently, one of my friends had sent a cartoon. The cartoon had two pictures. One was a cartoon of a thin, cachectic

looking boy, just in his shorts. He was so thin that you can count the number of the ribs in his bare malnourished chest. Under the picture there was a word 'Malnutrition'

On the other side of the cartoon there was an obese boy in his jeans, baseball cap and shirt. He was so obese that his belly was bursting through his shirt and jeans. In front of him there was a huge, three layered burger. Under the picture the cartoonist had written 'Mall Nutrition'. Even though it was a cartoon, supposed to make me laugh, it made me think.

There is so much food in one part of the world where lots is wasted or abused. On the other part there is hunger, starvation and lack of even basic needs. The medical field, in particular pain management, is no stranger to this type of extremes. In Western countries, there are so many different analgesics available. In some countries they are so liberally used. We all know about the problem pain management is facing

currently in the United States. Stronger opioids were prescribed so freely to the extent that it led to increase in abuse of stronger analgesics like oxycodone. This was closely followed by a trend of increase in A&E admissions and death related to drugs abuse especially analgesics.

On the contrary, in developing countries patients can't even get simple painkillers regardless whether for acute, chronic or cancer pain. One of the News items from the 'Pain in Developing Countries SIG' in this edition of *Pain News* gives a clear account of this. Three pain management professionals who worked in three different developing countries share their first hand experience. They describe how health professionals manage pain in patients in poorly resourced settings. One of the authors describes her experience and reflection on management of terminally ill young palliative care patients who died in pain due to lack of necessary painkillers. The only available painkiller was paracetamol to manage his pain. The article also mentions about local and international initiatives to improve the situation. Hopefully local initiatives like The Palliative Care Alliance of Zambia and the international initiative by WHO will change this in the future. There is also another article 'Bad backs and silverbacks' by Victoria Tidman about the

same subject. Victoria has written about her experience in managing patients with chronic pain in Rwanda. To help the locals to continue providing the service Victoria has taken several initiatives to empower them.

In my pain clinic, while finalising the treatment plan, I tell my patients that coming to my clinic is like going to a restaurant. I give them the menu - options for pain management, but it is up to them to decide what they want. An article Aide-memoire for treating chronic pain - making more of a meal out of it gives a different perspective to 'nutrition' and menu in pain and pain management. The authors quote Patrick Wall's description of pain as a complex sensation, which is similar to thirst and hunger. They push the analogy further and invite us to consider treating pain as similar to quelling thirst and hunger. We use food and drinks to improve thirst and hunger. Similar to that we use medications and interventions in treating pain. In the same analogy the authors classify the pain management treatment into starter, main course and dessert. They also advise us to be a 'good host' and cater for the preference of the patient.

This year ASM at Glasgow is around the corner. Scientific Committee once again have come up with wonderful program. Please come along. I hope to see most of you there in Glasgow.

Dr William Campbell



THE BRITISH PAIN SOCIETY

Pain News

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A new year – a new website

Over the past few years, Dr Raj Munglani worked on the criteria needed for a new British Pain Society (BPS)

website, so

that it would be easier to navigate and update. During the past year, Dr John Goddard together with Mr Steve Walmsley, project manager, have brought this task to fruition. Naturally, there was an enormous input from Mr Ken Obbard (migrating membership details onto an entirely different database platform) and Mrs Jenny Nicholas (working on the many additional details). Nick Allcock, Meherzin Das, Antony Chuter and Christina Liossi have made major contributions to a steering group.

You should find that the website is more orientated to BPS members, but to gain full advantage, you will be required to update your details using your registered email address and a temporary password that has been emailed to you. Naturally, many parts of the website will be open to the media and patients – including patient publications – but other parts will be restricted to members only – a feature that I desired for many years. The website will evolve and change over the coming months and years, but one of the great advantages of the new system is

that the secretariat will be able to update data much more easily than in the past, so the site can be kept up to date on a day-to-day basis, for both our and your needs.

European Federation of Pain EFIC Pain Schools

Since the BPS is the UK Chapter of the International Association for the Study of Pain (IASP), as well as the European Federation of IASP Chapter (EFIC, now called European Federation of Pain EFIC), we will be notifying you from time to time about matters from which you, as BPS members, may benefit. One of these is the EFIC Pain School. Only the EFIC Chapter members are eligible to apply, that is, members of the BPS. Some schools are for non-medics and others are orientated towards medical practitioners only.

Information about these schools can be found at <http://efic.org/index.asp?sub=H9CO1JNBRB3170>

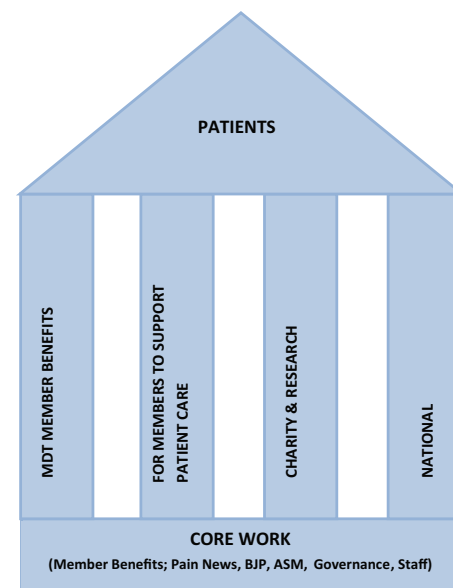
EFIC Fellowships at <http://www.efic.org/index.asp?sub=WKO28YcOi2B6H8>

We will also notify BPS members about these matters by push email and through the new BPS website. Applications should be submitted as per the BPS guidance in the first instance to permit time to choose two candidates for each category. It is then up to the local UK Councillor (in the United Kingdom currently that is myself – president@britishpainsociety.org) to provide a letter of support, the curriculum vitae and application form to EFIC, to make the final decision. Applications will not be accepted except through the UK Councillor. Deadlines are tight and

critical, so do watch the BPS website on a frequent basis. Applications for the EFIC Pain Schools for this summer closed in early January, but do watch out for further schools.

The BPS financial status and Secretariat staff restructuring

The BPS is capable of running on membership dues alone, but only as far as our quarterly publications (*Pain News* and *British Journal of Pain*), in addition to office costs, Council meetings and some charitable work. Any activity above this requires additional revenue. In the past, there was sufficient surplus following the



This image represents the Society's business plan model. The core work being those items essential to the running of the Society, with four clearly identified 'pillars' of additional activities, which all support improving patient care.

Annual Scientific Meetings (ASMs) and from unrestricted industry grants that we were able to run various topical working parties, with resulting well-respected publications. This latter work gave the BPS a very high profile over the past 10–15 years. Over the past 7 years, there has been a gradual reduction in grants and donations from the industry as they too are under financial pressure. Many other medical organisations have this problem. It is through the hard work of the Council and the secretariat that we are attempting to minimise the erosion of our currently healthy reserves. In particular, Dr Andrew Baranowski and Mrs Jenny Nicholas have been working very hard to establish ways of improving the situation.

Last autumn, the BPS Executive team agreed that a restructure of secretariat staff activities could improve efficiency. To this end, there was a consultation period among the secretariat about roles and activities within the BPS office. The Executive team agreed that we needed a Chief Executive Officer whose prime role would be to fundraise for the BPS, and as a result, we would need a new Office Manager with support staff for membership, study days and Special Interest Groups (SIGs), as well as for the

ASM, which is a mammoth task each year.

Mrs Jenny Nicholas is our new Chief Executive Officer. Interviews were held early in January for the new Secretariat Manager (Ms Dina Almuli – who will be on maternity leave during this calendar year), Conference & Communications Officer (Mrs Rikke Susgaard-Vigon) and Membership & Events Officer (Mr Ken Obbard). This restructuring was at minimal cost, yet secretariat salaries were protected. Congratulations to all in their new positions and thank you for helping this all take place.

The BPS ASM

The main event of the year for the BPS is its ASM – this year to be held in Glasgow – a very popular venue – between 21 and 23 April. The Scientific Programme Committee is led by Professor Kate Seers, and they have provided some excellent speakers. Professor Andrew Rice will be delivering the BPS Lecture, followed by presentations covering a wide variety of topics and concluding with a plenary presentation from Professor Dame Carol Black – ‘The painful workplace’. Of course, there are

great opportunities to network with colleagues and socialise in the evenings as well! Registration should be carried out on line:

<http://www.britishpainsociety.org/2015-asm/asm-2015-how-to-register/>

There will be the usual reduced registration fee for paid-up members of the BPS.

Voting for new Council Members – and my successor!

There will be four vacancies on Council from 22 April 2015. In addition, we will need a new President Elect to succeed me in 2017. Could I please ask you all to vote for those who have put their names forward to represent the various disciplines on the Council of the BPS. This process will take place electronically this year.

I look forward to meeting up with you all very shortly in Glasgow!

Congratulations!

Dr Beverly Collett was awarded OBE for services to pain management in this year's Queens New Year's Honors List (see pages 19-20).

National Institute for Health and Care Excellence (NICE)

The Society is a generic stakeholder for National Institute for Health and Care Excellence (NICE) guidelines. The Society is also a generic stakeholder for Interventional Procedures and Health Technology Assessments for NICE.

Since December 2014, the Society has received over 25 communications from NICE on topics with relevance to pain. Of those, the Society has formally responded to the following topic:

- Prostate Cancer – NICE Quality Standard consultation (submitted January 2015).

Dr Martin Johnson



THE BRITISH PAIN SOCIETY

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SAGE



For those of you who are not used to the publishing process, there is a long lead in time involved. Thus, I am now writing my Spring Report in mid-January

with the image of some of the vibrant colours of nature in my mind instead of the dull frozen environment that exists outside at present!

To all those who missed my last report, apologies, but unfortunately, work was particularly busy due to a regulatory inspection. Yes I know, nobody really missed reading it!

Membership benefits

As I have written before, we have a working party looking at how to retain and increase membership. Before you read this article, I am hoping that we will have had a further meeting to look at the potential for a web membership category – full details will be revealed later (if the group thinks it is viable)! To attract new members, it is also important to look at what benefits you get from membership, for example, reduced Annual Scientific Meeting (ASM) rates, *British Journal of Pain/Pain News*, a united voice for negotiation and so on. We are looking at other potential benefits such as travel clubs, reduced insurance rates and so on. If you are aware of any benefits that

another Society offers that you believe would be attractive to the British Pain Society (BPS) members, please let me know.

By now, I hope you have managed to look at the new BPS website – this has been completely redesigned and I am sure will be a huge benefit to all of the members. You will notice that there is now more contained with the ‘members only’ section – again to encourage membership. A big thanks to all of the team who have put it together under the leadership of our Vice President John Goddard.

Good news

It is always good to start the year off with good news. January saw the birth of a baby boy to our new Secretariat Manager, Dina. Many congratulations!

Also for those who haven’t heard yet, Dr Beverly Collett was awarded a well-deserved Order of the British Empire (OBE) in the New Year Honours list. Beverly’s list of contributions to the Pain world are exceptional and deserve to be highly recognised.

I would also like to congratulate Jenny Nicholas as she takes up the new position of Chief Executive Officer of the BPS.

Chronic Pain Policy Coalition

The second mention of Beverly is due to the fact that at the end of 2014, she stepped down from chairing the Chronic Pain Policy Coalition (CPPC). At the same time, the manager Rachel Downing also left the CPPC – Rachel has joined the Royal College of Physicians where she continues to

wave the flag for chronic pain. Again many thanks to both Beverly and Rachel for helping to drive the chronic pain ‘political’ agenda for the last few years. This of course included the Pain Summit in November 2011 and its subsequent report ‘Putting Pain on the Agenda’ in July 2012. At the end of 2014, the CPPC, Royal College of General Practitioners (RCGP), Faculty of Pain Medicine (FPM) and BPS all met in the House of Lords to deliver an update on progress since the Summit. Most of the work streams are still ongoing, including the BPS epidemiology of chronic pain working group. I suspect we will have further meetings in the future!

Neil Betteridge and myself have taken up the reins of co-chairing the CPPC jointly. We have just appointed a new manager, Maya Desai.

National Institute for Health and Care Excellence

For those who have doubts or debates in their local area’s about various National Institute for Health and Care Excellence (NICE) guidelines, a speaker from NICE, at the Westminster Health Forum, ‘Next steps for NICE and issues for the pharmaceutical industry’, on 15 January 2015, reminded the audience of the judicial review ruling clarifying that NICE Guidelines could not be ignored or not implemented because at the local level there is disagreement with the evidence on which NICE took its decision. Any exemptions need to be evidence based, for example, safety, patient choice and so on – reasons which NICE has set out on its website. Otherwise, there is no

legal justification for non-implementation, including lack of funding.

Members of the BPS continue to give input into the development of quality standards and the development of guidelines. Thanks to Tim Johnson for collating our responses to NICE. The latest guideline in production from NICE is the *Safe use and management of controlled drugs*.

Map of medicine

The Map of Medicine® group has informed us that an increasing number of health communities are referencing the pain pathways. They particularly noted that North Somerset Clinical Commissioning Group (CCG) is using them. Internationally, they are being used in Australia and New Zealand. If you know of any other place where the pathways are being used, please let us know.

For my GP readers, I am hoping that you will have received a booklet with a copy of the *GP* magazine in late January. The booklet distils the essence of the five pain pathways into an easy reference guide, including an update concerning the

NICE neuropathic pain guidelines. I am hoping this will lead to increased use of the pathways and potentially improvement in quality of referrals and so on.

Special Interest Groups

As from the Council meeting of the 24th September 2014, the Society now has 14 Special Interest Groups. At the Council meeting the 14th SIG, concentrating on headaches, was unanimously approved following a proposal from Dr Vivek Mehta. It should be noted that the new SIG will also deal with oro-facial pain. I am sure we would all agree that this SIG covers an important clinical area and potentially opens up doors for new members e.g. amongst neurologists interested in pain. We welcome them to the 'SIG family' and look forward to hearing more about their plans.

Council elections

The Council has voted to appoint the successor to the Honorary Treasurer and my position as Honorary Secretary. As a consequence, our new officers are

Honorary Treasurer (elect) – Heather Cameron

Honorary Secretary (elect) – Roger Knaggs

Thus, I offer my congratulations to Heather and Roger who will take up their official (elect) positions at the Annual General Meeting (AGM) in Glasgow in April 2015.

As William has mentioned in his column, by the time you read this edition of *Pain News*, you should have received information about nominating four Council positions that become vacant in April 2015 and also for our new President elect. With the use of the new electronic voting system, I am keeping my fingers crossed for a high turnout of votes!

Finally, I want to mention my support to Andrew in his unenviably difficult task of producing a realistic budget for the Society (and no red battered case to hold high). I am very glad that Richard persuaded me to put my name forward for the Secretary role and not Treasurer!

A surprise bill didn't worry Dawn even though she was on long-term sick leave.

Thank goodness for PG Mutual's income protection cover

BRITISH PAIN SOCIETY
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News from the Pain Service at Great Ormond Street Hospital – 10th Paediatric Pain Symposium: back to basics, getting it right

Matthew Jay *Pain Control Service, Great Ormond Street Hospital*

Friday, 5 December 2014, saw the 10th Paediatric Pain Symposium, organised by the pain management team at the Great Ormond Street Hospital. The event was hosted in the historic (and refurbished) surroundings of the Royal College of Nursing at Cavendish Square, London. A total of 85 delegates attended for a day of talks, workshops and networking with colleagues in the field of children's pain management.

Lectures

The morning kicked off with a talk from Becky Saul, Lecturer Practitioner and Clinical Nurse Specialist in Pain, who gave an in-depth discussion on techniques and tools used for assessing acute and chronic pain. Becky explained the importance of using validated and developmentally appropriate pain assessment tools. The key is using them regularly, recording scores clearly and using them to inform clinical decision-making. Becky also highlighted the service's use of biopsychosocial patient reported outcome measures in its chronic pain clinic using a novel, electronic system for collecting these data.

Mary Rose, Consultant in Paediatric Anaesthesia, spoke about acute and procedure pain in children. She identified the very high prevalence of acute pain in children, especially in neonates admitted to intensive care, who often require



multiple procedural interventions as part of care. Pain associated with repeated procedures can have short- and long-term consequences, such as delayed recovery and discharge and persistent changes in pain processing. Mary discussed the biopsychosocial management of pain in children through the appropriate use of multimodal medical and psychosocial interventions.

The talk by Alison Bliss, Consultant in Anaesthetics, was an insightful look into chronic pain in children. 'Chronic pain destroys lives' was the key message. Although the epidemiology of chronic

pain in children is not altogether clear, it is definitely widespread. As with acute pain, the biopsychosocial approach to managing pain was emphasised as crucially important. To understand and properly treat chronic pain, it is important to appraise it in its social context as well as targeting psychological and neurobiological mechanisms.

Dilini Rajapakse, Consultant in Palliative Care, spoke to us about pain and symptom management in children with life-limiting conditions. She highlighted the similarities between the Total Pain and biopsychosocial models of

pain. Ethical decision-making was at the heart of the presentation, with the child's pain seen as central to such decisions. It was not long before the inevitable questions around assisted suicide and euthanasia arose in the context of a child who could not tolerate feeds and for whom the continuation of IV fluids was considered by an ethics review to be prolonging 'intolerable suffering to the patient in light of complex pain which could not be easily controlled'.

The final talk of the day was given by Anna Gregorowski and was on transitioning children to adult care. The consequences of poor transition can be serious, including a failure to properly engage with adult services, detrimental impact on outcome and increased hospital admissions. Anna talked us through successful strategies – among others, transition clinics, education, encouraging self-management from early on, managing expectations and planning. Anna highlighted the particular difficulties in transitioning pain patients. Multi-speciality patients with complex needs and unclear prognoses need particular attention. Difficulties include lack of central co-ordination, inconsistent referral criteria and age limits between paediatric and adult services, sometimes a complete lack of adult services and loss of the paediatrician who has been central to the young person's healthcare until the point of transition.

Workshops

This year saw the return of Monica Samuel's musculoskeletal pain workshop, which was run with Amelia Powell. Delegates considered the

impact of musculoskeletal pain on individuals and the wider community and the patient's perspective. The fear avoidance model of musculoskeletal pain and various assessment techniques (e.g. paediatric Gait, Arms, Legs and Spine (pGALS), hypermobility, sit-to-stand test) were covered, as were the kinds of outcomes expected of treatments.

Delegates also had the opportunity to attend three new workshops. Judy Peters and Susie Turner looked at pain in children with neurological deficit and the cognitively impaired child. The particular challenges faced in the assessment and management of chronic pain in these diverse populations were discussed along with assessment tools which can be used in a variety of settings. Historically, these children have been excluded from mainstream pain research, and the published literature still only makes up a small proportion of all pain papers. Nonetheless, there are now a wide range of validated pain assessment tools which can be used to help properly treat the pain in children with complex needs.

The second half of the workshop focussed on the management of cerebral palsy in children and how to deal with painful treatments and procedures. Susie highlighted the fact that for most adults with cerebral palsy, physiotherapy was among their most painful memories as a child. She explored the importance of modifying equipment to suit the child (not the other way around) and the clinical use of botulinum toxin type A in treating pain.

Suellen Walker and Kirsty Keen ran a workshop on the neural mechanisms of

pain in children. Importantly, the workshop highlighted the developmental aspects of pain neurobiology, as pain can be processed differently in early life. In addition, conditions where understanding the underlying pathophysiology of pain has informed or changed management were discussed.

Delegates were also treated to an experiential workshop by Suzy Gray and Nicola Chaloner. Using ice cubes and jellied sweets, participants were taken through the differences between distraction, relaxation and mindfulness. They used these experiences to consider how these techniques could be incorporated into their clinical work.

Further information and next event

The content of the symposium this year was heavily underpinned by the e-Pain children's module, five sessions of e-learning focussing on important aspects of acute and chronic pain in children, part of the e-Learning for Healthcare programme. E-Learning for Healthcare is open to all National Health Service (NHS) staff and is an excellent opportunity for all clinicians to learn about pain and its management. Delegates who want to brush up on their pain knowledge or learn about aspects of it for the first time are strongly encouraged to take a look at <http://www.e-lfh.org.uk>

The 11th Paediatric Pain Symposium will be held in December 2015. Anyone interested should take a look at the website – <http://www.gosh.nhs.uk/paincontrol-noticeboard> – for more information.



Pain in Developing Countries SIG: improving global access to opioids – the view from the ground

Dr Clare Roques *Chair Pain in Developing Countries SIG*

In 2012, the World Health Organization (WHO) published a briefing note stating,

The World Health Organization (WHO) estimates that 5.5 billion people (83% of the world's population) live in countries with low to non-existent access to controlled medicines and have inadequate access to treatment for moderate to severe pain. (Available at http://www.who.int/medicines/areas/quality_safety/access_to_cmp/en/)

The issues surrounding this lack of access to pain treatment, and in particular to strong opioids, are extremely complex and particularly notable in poorly resourced countries. A number of high-profile organisations, including the WHO, are attempting to improve this situation, and although a detailed description of the work of these groups is beyond the scope of this article, of particular note is the work of the Global Opioid Policy Initiative (GOPI). This collaborative group has evaluated the accessibility of opioids across the world and published this as a dedicated supplement in the *Annals of Oncology* in December 2013. Also of note is the website of the Pain and Policies Study Group (<http://www.painpolicy.wisc.edu>) at the University of Wisconsin, which contains very clearly represented data of yearly opioid consumption by country and region.

This article has been compiled from the writings of several members of the

Pain in Developing Countries Special Interest Group (SIG) who have first-hand experience of working in poorly resourced settings where access to opioids is limited. It contains both the stories of patients who are suffering as well as some of the explanations and possible solutions to the problem as seen through the eyes of frontline healthcare workers.

Zambia

Kaly Snell, palliative care doctor from the United Kingdom, currently working in a newly formed palliative care unit at University Teaching Hospital (UTH), Lusaka, Zambia, describes the situation she has faced.

Mr M, 22 years, was diagnosed with an osteosarcoma of the right distal femur in June 2014 and had undergone an above knee amputation. He subsequently presented with recurrence of the primary and lung metastases in September 2014 and was referred to the palliative care team.

*We met an emaciated and dying young man whose priorities were to manage his severe right leg pain – felt to be nociceptive in nature, to understand what was happening to him (he was waiting to receive treatment to 'eradicate' the cancer) and to manage his constipation. He had been taking paracetamol 1 g QDS. We knew codeine and tramadol were currently unavailable. We suggested normal release liquid morphine 2.5 mg 4-hourly and lactulose – both included in the *Zambian Essential**

Drugs list. We also had an open discussion with Mr M and his mother, with their permission and at their pace, on his diagnosis and prognosis.

On returning to review the patient a day later, we were informed that the morphine was unavailable (as was the lactulose) due to a 'stock out'. The lactulose was sourced from a private pharmacy. Mr M's mother was paying the bill. UTH's morphine powder had run out in May (5 months earlier), an order had been actioned in July, but as yet no powder had arrived in the country. The paperwork was 'with the Ministry [of Health]'. Frustratingly, 700 × 5-L containers of morphine liquid had been destroyed the week before our visit to Mr M as it had expired, unused, sitting in medical stores.

Mr M died, in the same severe pain we had found him, a few days after our initial meeting. His mother presented us with a handmade rug, thanking us for our care.

Our failure, in what should have been basic care for this patient, was perhaps evidence of some of the complexities of opioid access in a low–middle income country. Zambia has a national opioid prescribing policy, and there are many advocates (governmental and non-governmental) driving the agenda forward. Why don't people like Mr M receive the analgesia they need? Some of the intertwined issues here can relate to

- lack of healthcare professional education
- a healthcare culture of pain being an ignored entity (swamped under the

enormity of some of the other priorities professionals may identify)

- a reciprocal lack of expectation from patients and families regarding having their pain addressed
- ongoing fears of opiate prescribing and dispensing, perpetuated and complicated by some poor practices in these areas
- limited numbers of prescribers
- limitations regarding the laborious production of the syrup required for oral morphine reconstitution and limited dispensing sites. Linked to this is the limited shelf-life of the reconstituted syrup – even when refrigeration is possible.

These issues may be compounded by a lack of robust systems, central co-ordination and infrastructure to support and implement healthcare delivery. Sadly, some existing systems are perhaps fragmented and disrupted by bureaucracy and a multitude of, sometimes, differing agendas, in-country and external.

Many colleagues are working to tackle the challenges and have been doing so for several years. The first cohort of medical students has just completed palliative care training. The Palliative Care Alliance of Zambia has created a multidisciplinary, in-service training course. A consultant oncologist is working as national pain lead, supported by the International Pain Fellowship, Wisconsin University, USA, and lead pharmacists are concentrating on central production of syrup for morphine reconstitution for national distribution to an increased number of approved dispensing sites. Discussions are underway to set-up a national pain association.

These ventures will take time, but are moves in the right direction. In the meantime, it is a week before Christmas, 2 months after Mr M died in severe pain on the orthopaedic ward, we've been called back to see another 19-year-old man, Mr D, dying with metastatic osteosarcoma and in excruciating pain. We still do not

have morphine. Pethidine, clearly less than ideal, remains the only easily available opioid we can presently access.

Amitriptyline is not available due to a 'stock out'. We returned to pharmacy – the morphine order is still 'being processed'. We will continue to follow-up at national level. Sadly, I suspect it will be too late for Mr D and probably subsequent referrals over the coming weeks.

Rwanda

Vicky Tidman, an anaesthetist also from the United Kingdom, has recently returned from working in Rwanda – she describes some of her experiences. (Please see her article on chronic pain management elsewhere in this edition of Pain News.)

Rwanda was the first African country to launch a standalone national palliative care policy in 2010, stating that all citizens with the government based insurance scheme (Mutuelle) should have access to morphine for severe pain secondary to terminal illness. This has led to a massive increase in their allowance of oral morphine from the International Narcotics Control Board (INCB) from 1 kg 3 years ago, to 39 kg in the 2014–2015 period.

Earlier this year, I worked to develop a pain service at the Rwandan Military Hospital (RMH), one of the top referral hospitals in the country. While there was access to parenteral morphine, there was no access to oral formulations of opioids except for tramadol. Patients requiring morphine had to obtain it from the nearest palliative care hospital. I liaised with the head of the Rwandan Biomedical Centre and our local pharmacist to secure the first supply of oral morphine for RMH. I was able to see the immediate benefits of this in a man with metastatic prostate cancer who was wheelchair-bound. After carefully titrating his dose of morphine, he was able to walk and enjoy his final days with his grandchildren.

Despite the increased allowance of morphine from the INCB, there were still

considerable barriers to its use. Doctors and nurses had very little training in pain assessment and management. Pain scores were not regularly recorded, and doses of morphine were often missed, leading to terrible breakthrough pain that was often treated inappropriately with intravenous pethidine. I reviewed a young man who was dying from an HIV-related condition and had experienced considerable relief from a regular small dose of morphine. Despite this, a week later, the resident doctors had stopped it, telling the patient that he would become addicted. This also illustrated the high prevalence of opiophobia experienced by both healthcare professionals and patients. I worked hard along with others to dispel these misconceptions, but much more work is needed.

What also concerned me was the storage and administration of the morphine. At the RMH, the opioids are not locked away, and a single nurse can administer morphine. Documentation is often poor, and there seems to be an absence of a secure central storage capability. As the supply of morphine in developing countries will inevitably increase in the future, this is definitely an issue that needs to be addressed.

These descriptions from both Zambia and Rwanda, while demonstrating the horror for individual patients, also highlight some of the complex factors which contribute to inadequate pain management. These problems or barriers are often described under the three headings of policy, drug availability and education.

Uganda

Barbara Duncan, a pain specialist from the United Kingdom, is currently working on a research project in palliative care in Uganda and describes some of the strategies that have been implemented to improve the delivery of palliative care in Uganda. Provision of palliative care and strong opioid analgesics in Uganda is a demonstration of the use of the WHO Public Health Strategy.¹

Pain in Developing Countries SIG: improving global access to opioids – the view from the ground

Implementation

Implementation must be within the context of the culture, disease demographics, socioeconomics and healthcare system of the country. Good analgesia is essential for palliative care in low resource settings where diseases frequently present late.

Drug availability

In 1993, Dr Anne Merriman and her team chose Uganda to develop an economically and culturally suitable African model of palliative care. They founded Hospice Africa Uganda (HAU). Anne knew a formula of pure morphine that could be made into a cheap oral solution. The Minister of Health gave permission for powdered morphine to be imported in 1993. Anne and her team were using oral morphine solution from then.

Policies

Further progress was made in 1998 when Dr Jack Jagwe, a Ugandan physician, became involved as senior advocate for HAU. He knew that existing legislation allowed midwives to prescribe pethidine. In 2002, the statute was changed to allow nurses and clinical officers to prescribe morphine after appropriate training.

Education

HAU founded the Institute of Hospice and Palliative Care in Africa that provides undergraduate and postgraduate training for African countries. Dissemination of knowledge on safe prescribing and use of morphine is crucial; 80 out of 112 districts in Uganda now have at least one trained healthcare professional who can prescribe morphine. In 1993, the Morphine Equivalent consumption per capita in Uganda was 0.073 mg. In 2010, it was 0.74 mg compared to the United Kingdom's consumption of 56.4 mg. There is still a long way to go.

The work of Anne Merriman and her colleagues in Uganda demonstrates a

successful project and presents a more hopeful scenario, but it also highlights the huge amount of work and commitment that is required to effect and maintain such change.

India

It is also easy to focus our attention only on the African continent, but the issues of a lack of access extend to many corners of the world. Senthil Vijayan, an anaesthetist and pain specialist from the United Kingdom, has considerable experience of working in India and describes some fundamental recent changes in the country, particularly with respect to policy.

Historically, the availability of strong opioids like morphine has always been difficult in India. The recent passing of the Narcotic Drugs and Psychotropic Substances (NDPS) Act Amendment Bill by Indian Parliament will hopefully help the pain and palliative care movement as morphine becomes more accessible to those suffering from chronic pain. The bill also authorises the government to 'recognise and approve' treatment centres to manage drug dependence and usage of opioids for medicinal purposes including pain relief.

At the same time, concerns have been raised from some quarters that with the relaxation in the NDPS Act, there will be a sudden surge in the demand for morphine, which may not be met as over 90% of the opium produced in India is exported. Data show that 'India last year consumed around 300 kg of morphine for pain relief, while the actual annual requirement is estimated at 36,000 kg' (from the Cairdeas International Palliative Care Trust, Annual Review 2013–2014, available at <http://www.cairdeas.org.uk>).

Even though the legal barriers are sorted with this bill, it highlights yet another issue, of whether doctors feel comfortable prescribing opioids for pain relief. This needs more emphasis on training right from the undergraduate programme. India still has a long way to

go as far as sensitising the medical fraternity to providing pain relief, teaching medical undergraduates about pain and palliative care and training them to put their knowledge into practice are concerned.

I was recently invited to provide a 2-day training programme at the Christian Fellowship Hospital in southern India. It was very encouraging to see the enthusiasm among doctors and nurses to learn more about recognition, assessment and management of pain. But the availability of morphine is still very patchy.

I strongly believe with this new amendment of the Narcotics Act, we will be able to bring a smile to the faces of those patients who have been suffering in silence for a long time now.

I am looking forward for my next visit to the hospital in 2015 to assess the impact of these changes.

All of these accounts demonstrate both the complexity and enormity of the task of improving pain management across the world, and I think it is also worth noting at this point the relative lack of dialogue related to the appropriate use of opioids in the treatment of non-malignant pain, both chronic and acute. However, there are also descriptions of success, and I hope that we can learn and gain inspiration from the work of both individuals and organisations to strive to improve global access to pain management.

If you would like to be involved in the work of the Pain in Developing Countries SIG, please contact the British Pain Society (BPS) office at: members@britishpainsociety.org.

This article was compiled by Clare Roques with contributions from Kaly Snell, Barbara Duncan, Vicky Tidman and Vijayan Senthil (all members of the Pain in Developing Countries SIG).

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News from the Patient Liaison Committee: The brave new world ‘How are pain services evolving – the impact on patients?’

Antony Chuter *Chair of the Patient Liaison Committee*

After months of planning by Geraldine Granath, Colin Preece, Liz Killick, Austin Leach and Antony Chuter, a group of 35 people attended the British Pain Society (BPS) Patient Liaison Committee seminar. Two-thirds of those who attended the seminar were health care professionals and the remaining one-third were patients.

The programme consisted of presentations from speakers and, later, small discussion groups. Dr Cathy Price, Ms Jean Gaffin OBE, Dr Austin Leach and Dr Ollie Hart gave the lectures. In the discussions groups, the participants were asked to write up priorities of what we (BPS and the Pain Community) should ‘Stop doing’, ‘Keep doing’ and ‘Start doing’. Below are the top suggestions from the four groups. The President of the BPS wrapped up the day along with the chair of the Patient Liaison Committee, Antony Chuter.

It was a deeply interesting and thought-provoking day. The challenge now is to take the output from the day and see what can be done. Many things are already subjects, which are in progress in different parts of the country, but others are new to me and perhaps new to you too.

The highlights for me (it was not easy to choose) are

Keep doing:

- Disseminate positive accounts of person-centred pain services.
- (As A.C. says, it is a competitive market and these accounts will assist the figures to come to life for commissioners).

Start doing:

- Increased training for general practitioners (GPs) and health care professionals.
- (As A.C. says, with 52,000 GPs seeing 1,000,000 people every day and 7 out of 10 consultations involving pain, GPs are a major asset to the public who are under-utilised when it comes to pain management).

Stop doing:

- Discharging patients, limiting the new: follow-up ratio for chronic pain patients in pain clinic – chronic pain is ongoing.
- (As A.C. says, this was the hardest category to choose – I was torn between this and the cutting of services – but this is a much bigger issue for people who live with pain. It is not that

everyone needs an annual appointment, but it is about accessibility and extra support for people when they need it. The current system where patients have to be re-referred by their GP really doesn't work for patients – in place of this, people need the ability to have an ongoing relationship if they need it. I know there will be barriers, but there must be a way. As an example, think about the everyday patient living with back pain, they get referred to you and maybe do a pain management course. They do well, but 18 months later, they have a car accident or fall over and hurt themselves. That injury exacerbates their pain, and instead of going through the hurdles of re-referral by their GP, what if they could phone and talk to a specialist pain management nurse who either gives guidance and support on the phone or makes an appointment for them to get further help and support.

Top priorities from the four discussion groups:

News from the Patient Liaison Committee: The brave new world 'How are pain services evolving – the impact on patients?'

Keep doing:

- Promote self-management with support
- Offer a psycho-social-physical approach to rehabilitation
- Enable patients to become an expert in their own condition
- Listening to patients
- Keep talking to patients, commissioners, or anyone who will listen
- Keep pain medicine multidisciplinary
- Stressing the cost-effectiveness in dealing with pain quickly and effectively (where possibly in terms of condition)
- Self-management promotion
- Disseminate positive accounts of person-centred pain services

Start doing:

- Think of a better way of improving care than guidelines (very poor compliance)
- Self-help pain management groups in all localities
- Tutor pain staff in pain clinics to set up support GPs who can be self-managers to support pain sufferers and campaign for services
- Education of patients
- Get pain recognised as an important component of many medical conditions
- Start talking about misuse of alcohol and prescription painkillers to treat pain (spurious concerns: re-addiction should not deny useful treatments; careless prescriptions should not allow patients to be inappropriately treated)

- Patient-centred goals (system to support)
- Increased training – GPs and health care professionals

Stop doing:

- Discharging patients, limiting the new: follow-up ratio for chronic pain patients in pain clinic – chronic pain is ongoing
- Cutting pain services and closing pain clinics
- Injections as first-line treatment
- Assuming pain is a natural part of growing old and therefore it does not matter too much
- Talking down the effectiveness of pain medication and talking up addiction
- Pain clinics seen as end of the line
- Throwing medication at people

Aberdeen Interventional Pain Workshop

May 28 and 29, 2015

Suttie Centre, University of Aberdeen, Aberdeen, United Kingdom

This two-day workshop provides participants a comprehensive review, hands-on skills training and intense learning opportunity in the diagnosis and treatment of low back pain.

Lectures and Live demonstration – May 28

- Anatomy and technique of lumbar medial branch blocks and radiofrequency neurotomy
- Anatomy and technique of sacral lateral branch blocks and sacro-iliac joint radiofrequency neurotomy
- Sonographic anatomy of lumbar medial branch, facet and sacro-iliac joints

Cadaver Workshop – May 29

This intensive hands-on session provides opportunity for participants to learn and practice each procedure under direct supervision of course instructors in small groups.

Registration fees: £500 (inc. lunch, refreshments, and course dinner)

Course Director: Dr.S.Kanakarajan, Aberdeen, UK

Faculty: Prof.A.Chambers, Aberdeen, UK

Dr.R. Nagaraja, Aberdeen, UK

Dr.N.Evans, High Wycombe, UK

Dr.A.Swayamprakasam, Manchester, UK

Dr.A.Hartog, Rotterdam, Netherlands

Dr.M.Sharma, Liverpool, UK

Dr.M. Araujo, Green Bay, USA

Prof D Harmon, Limerick, Ireland

Applied for 10 CPD points from Faculty of Pain Medicine, Royal College of Anaesthetists, London, UK

Please visit our website: www.painworkshop.co.uk for further details.



News from the Medicolegal SIG of the British Pain Society

Dr Kevin Markham *Chair of the Medicolegal SIG*

Since its inception approximately 3 years ago, the Medicolegal Pain Special Interest Group (SIG) has grown in terms of its membership and has an increasingly active and vocal section on the Pain Consultants' Forum established by Dr Raj Munglani.

Although no workshop was run at the last British Pain Society Annual Scientific Meeting in Manchester, the preceding year saw a very successful workshop delivered in Bournemouth. The workshop titled 'Chronic Pain Syndrome' attracted over 100 delegates who rated the workshop highly successful. The introduction was given by myself followed by highly entertaining and informative lecture delivered by Dr Charles Pither examining the validity of the title Chronic Pain Syndrome causing much debate among delegates. Additionally, Dr Leigh Neil, a highly experienced psychiatrist in the field of medicolegal matters, delivered an excellent discourse examining the role of a psychiatrist in the medicolegal arena. His talk was very well received and clarified many of the rather nebulous

concepts that we sometimes see in medicolegal practice.

Following the workshop, an annual general meeting was held in which the following officers were elected: Immediate Past Chair: Dr Jon Valentine; Current Chair: Dr Kevin Markham; Secretary: Dr Joshua Adedokun; Treasurer: Dr Neil Collighan.

The aspects of the SIG have had its proposal for a parallel workshop at the Glasgow Annual Scientific Meeting of the British Pain Society accepted. This workshop will examine impartiality of medical experts in the field of pain. I plan to introduce this meeting and then hopefully a healthy debate will ensue following presentations given on behalf of primarily claimant instructing solicitors represented by Mr Richard Lowes of BLB Solicitors and countered by Mr John Lezemore of DWF Solicitors.

My plan for the next year will focus on enlarging the membership of the Medicolegal SIG and engaging in educational activity promoting a better standard of medical report writing in this

arena. An enhanced membership will hopefully come about in part through the development of the SIG's involvement in the new British Pain Society website, and I would welcome members of the SIG to contribute content. It is envisaged that members of the SIG committee will discuss during the Glasgow meeting enhanced cooperation with other SIGs and international bodies representing medicolegal pain practitioners. It is also hoped that other educational opportunities will be provided focusing perhaps on a day meeting dealing with the 'nuts and bolts' of medicolegal practice such as report writing and presentation in the courtroom.

I would implore members of the British Pain Society who wish to engage in medicolegal practice to join the medicolegal SIG as it consists of a very substantial number of experienced practitioners who can assist in the logistics of developing a medicolegal practice and also give timely advice on an anonymous basis regarding conceptual issues in the medicolegal arena.

Flying the Pain Education flag in Argentina

Dr Emma Briggs *Chair of the Pain Education SIG*

The International Association for the Study of Pain (IASP) 15th World Congress on Pain took place in the beautiful city of Buenos Aires, Argentina, in October 2014. It was the first congress to be hosted in a South American country and was attended by around 5,000 people. This article offers some reflections on the congress and shows how, from a UK and international perspective, pain education continues to go from strength to strength.

Fernando Cervero (President 2012–2014) opened the congress by pointing out the two pillars of the society – education and research. Continuing, he explained that there were three core principles supporting these pillars: being interprofessional, being international and being a membership organisation. The international and interprofessional members were treated to a wide programme of sessions over the 5 days. However, the pain education pillar was at its strongest (reflecting on the last three world congresses I have been able to attend), with workshops, numerous posters and an industry sponsored symposium, all devoted to advancing pain education.

The IASP Pain Education Special Interest Group (SIG) had the privilege of two workshops being accepted. The first explored core interprofessional competencies for pain management. Led by Scott Fishman (United States), Judy Watt-Watson (Canada) and Debra Gordon (United States), the symposium examined the IASP Interprofessional Pain Curriculum Outline, the IASP-endorsed Consensus-Based Core-Competencies for Pain Education and strategies for evaluation of competency based education. The second workshop explored innovations in



IASP congress logo

pain education. Dr Andreas Kopf (Germany) presented on the Local Pain School for Low Resource Countries, a train-the-trainer model that is supported by the European Pain Federation (EFIC). Dr Beth Murinson (United States) discussed utilising the pain narrative to promote competence and compassion in healthcare providers drawing upon her work at Johns Hopkins University. Finally, I presented on the topic of interprofessional pain education exploring innovations and impact based on work on our interprofessional learning experience at King's College London that includes 1,300 students from six disciplines.

In the wider programme, there was a strong and proud UK contingency presenting posters and workshops. Our own committee member and secretary Dr Alison Twycross convened and presented a workshop on acute pain in hospitalised children exploring what we know and where we go from here.

UK representatives have the exciting opportunity to influence pain education on an international lever. Dr Paul Wilkinson became chair of the IASP Education SIG (many congratulations Paul!) taking over from Dr Eloise Carr who led a team in establishing such a popular and dynamic SIG. Following an invitation, I have joined the IASP



Drs Alison Twycross, Fernando Cervero (IASP President 2012–2014) and Emma Briggs



Dr Paul Wilkinson IASP Pain Education SIG Chair

Education Initiatives Working Group and am looking forward to working with international colleagues to steer the education activities of IASP.

The 16th World Congress on Pain (Yokohama, Japan) seems a long way (both in distance and in time!), but there is a lot to celebrate in the pain education world and a lot still left to do. Onwards and upwards, and here is to even more to celebrate in 2016.



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SAGE



Primary & Community Care SIG – assessing pain & agreeing management plans; including FPM Pain Summit workstream on Complex Pain

Dr Chris Barker *Chair Primary & Community Care SIG.*

A good proportion of our focus within the Special Interest Group (SIG) is on how we can improve the profile, assessment and management of pain in the community. Some of us here have spent many years with this in mind. The last 12–18 months have been particularly interesting and rewarding for us as a SIG.

We started 2014 with our second education day in London. Our focus was 'Beyond Problematic Pain – Shared Decision Making'. There has been lots of discussion about problematic pain (now renamed to 'Complex Pain' – more later), which is really important to have, and we wanted to build on this beyond the assessment and into the decision making. It proved very popular, and we had some great speakers, including a new addition to our agendas 'Hyde Park Corner'. This was a chance for the delegates to stand on their metaphorical soapbox and discuss their chosen area of pain. We had a very interesting soapboxer and great discussion around the cultural and ethnic aspects of community pain which was a good way to launch this type of format within an educational day. Our next day is planned for July when we hope to collaborate with the Royal College of General Practitioners (RCGP). Many of us in the

primary and community group (PCC) SIG have been involved in previous RCGP Pain days, and so, it seems natural to work jointly. It also gives us an opportunity to raise the profile of the British Pain Society (BPS) and try and engage more membership.

We continued our theme of shared decision making at our PCC SIG workshop at the ASM in Manchester. It was well attended with lively discussion around the ethics, patient and clinician benefits, and practicalities of shared decision making. In addition, we facilitated worked examples in a workshop style. Ethical issues in pain treatment are especially relevant. Like other areas of healthcare that can involve an array of possible treatments, unless we really have explored patient wishes and presented treatment options fully, we cannot claim to have fully informed consent. Recognising the pain consultation as a 'meeting of experts' between clinician and patient, and using that expertise to share the decisions can be useful concepts here. Feedback from this session was very good, both verbally on the day, and from structured measures. What is striking, among those who attended, is the value placed upon this approach and how it generates much greater patient and clinician

satisfaction, especially when difficult pain problems exist.

The concept of 'Problematic Pain' was born from this and proposes an alternative to our traditional temporal 'acute or chronic' thinking. It's philosophy is simple, and lies in quickly recognising those who could benefit from extra help with managing their pain. This could be acute pain conditions associated with Yellow Flags, where early effective intervention may reduce or prevent chronicity, or those with more established chronic pain who need additional medical, psychological or functional interventions. It also recognises the need to avoid medicalising those who will recover on their own, or manage well without support.

FPM activity; Complex Pain

The English Pain Summit meeting in 2011 recognised this as an important concept, and delegated the Problematic Pain work stream to the Faculty of Pain Medicine (FPM), who in turn involved individuals who are also members of the PCC SIG. Whilst these individuals did not represent the SIG in this activity, we mention their achievements here as it is relevant to our aims.

- UK stakeholder event;
- Consensus on concept and definitions;
- Formulation of consensus document;
- Polling of general practitioners (GPs) nationally via RCGP for pre-screening tool;
- Presentation of findings in the House of Lords Pain Summit update meeting;
- Pilot phase for testing pre-screening questionnaire in GP surgeries.

During the initial UK stakeholder meeting in late 2013, we discussed the term 'Problematic Pain'. There was mixed opinion; some felt while the term may be an accurate descriptor, it risked being misinterpreted that the person with pain was themselves somehow being 'problematic'. For this reason, the alternative term 'Complex Pain' was proposed, aiming to still encapsulate the biopsychosocial aspects of pain.

Pre-screening tools are used in other areas of medicine, for example, mental health. A two-question tool has been validated for use in the identification of those who may have depression. The idea is to use such a tool if depression is suspected – if the response is positive, a more accurate, diagnostic tool is used (e.g. Patient Health

Questionnaire-9 (PHQ-9) or Hospital Anxiety and Depression Scale (HADS)). It saves giving questionnaires to everyone who is suspected of having depression.

In the same way, we can use this concept in pain. The evidence base around key prognosticators in primary care has helped strengthen this idea. Distilling these prognostic factors down can yield a very short two-question tool, which may help clinicians in short consultations identify those who need a more proactive approach:

Over the past two weeks has pain been bad enough to interfere with your day to day activities?

Over the past two weeks have you felt worried or low in mood because of this pain?

If the response to either question is positive, it is a cue for the clinician to explore pain and the psychosocial factors in more depth. There are a number of decision making tools and pathways emerging (e.g. BPS Map of Medicine) to aid non-specialist clinicians in the assessment and management of pain.

It was important for us to understand first the usability of this brief tool, so we contacted the RCGP and devised a

national survey released to all its UK membership. Results will be shown in a poster at the ASM this year, but a sneak peek here was that the majority of GPs were supportive of the concept and the majority of responders said they would use the questions in their practice.

Clearly, if we are to propose a more detailed validation study, we will require in-vivo information. We are currently identifying pilot sites around the United Kingdom to trial the tool and get real life data. Please contact the SIG if you are interested in knowing more about this.

On behalf of the FPM, Ann Taylor and myself together with Kate Grady and Andy Nicolaou presented a summary of the work stream in the House of Lords during November. This was a great opportunity to showcase again the results of collaborative working from professional organisations and colleges.

It is clear that collaborative working is a very important principle for us as it underpins the values of the multi-professional team. In 2015, we have more planned in the form of another educational day, this time in the summer with the RCGP. We also are looking forward to our ASM workshop focusing on 'Primary Care Pain Tools – Evidence & Consensus' – hope to see you there.

Dr Beverly Collett OBE



THE BRITISH PAIN SOCIETY

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SAGE



The British Pain Society is proud to announce that Dr Beverly Collett was awarded OBE for services to pain management, in this year's Queen's New Year Honours list.

Dr Collett's tireless work to improve the lives of those who live with daily pain and her massive contribution to the management of pain are acknowledged nationally and internationally.

Acclaim in her area of specialist interest led to the first of her many leadership roles in Pain Medicine, as President of the International Pelvic Pain Society. In the UK, Beverly's work on the Council of the British Pain Society (the pre-eminent organisation for healthcare professionals and scientists working in the field of pain medicine) led on to her becoming Honorary Secretary and

culminated in her election by the membership to the Presidency. Her Presidency saw significant progress for pain medicine with an authoritative survey of prevalence and publication of much cited practice guidelines.

She played the leading professional role in the founding of the Chronic Pain Policy Coalition (CPPC), a not-for-profit organisation to promote policy solutions that contribute towards the improvement of the quality of life of those affected by chronic pain. She has brought together professionals, parliamentarians and patients with the aim of raising awareness of pain amongst the public, politicians and policymakers to achieve national strategies and resourcing for people with painful conditions.

Dr Collett was Chair of the Executive Committee comprising voluntary and patient organisations, leading figures in the area of chronic pain, academic institutions, professional and NHS representative bodies, medical and nursing Royal Colleges and healthcare companies that specialise in pain management. In all there are 29 academic bodies (six Royal Colleges and

Faculties and three medical societies), twenty patient organisations and six corporate members.

Under Dr Collett's leadership, the CPPC (together with the British Pain Society, the Faculty of Pain Medicine of the Royal College of Anaesthetists and Royal College of General Practitioners) organised the first English Pain Summit, which took place in Westminster in 2011 (Final Report: 'Putting pain on the Agenda'). Dr Collett's motivation and commitment ensured that this event was a resounding success, generating four ongoing work-streams with further important output expected later this year.

Her international roles in the pre-eminent global pain medicine organisations are equally impressive, having served as Treasurer of the International Association for the Study of Pain (IASP) and Honorary Secretary of the European Federation of IASP Chapters, in addition to chairing the IASP Special Interest Group on Pain of Urogenital Origin. She was also facilitator for IASP's theme for their 2007-8 'Global Year against Pain' campaign: 'Pain in Women' – a subject



These pictures were taken at a summit update meeting at the House of Lords. Presentation to Beverly by Lord Luce as she stood down as Chair of CPPC.

Dr Beverly Collett OBE

in which she is one of the world leading authorities.

Most recently, she was one of one of only two successful candidates in the first election to the Board of the Faculty of Pain Medicine of the Royal College of Anaesthetists.

The astonishing truth is that in the face of these high achievements and onerous duties, Beverly has continued to fully deliver an exemplary service as a consultant in Pain Medicine and Assistant Medical Director for her NHS Trust in Leicester.

Dr Beverly Collett's astounding contributions, resulting from her dedication, infectious enthusiasm, evangelical work for people living with pain, energy and sheer hard work have made her an internationally recognised name in pain management.

British Pain Society Grants & Awards

CLULOW RESEARCH GRANT 2015

The British Pain Society invites proposals for the 2015 Clulow Research Grant competition. We invite submissions from BPS members from a wide range of disciplines; from basic science to clinical services.

A grant of up to £50,000 will be awarded. The funds may be awarded for a variety of purposes in support of a research project (e.g. small project grant, salary support, capital equipment purchase, running costs or additional funding to an existing grant). However, should the Grant be awarded to cover a proportion of the total costs of a research project, it will not be released until funds covering the full costs of the project are in place. Applications will be peer reviewed and a decision made by the British Pain Society Science and Research Committee by October 2015.

The application form and a copy of the Society's research grant conditions can be downloaded from the British Pain Society website at: www.britishpainsociety.org/members_grants.htm.

The closing date is Monday 11 May 2015.

STUDY DAY BURSARY

The Society has made limited funds available to assist those members of the British Pain Society who require financial assistance to attend our study days and will be awarded on a first come, first serve basis. The study days are designed to be refresher days for established pain practitioners, and educational days for doctors, nurses and other healthcare professionals in training. Assistance will be provided towards the cost of registration and travel.

Eligibility

- The applicant must be a current, Ordinary member of the British Pain Society, in good standing
- The applicant must have an income of less than £25,000/annum
- The applicant may not apply for this bursary if he/she has been granted other British Pain Society bursaries within 12 months of this application.

Application

- An application form is available on request from the Secretariat at: meetings@britishpainsociety.org.
- A completed study day registration form must accompany the application form.

New BPS website

Dr John Goddard



THE BRITISH PAIN SOCIETY

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SAGE

Your new website went live on the Friday 9th January; you were informed on the 12th January, which gave the “internet” a weekend to adjust to our new ISP, Calm Digital. In actuality, I had access in Sheffield on Friday evening and there were “hits” from as far afield as Australia and Africa over the weekend! The potential power of the internet is truly amazing. That said, at work I am still taken to the “old” home page, but am able to access the whole of the new site from this page via the “bad link” page: NHS systems are still archaic I guess!

Any transition from an old to new site requires Google, and other search services, to update their records, locate the new site information and where it now lives. This unfortunately takes time; whilst there are things we can do to speed up this process (which have been done), it still relies on the search service checking this information (automatically, using “bots”) and updating their records. In the meantime, any one searching for the Society on e.g. Google may be presented with out of date links on the search page, leading to a broken link message from our site. Should this happen, it's worth going to our home page and searching for content on the site itself rather than through Google. This will change over time as records are updated.

Hopefully you will all have accessed the site with your temporary password and updated your registration details to enable you to make full use of its functionality. If you have lost the email that gave instructions to do this, you can still access the members section by using the “forgotten password”



link, but please update your registration details to make full use of the site.

You will be aware that we are making full use of the back office functions. Registration for the ASM is now occurring via our website; albeit, because of timing issues, initially with a temporary webpage that has now migrated. If you haven't registered yet, please consider doing so. Your membership renewal has been actioned electronically and, as I write this, Council

elections are about to be undertaken electronically too. All has gone smoothly so far, although deadlines have been tight.

An effective website is not a static creation; it needs to be monitored and developed. Google analytics will enable us to monitor usage of the website, identifying content that is accessed frequently, or not at all. As you navigate the site, particularly the member's area, you will, I hope, have become aware of several sections within the “healthcare

New BPS website

professionals" link that are under construction. Content in these sections, for the benefit of members, will require input from members of the Society. Enthusiastic members to lead on these sections are being identified. Similarly, content within the SIG pages is following the same process. The Communication Committee is about to "publish" a communication strategy for the Society;

it is envisaged that this will provide some structure for content development.

A Parallel thread to our website development is the embracement of social media. From a website perspective it is important that our new site is functional on mobile devices: I have viewed it on an iPad and iPhone 6 (not mine!) and it seems to be. Let us know if you think differently.

Finally, I once again extend my thanks to the many who have worked so hard to make this happen. Particularly: Steve Walmsley, project manager; Calm Digital; Jenny Nicholas and Ken Obbard, secretariat; Nick Allcock, Meherzin Daz, Antony Chuter, Christina Liossi – project group.

I hope you will enjoy, value and contribute to your new website.



The Tyranny of Diagnosis

Special Interest Group of the British Pain Society for Philosophy and Ethics.

Launde Abbey, near Leicester, 29th June to 2nd July 2014



"When accurate diagnosis is impossible and appropriate treatment unavailable we delude both our patients and ourselves by using diagnostic labels and prescribing specific treatment"

James McCormick

"Today the kingdom of the well is being rapidly absorbed into the kingdom of the sick, as clinicians and health services busy themselves in ushering people across the border in ever increasing numbers".

Iona Heath

When we have put a chronic pain patient in a diagnostic box which determines a course of intervention (or fail to make a diagnosis) do we stop thinking about their real needs?



The Clulow Award: A decade of pioneering pain research

Prof Maria Fitzgerald *Neuroscience, Physiology, Pharmacology, University College London*

A generous and inspired bequeath from the Clulow family has given pain researchers in British labs the opportunity to explore new ideas and pioneer new studies in the pursuit of understanding and curing pain. These are competitive awards judged by the scientific panel of the British Pain Society on the basis of originality and potential for clinical impact. It is expected that the Clulow award will lead to further external research funding in pain research.

Highlights from the last decade include advances in pelvic pain, dental surgical pain and infant pain. Two studies have focussed upon acute pain activity in the brain, an area we know surprisingly little about in a clinical setting. Tara Renton, Professor of Oral Surgery at Kings College London used the award to pilot a novel form of perfusion magnetic resonance brain imaging with continuous arterial spin labelling (cASL) to monitor those areas of the brain that are activated following painful third molar surgery both with and without paracetamol infusion. This important study will help to predict those patients that develop chronic nerve injury pain following such surgery and so lead to better pain relief strategies (1,2). Maria Fitzgerald, Professor of Developmental Neurobiology at University College London used the award to develop methods for recording the first somatosensory evoked potentials from the preterm and term infant brain. Her

team's discovery of unique nociceptive brain potentials in infants has since been used to study the development of cortical pain processing, the effects of repeated intensive care procedures and the effects of analgesics in hospitalised infants (3-5). Both of these investigators went on to gain further significant further funding in pain research from the Medical Research Council (TR & MF), Wellcome Trust (MF) and Royal College of Surgery (TR) following the Mildred Clulow Award.

The award is currently funding a study in chronic pain by Gary MacFarlane, Clinical Professor of Epidemiology in Aberdeen. A cross-sectional postal questionnaire population survey among 5300 women will be used to assess the prevalence of and factors associated with Chronic Pelvic Pain (CPP). This study will be a foundation for a more comprehensive and prospective evaluation of CPP which can inform the development of CPP management strategies. The results will be reported to the British Pain Society Annual Scientific Meeting in April 2015.

The 2015 Clulow Award is open to applications from members of the British Pain Society. Closing date, May 11th 2015. See

<https://www.britishpainsociety.org/members/grants-and-awards/> for further details.

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Reflections upon the pain experience – part 1: symptom validity and robustness of the pain diagnosis

Dr Rajesh Munglani *Consultant in Pain Medicine, Cambridge*

The great art of life is sensation, to feel that we exist, even in pain.

Lord Byron

Certainty generally is illusion, and repose is not the destiny of man

Oliver Wendell Holmes, Associate Justice of the Supreme Court of the United States from 1902 to 1932



A day in the life ...

A not infrequent scenario for me is to see somebody in

the pain clinic, who, having failed conservative therapy, turns up to find out if 'anything more can be done' in the pain clinic.

It sometimes feels more like an Undertaker's than a place of hope. By the time patients come to me, patients often also have a fairly firm view of what is wrong, as well as being more despairing.

I am told in no uncertain terms by the patient that the *real* reason for their sciatica is that the sacroiliac joint or facet joint 'keeps slipping out', and it is only through the skilled ministrations of a particular osteopath or chiropractor (usually) that the patient has been as mobile as they have been until now.

Additional diagnoses I am presented with include restricted cranial suture movement causing inhibition or blockage

of cerebrospinal fluid (CSF) flow and dental mal-alignment, both causing chronic widespread pain or fibromyalgia.

Very smugly, I point out that there is little movement in the sacroiliac joint and that a dislocated facet joint would be intensely painful and sometimes extremely difficult to treat without operative intervention. As for dental mal-alignment, I remain to be convinced that it causes anything more than headaches in some.

Restricted cranial suture movement? I usually use *that* comment to come to a rapid decision that the belief structure of that patient is such that the sort of medicine I practice is unlikely to be of help.

How do we diagnose pain?

However, these encounters caused me to think about how certain we are about *any* diagnosis in a field where we have to rely primarily and fundamentally upon the testimony (if available) of the patient.

Unfortunately, we have made things difficult for ourselves, or more precisely Harold Merskey did in 1964 when he decided to define pain in terms of tissue damage in the well-known definition which was subsequently adopted by the International Association for the Study of Pain (IASP):

an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. (Harold Merskey, *Pain* 1969: 6; 250)

This means, unwittingly, at times, all of us who work in the healing arts are likely at some point, if at all possible, to try and justify someone's experience of pain in terms of actual bodily pathology.

On this basis, therefore, we continue to seek out consensus or agreement when examining patients who clearly are suffering and distressed by the magnitude of their symptoms which they (assuming that they can) call 'Pain'.

Going back to the chiropractors, an interesting study showed that if you took five chiropractors and asked to examine the same patients with low-back pain, the kappa value for agreement about manipulating part of the lumbar spine was 0.47 (where a kappa value of 1 means complete agreement, 0 means chance agreement and -1 would mean precisely no agreement at all). This means, very roughly, that it was more likely than not that they *would agree only* less than 50% of the time, beyond chance, which segment to manipulate.¹

One could say that I am being a little harsh, and in fact, it was almost even chance that they might agree on a painful lumbosacral spine. However, the same study suggested that agreement that if it was thought to be either the L4/5 segment specifically or the sacroiliac joint, there was only a slight agreement of approximately 0.09 or thereabouts. At the L5-S1 level, the correlation was slightly better at 0.25, and of course, this is a common level for

spinal problems. This does not inspire one to confidence, especially if one is spending money and time going for such treatment.

But do doctors fare any better? In one study, they performed *worse* than physiotherapists when comparing inter-examiner reliability for low-back pain, but to be fair, the doctors had not worked as long together as the physiotherapists in the study.²

But there is an even more fundamental problem: what happens when the sign that you are looking for, say, a tender trigger point, also seems to be prevalent in the more or less asymptomatic general population?

In one study, physicians examining patients in pain reported that the prevalence of trigger points of active myofascial trigger points was $46\% \pm 27.4\%$.³ In contrast, Simons⁴ (of Travell and Simons Trigger Point Manual fame) noted that the prevalence of trigger points among fit healthy and young Air Force personnel was 54% in women and 45% in men.

What about something as simple as neuropathic pain? Some of the most eminent researchers in the field recently concluded,

*We still lack gold standard of diagnosing neuropathic pain, i.e., there are no clinically feasible means, in the clinic or laboratory, to differentiate neuropathy with pain from a neuropathy without pain ...*⁵

A well-respected reviewer of the epidemiology of neuropathic pain also commented as follows:

*It was surprising that some articles did not provide a working definition for neuropathic pain as a starting point*⁶

before finally concluding in that same article that the incidence of this poorly defined entity of neuropathic pain was 7% to 10% in the general population.

Looking again at inter-examiner reliability for neuropathic pain reveals that agreement was associated with a kappa value of 0.8 which is good compared to consensus about pain in general which is about 0.5 in most studies; however, more importantly, clinicians *could not agree* on the severity of the neuropathic pain in an individual patient with a kappa value of only 0.3.⁷ This has profound implications for which patients we treat and whom we do not, as we certainly cannot treat all 7% to 10% of the population who have neuropathic pain. Should we be exposing patients with only modest neuropathic pain problems to potentially very aggressive treatments, which may have significant morbidity mortality, for example, insertion of spinal cord stimulation or microvascular decompression. Even long-term administration of co-analgesics carries its own risks.

Diagnosis in complex regional pain syndrome and leaving patients in a diagnostic wilderness?

Dr Andreas Goebel, who is currently one of the world leading researchers in complex regional pain syndrome (CRPS), when asked about why he wanted to study this particular pain condition stated that it was because 'one can see something'. I understood what he meant, that is, to diagnose CRPS, one has to have, as well as pain, a set of signs as well of symptoms which include changes in sweating swelling temperature, skin texture, nail and hair growth and so on. Many of us will be very familiar with some of the more gross examples.

The problem is that many other conditions can give rise to a very similar clinical picture to CRPS including chronic infection, chronic arthritis, connective tissue disorders, erythromelalgia, compartment syndrome, crush injuries and even variants of neuropathic pain.

Goebel has significantly contributed to our understanding of CRPS as an autoimmune-like condition which may in

many cases be triggered by a seemingly minor trauma (or occasionally no trauma at all) leading to development of a picture which, in many cases, is not too dissimilar to other autoimmune conditions, that is, soft tissue/arthritis process of inflammation. Because, the antibodies which seem to be activated in CRPS are not present all the time, it is the chance association of trauma with the transient presence of antibodies which seems to cause the onset of CRPS, which is why many other traumas, in the same patient, at other times may not give rise to the condition.^{8–13}

It is likely that within the next few years we shall have a biomarker, a gold standard for CRPS, possibly based around an activated bone protein or possibly the antibody in question, laying to rest much argument about how to define this disease process.¹⁴

However, at the present time, in the absence of any validated biomarkers, we rely upon clinical criteria, most recently redefined by Harden and his colleagues, which are known as the 'Budapest' criteria and have now been adopted by most clinicians and researchers in the field as the best way of diagnosing CRPS. These criteria are much more strict than the previous criteria of the IASP and Veldman to diagnose CRPS.¹⁵ Unfortunately, despite their best intentions, the presence of such varied criteria has caused considerable uncertainty both for clinicians and patients.

It is important to emphasise again at this point that currently in the diagnosis of CRPS, we are relying on collections of clinical signs and symptoms, none of which are really specific and which can easily be due to other diseases because we still do not have a gold standard for a diagnosis of CRPS. With this inherent weakness in mind, a study in 2007 looked at clinicians' ability to diagnose CRPS using three sets of diagnostic criteria (the IASP, Bruehl et al. and Veldman et al.) based on patient reports

Reflections upon the pain experience – part 1: symptom validity and robustness of the pain diagnosis



This patient probably has CRPS ...



But what about this patient?

and physicians' assessments of signs and symptoms in 372 outpatients suspected of having CRPS. They found agreement between CRPS I diagnosis among the three sets was poor (kappa range: 0.29–0.42), leading to positive CRPS I diagnoses according to Veldman et al.'s criteria in 59% of patients. Using the less strict IASP criteria, a consensus diagnosis of CRPS was achieved in 72% of patients, and using the strictest Bruhl et al. criteria (which then formed the basis of the Budapest criteria), consensus diagnosis of CRPS was achieved in just 35% of patients.

In another study, the final diagnosis of CRPS showed poor clinician agreement with a kappa value of only 0.2. However, the application of Bruhl's (Budapest) criteria resulted in an increase in agreement between clinicians achieving a kappa of 0.38, but then *frequency* of CRPS diagnosis decreased from 73% to 43% in comparison with physician's own diagnosis. Thus, again stricter CRPS criteria mean more certain agreement between physicians and probably a more

certain diagnosis, but importantly, this was achieved in fewer patients.¹⁶

Leaving patients without a diagnosis

Currently, the Budapest criteria of signs and symptoms are considered the clinical 'gold standard' for the diagnosis of CRPS since we do not have a specific 'biomarker gold standard'.

Thus, the increasing diagnostic certainty achieved by strict application of the Budapest criteria unfortunately has meant that many patients with pain associated with odd features of swelling temperature changes and so on have been left in a 'diagnostic wilderness' as they no longer achieve these stringent standards set for a diagnosis of CRPS.

Is this merely an academic point or is it actually something more profoundly troubling? Many patients need the 'dignity of a diagnosis' (a remark attributed to Bogduk in 1994) to validate their pain experience and many have now lost this. This causes acute distress to many patients who believe they do suffer with significant CRPS pain who now rightly feel that they are 'no longer believed'. In such a situation, medico-legally, a lack of a CRPS diagnosis may have very significant adverse financial consequences for a patient/claimant.

Unfortunately, it is not just disgruntled patients who we have to deal with, there is now a political and racial dimension that too needs to be addressed. It is now being recognised that the Budapest criteria were based around an overwhelmingly White Anglo-Saxon population. It does seem that even when the diagnosis of CRPS is likely to be certain, other races such as the Japanese may present with CRPS in different ways and by using the Budapest criteria they may 'miss out' on a diagnosis of CRPS.¹⁷ The response of the Budapest group to this observation was to reject the suggestion that racially specific CRPS diagnoses should be set

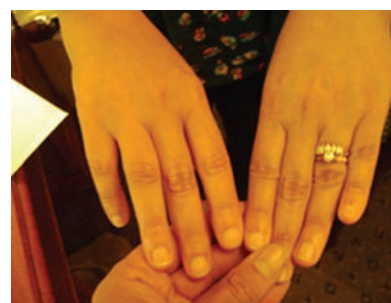
up as they were worried about the uncertainty it would cause clinicians!¹⁸ This obviously raises the question about what the role of the clinician is. Whom do we serve? If the tests that we all decide upon are actually shown not to be helpful and leave patients highly distressed and uncertain, then whose uncertainty should we tolerate? Ours, as clinicians? Or that of our patients?

On a more positive note, a recent paper showed that the use of thermal imaging to 'visualise' temperature changes in CRPS does seem to significantly improve consensus diagnosis in CRPS and may be particularly helpful in the medico-legal setting in my experience as seen in the example that follows.

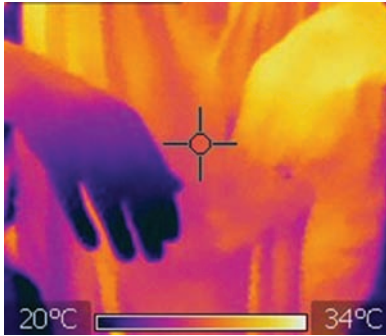
Criticism of the IASP definition

Again one wonders, therefore, whether there is any meaningful correlation between the presence and absence of *physical* symptoms and the presence of pain. We come back to question the validity underlying the implicit message of the IASP that 'pain represents actual tissue damage or is described in terms of such'.

Understandably, the definition of pain adopted by the IASP has come under



This patient complained of severe pain every time she used the dominant right hand; it swelled. It certainly felt different, but the photograph itself only shows possibly slight swelling on the affected side and one could wonder what the problem is. Really the photograph is not that convincing. Because she was no longer able to work as a highly paid professional as she previously did, the claim was for a very large amount of money.



Thermographic imaging, in this case, revealed that the temperature of the two hands were in fact very different, and this convinced the judge to settle considerably in her favour.

increasing criticism.¹⁹ Wright argues that fundamentally of course no part of this statement can be assumed.

Wright goes on to ask the question 'what meaningful statements can be made about subjective (*pain*) experience?' and he continues,

The IASP's solution is to qualify an imprecise characterisation of pain's phenomenal qualities through an association with tissue damage ... and an ability to recognise pain sensation.

Wright argues further that another fundamental weakness of the IASP definition is that one actually has to report pain. What about neonates, those suffering from dementia and others who do not have the ability to communicate? On a positive note, he recognises that the role of the IASP was to assist clinicians examining patients in attributing pain to them – if that is what they felt was true – using terminology that would be recognised and accepted by other clinicians in the field, allowing treatment of the patient and pain, if possible.

Thus, objective physical external correlates of the 'internal pain experience' continue to be sought actively by many of us, not only early on but also years on into the pain experience of an individual.

Pain: a sensation versus a feeling and a clue to what is going on here

There has been an argument raging, in a meaningful sense, probably for the last 2,500 years about *whether pain is a sensation* (like touch is) or *pain is more of a feeling or emotion*.²⁰

It is important to understand the difference. If we say pain is a sensation, then that means it is very specific and, for example, is completely separate from the sensation of say itch or the perception of cold or heat.

The second main theory is that pain is primarily a feeling or an emotion. Aristotle (384–322 BC) considered the heart to be the seat of feelings and understood the cognisance of pain to be the most important factor. He therefore argued that pain was an emotion. Not all the Greek philosophers agreed with him; however, his view prevailed at the time.

Galen (AD 130–201), a leading physician and Surgeon General of Alexandria, used experimental studies and disagreed with Aristotle. While Galen recognised that the brain was the seat of feeling, he placed the pain completely in the sphere of a sensation, that is, a distinct sensation that we distinguish, for example, from touch, temperature or itch, as indicated above. Avicenna (AD 980–1037), a renowned Muslim philosopher and physician, also recognised that pain can disassociate from touch or temperature and again proposed the pain to be an independent sensation.

Recognition that there are specific anatomical pathways for pain indicating pain must be a specific sensation just like touch is.

Very little progress was then made on this argument until the last 200 years when the exact anatomical pathways, that is, the somatosensory pathways, for pain have been characterised.

It is recognised that there can be, within these spinal cord and brain pathways, both amplification and indeed diminution of the specific pain sensations

or interpretation of non-painful stimuli as painful. This modulation of the signal is the area where many pain consultants work. We spend our lives trying to turn down the 'amplifiers' within the spinal cord or brain when the system seems to go hay wire and not control the level of symptoms adequately. The concept of hyperalgesia (i.e. an ordinary painful stimulation being amplified up to something more severe) or allodynia (i.e. a non-painful stimulus being interpreted as a painful stimulus) comes from these latter studies over the last 200 years.

There is evidence that as pain becomes more chronic, the neural circuitry becomes more centralised in the brain and focuses on the feeling/emotional areas.

The emotional aspect cannot be forgotten because now that we have functional magnetic resonance imaging (MRI), we recognise that with time, pain shifts from the initial specific somatosensory circuitry (i.e. a very distinct anatomical pathway associated with pain) to the more emotional circuitry.²¹

That is, as pain becomes more chronic, it changes from a 'sensation' perhaps associated with more peripheral inputs to a 'feeling or an emotion', which is much more centrally driven.

Therefore, having spent the last 200 years outlining the specific peripheral somatosensory pathways of pain, we now are back to the original conversation whether pain continues to be a sensation based around somatosensory circuits or whether it is now more of a feeling or emotion based in the brain; the 2,500-year-old discussion continues and will be continued also in the next linked article.

Declaration of conflict of interests

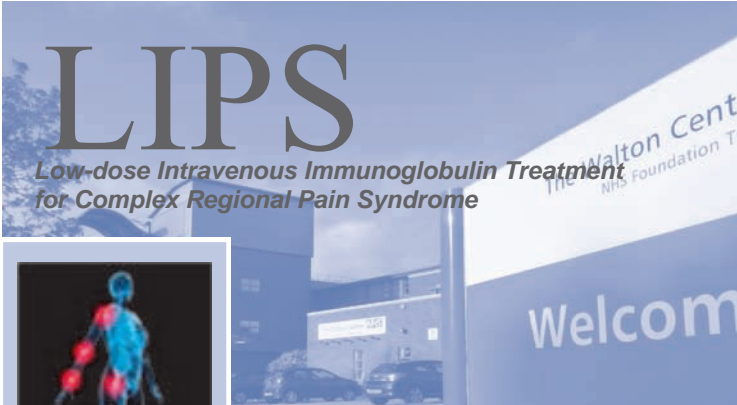
This essay is loosely based on an invited talk that was given at a 9 Gough Square Seminar at the Law Society, Chancery Lane, on 11 September 2014.





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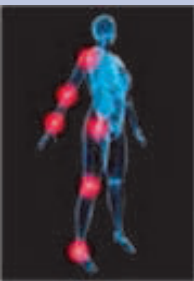
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BATH

CAMBRIDGE

GLASGOW

LIVERPOOL (LEAD)

LONDON

NORFOLK & NORWICH

LEICESTER

Inclusion/ Exclusion Criteria:

- Patients with a diagnosis of complex regional pain syndrome I or II according to Budapest criteria
- Moderate or severe pain
- Aged 18 years and above
- Disease duration of between 1-5 years
- No other significant chronic pains, or unstable medical conditions.
- Willing and able to travel to a recruiting site

(if you are uncertain of any of the study requirements please contact us to discuss)

This trial is led by Dr Andreas Goebel, Consultant in Pain Medicine at the Walton Centre NHS Trust and is managed by the King's Clinical Trials Unit (UKCRC) London. It is funded by MRC/NIHR (EME).

Recruiting investigators are:

ANDREAS GOEBEL
The Walton Centre NHS Trust, Liverpool

CANDIDA MCCABE
Royal National Hospital for Rheumatic Diseases, Bath

NICHOLAS SHENKER
Addenbrookes Hospital Cambridge

MICK SERPELL,
Gartnavel General Hospital, Glasgow

NICK PADFIELD
Guy's and St Thomas' Hospital, London

MARK SANDERS
Norfolk and Norwich University Hospital, Norwich

KARIM SHOUKREY
University Hospital of Leicester NHS Trust.

All participants for the study need a referral letter from their GP or pain Specialist. This should include all relevant clinic letters. If you have a patient who wishes to take part and you would like a referral template, or for any other queries about the study please contact Miss Holly Milligan on h.milligan@liverpool.ac.uk, or on 0151 529 5835.



Reflections upon the pain experience – part 2: the determinants of chronic pain, or the possible diminishing role of chronic pain in chronic pain syndrome

Dr Rajesh Munglani *Consultant in Pain Medicine, Cambridge*

Dr Michael D Spencer *Consultant Psychiatrist, Cambridge*

*Physical pain however great ends in itself
and falls away like dry husks from the mind,
whilst moral discords and nervous
horrors sear the soul.*

*I suppose one has a greater sense of
intellectual degradation after an interview
with a doctor than from any human
experience.*

Alice James



Alice James (1848–1892) was daughter of Henry James Sr, a theologian and sister of psychologist and philosopher

William James and novelist Henry James Jr, and probably had more of a right than most to speak about pain and suffering. Although born into a wealthy and intellectually active family, she developed psychological and physical problems that would plague her until the end of her short life. She suffered numerous major breakdowns before finally succumbing to breast cancer at the age of 43.¹

Persistent pain can be experienced in the relative absence of ongoing ‘pain generators’

Why do some people suffer so much with chronic pain, and can we predict who is going to get chronic pain?

The problem was highlighted again recently in a High Court case in which we were both called to present expert evidence (*Downing v Peterborough NHT Trust (2014) EWHC 4216 (QB)*).² Richard ‘Ritchie’ Downing, whom the Court heard was a brave and rising star in the British Armed Forces with an unblemished career record and commendations for bravery, underwent what was subsequently agreed to be an unnecessary operation in 2006, supposedly to alleviate snoring (the operation was in fact effectively useless, due to his condition being of a non-operable subtype). Unfortunately, as a result of the operation, he suffered a catastrophic severe reactive arthritis leading to the development of a chronic pain condition, which meant that he walked on tiptoes, hunched over and with painful joints all over his body.

By the time he was seen in 2013 for the purpose of a Pain Medicine report, it was clear (to me, R.M.) that he had mainly recovered from his reactive arthritis from the physical Pain Medicine point of view – suggesting significant potential for recovery from his condition. Like many soldiers, he put on a brave face at the time I examined him, and I was initially optimistic that despite the considerable time that had passed and the previous attempts to try and rehabilitate him, he might still improve.

Unfortunately, the psychiatric evidence (following examination in 2014; M.D.S.) indicated that in fact, despite apparent physical improvements, Downing had become entrenched in a pattern of pain behaviour and had already (and in retrospect, perhaps rather unsurprisingly after what had by then been some 8 years of chronic pain experience) become established within a vicious cycle of chronification of pain – involving psychological deteriorations including the development of depression and also *features of perceived injustice, loss of hope and lack of expectation* – which meant that his response to any physical rehabilitation was likely to be minimal. This

Reflections upon the pain experience – part 2



Pre-2006



2013

Photographs of Warrant Officer Peter Richard Downing (reproduced with his kind permission)

caused a radical shift in the Pain Medicine prognosis (R.M.) in this particular case.

The situation then arose that the High Court (in a case concerning *quantum* rather than *liability*) was required to judge how much to award an individual who, based upon objective physical measures, had largely improved from the original severe acute arthritic condition – but who continued to be grossly physically and psychologically disabled. There was a large claim including costs for care, assistance and loss of earning. Moreover, the Court was of course faced with the question as to how much physical care does one award a person whose requirement for such physical care was in large part psychologically mediated.

Let us make it clear the credibility of the Claimant was never ever in doubt. It was noted he had completely co-operated with all that the doctors had asked of him. Sir David Eady, sitting in judgment in the High Court, fully accepted the genuine nature of the significant chronic pain that the Claimant was suffering and indeed continues to suffer from and that it is fully expected that he will never work again. In the event, after the trial at the Royal Courts of Justice and after much detailed cross-examination of the experts, he was awarded a multi-million pound settlement.²

Cases such as these cause us as clinicians to reflect much. When one has

an injury and suffers pain and then the pain does not get better despite apparent improvement in the underlying condition, what are the reasons for this?

Persistent experience of pain causes patients to litigate

Does a patient continue to 'feel' pain when an arthritic process has disappeared? There is certainly the suggestion from some studies that patients continue to 'perseverate', to continue to feel the pain as if they were experiencing it at the time of their injury. Indeed, it has been suggested that these are the patients who are more likely to litigate – in other words, that it is *the persistent experience of pain that causes one to launch proceedings*, rather than litigation being the cause of the persistent pain.^{3,4} It is accepted that there are cases where of course the ongoing litigation will fuel the chronic pain experience – but it is a sobering thought that many patients only litigate because they continue to experience pain after a perceived injury.

A sense of injustice will fuel the chronic pain experience and may be associated with central dysregulation of pain control

Of particular relevance to the case discussed here, it is clear the literature

now indicates that if there is a sense of perceived injustice involved (and of course there was perceived justice in spades in this case: understandably so, because the operation was pointless and, because of it, a promising career in the Army was ended), then such a sense of injustice can fuel the chronic pain experience, and the potent effect of this particular factor should not be underestimated.⁵

In Pain Medicine, when we are asked by the Courts to state what percentage of people suffering traumas go on to develop significant chronic pain, we (in my experience, R.M.) usually say about 10%. If the role of perceived injustice is particularly potent than we might expect, in such situations, the percentage continuing to experience chronic pain into the longer term will be much higher. In fact, one particular study investigated veterans of the 1973 Arab–Israeli War – who were tortured after being captured in battle. Participants were at that time all young adults 18–26 years, and in good physical condition. A total of 60 male ex-prisoners of war (exPOWs) were compared to 44 control males.

The exPOWs were severely tortured during periods of captivity lasting from 6 weeks to 9 months. They were held in solitary confinement, at times handcuffed and blindfolded. They were usually held in tiny unhygienic spaces and were subject to brutal torture, including severe beatings, penetrating injuries, suspension, positional torture, electric shock to sensitive organs, burns and systematic deprivation of food and water. Physical torture was applied to the entire body, particularly the head and neck, the back region, genitalia and feet. Injuries inflicted during captivity were hardly treated, and in many cases, torture was inflicted to the wounds. Oppression and humiliation included not being permitted to use the toilet, verbal abuse such as curses and threats, demoralising misinformation about their loved ones and mock executions.

Over 30 years later, compared to the control group, the group that had been

tortured continued to show altered pain processing in apparently unharmed parts of the body. Specifically, they were extremely sensitive in areas of the body that had not been subject to torture, indicating a centralised dysfunction of pain processing. Unsurprisingly, the incidence of chronic pain decades later was almost 90% among those who had been captured and tortured.⁶

The potent role of prior psychological/psychiatric experience in determining the development of chronic pain after trauma

One could argue that the latter was a rather extreme example as these soldiers apparently were mentally robust prior to being captured, but it does seem that the literature now suggests that prior (usually psychological/psychiatric) experience is an important determinant of chronic pain after a subsequent incident.

Nowhere is this more discussed than in the onset of chronic widespread pain after what may be seemingly minor road traffic accidents which cause little or no soft tissue injury. The original classic work suggested that whiplash injury to the neck, more than other trauma say to the lower limb, would cause greater chronic widespread pain by an order of magnitude. In the original study, the incidence of chronic widespread pain after a whiplash injury was in the order of 22%, compared to about 2% in the lower limb trauma group.⁷

Subsequent work suggested that in those patients who developed chronic widespread pain, a history of trauma was found within the preceding 6 months.^{8,9} The latest evidence arising from a prospective study indicates that while trauma seems to be the 'trigger' for the development of a chronic widespread pain state, multivariate analysis suggests that the factors giving rise to the chronic pain outcome existed prior to the accident and were usually psychological/

psychiatric factors. Importantly, collision-related factors such as the speed of impact played little or no part in determining the development of chronic widespread pain.^{10,11}

Genetic and/or prior life experiences promote vulnerability to developing chronic pain after trauma

Observations such as these have led to speculation that either early or prior life experiences or perhaps genetic factors, or a combination of both, may provide the substrate for future pain experiences and may, on balance, predominantly determine outcome following many noxious events.

Genetic associations with chronic pain vulnerabilities are now well accepted. One study quotes heritability of chronic widespread pain as about 50%,¹² and another reports that monozygotic as compared to dizygotic twins are five times more concordant for low back pain – although also noted is the role of exercise and lifting.¹³ The cold pressor test has been shown to have a larger genetic contribution as compared to heat sensitivity.¹⁴

Furthermore, a landmark study revealed that magnetic resonance imaging (MRI) measures of white matter fractional anisotropy (FA) recorded at the onset of acute low back pain accurately predicted which patients would go on to develop chronic low back pain.¹⁵ Furthermore, prior pain experience seems to alter functional circuitry in the brain. The implications of all these studies are profound and suggest, as eloquently suggested by Irene Tracey, Katherine Bushnell and their colleagues, that there is a 'chronic pain endotype' and that chronic pain is a disease.^{16–19}

Does the underlying (so-called 'biological') pain not then matter?

In contrast, there is little doubt that far from diminishing the role of biological/

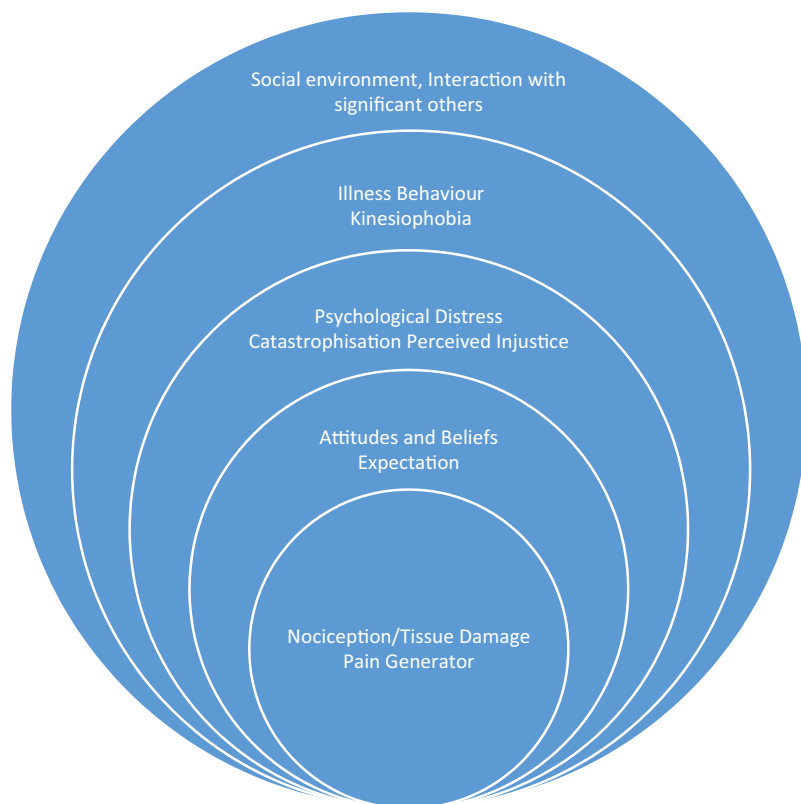
tissue substrate for chronic pain, genetic and trauma-related factors may play a significant role in causing development of altered peripheral and spinal functioning which gives rise to subsequent changes at a more cephalad level. These biological changes have been well described in the last three decades in particular including spinal cord apoptosis and reorganisation,^{20–23} but more recently, it has been shown that as a result of immune–glia interactions at a cellular level, the usually inhibitory K channels become excitatory and promote increased afferent input, and the cellular basis of decreased morphine tolerance has been understood.²⁴

It is likely for some individuals that these types of biological changes are the major trigger for chronic pain states, and treatment of these or ongoing peripheral pain generators (such as painful arthritic joints of the hip or spine) can be remarkably life-transforming. Intriguingly however, for many others, the eventual removal of the original or ongoing pain generator does *not* have the desired effect. There are too many other layers supporting and maintaining the pain experience.

While such interactions between the physical and the psychological are recognised within the 'biopsychosocial model', the model fails to capture what is considerable inter-individual variation in the relative importance of individual components – in that, for some, the physical pain generator is paramount and treatment of it can lead to significant improvements, whereas in others, removal of the physical pain source may make little difference.

Is the biopsychosocial model of pain an appropriate model on which to base treatment?

The biopsychosocial model (or its variants) is often displayed as a core nociceptive or other pain generator surrounded by layers of other factors



which may diminish or enhance the pain experience all sitting within a social milieu.

This is not actually a useful model for treatment purposes as, for many, it implies there is a logical pathway to treatment of the pain starting with the innermost circle and working outwards. In many cases, one has to tackle other components directly and independently – as they themselves may actually be the ongoing critical ‘pain generator’. In particular, we find that the belief structure and expectation of the patient is critical to whether the patient is ever going to improve.

Both R.M. and more recently Dr Christopher Bass have commented as regards how a simple diagnosis may promote disability – that is, the patient becomes disabled by simply knowing what the potential consequences of a disease state may be and becoming distressed and indeed disabled by it.

The matter is made worse when there may be doubt about the original diagnosis. Such diagnoses (often of exclusion, where there is no specific biomarker) may include chronic pain syndrome/disorder, myalgic encephalopathy/chronic fatigue syndrome (ME/CFS), fibromyalgia, chronic widespread pain and sometimes diagnosis of complex regional pain syndrome (CRPS), where it is uncertain (see previous article by R.M.). In the medicolegal setting, the negative effect of such a diagnosis can be profound in some patients due to secondary gain factors.

Although it may be the case that the achieving of a ‘settlement’ may ameliorate to a significant extent the sense of perceived injustice allowing a sense of ‘closure’, there is no easy or straightforward relationship between apparent improvement after a verdict and any possibility of malingering.^{5,25–28}

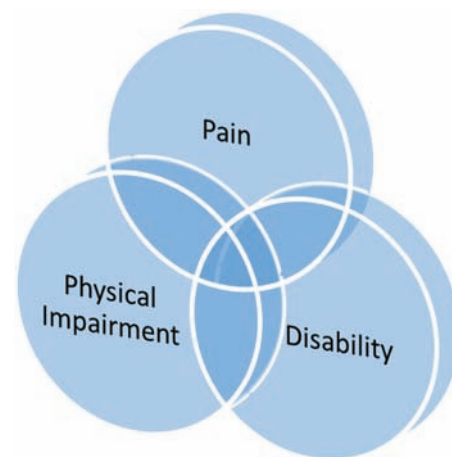
Practically, which are the major determinants of the chronic pain syndrome and can we ameliorate them?

Pain is not the same as disability, and in fact, neither has much to do with objective signs of physical impairment, with correlations of between 0.27 and 0.55 at most.^{29,30}

The role of pain catastrophising and kinesiophobia and post-traumatic stress disorder

Going back to the reported case of Downing, despite the intensely painful arthritic process eventually largely improving, the intense pain caused the development of fear of movement, which has persisted, and has been accompanied by *pain catastrophising* and *kinesiophobia* (‘fear of movement’) – which are major predictors of pain behaviour for many.^{31,32}

In some studies, the course of progression of pain experienced closely matches that of post-traumatic stress disorder (PTSD) symptoms, suggesting a strong role for this factor in the maintenance of the pain experience and indeed somatisation.³³ For others,



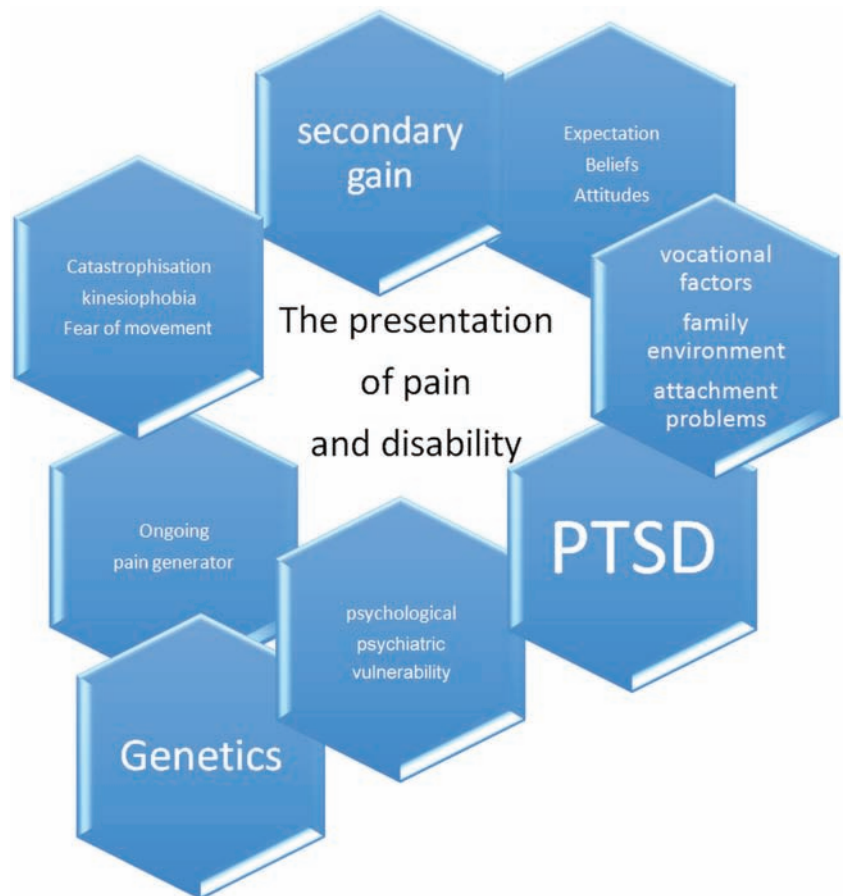
Pain, Physical Impairment, Disability are only poorly correlated and in some patients not at all

post-traumatic symptomology profoundly reduces chances of responding to treatment, an observation confirmed in veterans returning from the recent wars in the Gulf where it has been shown that there is effectively little point in trying to treat the pain until the PTSD has been dealt with. Interestingly, in many, treatment of the PTSD causes spontaneous reduction in pain experience.^{34–37} These types of observation suggest that for many, psychological/psychiatric therapy may need to occur before treatment of any residual ‘organic pain generator’ or certainly the treatment has to occur concurrently. This would also match our own experience that for a proportion of patients/claimants, the secondary gain factors that can be induced by an ongoing medicolegal process have to be brought to an end before there can be any meaningful reduction in pain experience.

We therefore propose an alternative model in which various factors can cluster to bring about the experience of chronic pain. The various factors will interact with each other and also may diminish or enlarge with time.

It is valid to consider whether any ‘half-decent’ pain management programme couldn’t sort this out. Unfortunately, a rigorous review suggested only modest improvements of 20%–30% on pain perception and function in only 50% of the patients selected for such programmes, and little or no effect on vocational outcome.³⁸

Further caution about the prospect for improvement comes from the work showing the chances of improvement with rehabilitation dramatically falls away the longer definitive rehabilitation is delayed after injury.³⁹ Again, The Judge in the case, Sir David Eady, concluded that Downing would not work again and allowed future loss of earnings based on submissions of such evidence (by R.M.).



Proposed alternative model which allows the various factors to cluster and interact, and the role of each may change, diminish or indeed increase with time

The power of expectation and psychosocial factors in determining outcome

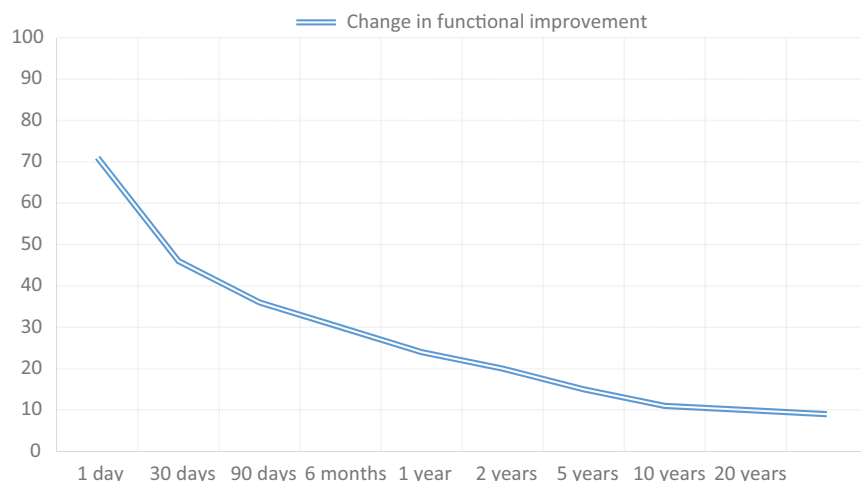
The power of expectation and psychosocial factors are highlighted again in studies which suggest that how much the patient expects to improve and how much they enjoyed their work prior to suffering a lumbar disc prolapse were far greater determinants of outcome post-discectomy than any spinal, pain or medical factor. While improvements in pain scores with discectomy were predictive of short-term improvement, they had no bearing on the long-term outcome which was entirely determined by the psychosocial factors mentioned above.^{40,41}

Concluding remarks

While we were both giving talks related to the subject of this article at the Royal Society of Medicine recently, at least one delegate commented that it could be argued that there was now no place for anaesthetists in the assessment of patients with chronic pain. We would agree that the time has passed for those without formal training or knowledge, based on experience of the breadth of pain medicine, to continue to run pain clinics.

However, in contrast, there is an absolutely critical role for Pain Consultants attuned to looking for ongoing (and hopefully treatable) pain generators, as well as being alert to patients' belief

REPORTED PERCENTAGE IN FUNCTIONAL IMPROVEMENT WITH TREATMENT FOLLOWING TIME SINCE INJURY (VORA 2012)



The longer rehabilitation is delayed after the injury, the less likely it is to work

structures, expectations and significant psychological, psychiatric and social factors within which the pain is experienced. The setting up of the Faculty of Pain Medicine of the Royal College of Anaesthetists with the introduction of appropriate standards of training and examination is very welcome indeed.

Accredited Pain Consultants need to work closely with their Psychiatric and Psychological colleagues (who similarly should have a specific interest in chronic pain) in helping determine appropriate treatment pathways for these patients.

Acknowledgements

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Declaration of conflict of interests

This essay is loosely based on talks given by both R.M. and M.D.S. at the Winter Meeting of the Personal Injury Barristers Association in London on the 15 November

and also given at a meeting of the Royal Society of Medicine, London, on 19 November 2014.

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Bad Backs and Silverbacks: establishing the first pain management service in Rwanda

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I spent 3 months at the Rwandan Military Hospital (RMH), Kigali, for my out-of-programme clinical experience between August and November 2014. The RMH is one of the top referral hospitals and treats 80% civilian and 20% military patients.¹ Before starting, I had agreed with Dr Christian Mukwesi and Dr Jerome Muhizi, two of the four Rwandan anaesthetic doctors at the hospital, that I would support the development of the first pain service in Rwanda. The idea of a pain service had been introduced by 2-week-long symposia in 2012 and 2013 by the charity Specialists in Pain International Network (SPIN),² and the Rwandan Ministry of Health has issued a

detailed set of guidelines for managing pain, which include everything from the World Health Organization (WHO) analgesic ladder to spinal cord stimulators.

However, when I arrived, I found there was nothing happening on the ground and a worrying lack of effective pain management.

Rwanda: a place of change

Rwanda is a small East African country famed for its gorillas and beautiful undulating landscape. Since the genocide in 1994, Rwanda has embraced political and economic change and is considered one of Africa's success stories. Infant and child mortality are among the lowest in Africa, and a large part of the population, including the extreme poor, is covered by public health insurance. Despite this progress, Rwanda remains one of the poorest countries in the world, with more than 80% of the population living on less than US\$2 a day.

I was struck by the strength of the Rwandan people's ambitions for a brighter future and the dedication shown by those I worked with.

Understanding the context was critical to influencing change

In my first week I explored walking the floors, speaking to staff and patients and

taking large group teaching sessions. I was warned by other aid doctors working in Kigali that resources were tight: 0.1 doctors per 1,000 (compared to 3 in the United Kingdom), only 16 consultant anaesthetists in the country and no history of a formal pain service.

The impact of donors on the healthcare environment was interesting: theatres and Intensive Therapy Unit (ITU) were of a surprisingly high standard with anaesthetics and ventilators similar to those in the United Kingdom. The wards were another world – peeling walls, bare concrete floors and beds packed tightly together with no privacy. I was impressed by the way staff kept things simple and made the most of what they had. However, it quickly became clear that most staff had received little or no pain training. Often, despite simple analgesics such as oral paracetamol being available, they were not prescribed or prescribed at an inappropriate dose or timing interval. There was also a large degree of opiophobia from both patients and staff. I had started a small dose of regular oral morphine to treat abdominal pain in a young man who was dying from an HIV-related condition. Despite him experiencing considerable relief from this, the resident doctors had stopped it, telling the patient that he would become addicted.

I began to see how culture impacts on the way pain is managed. Stoicism,



The RMH



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called *kwihangana* in Rwanda, is an important cultural value, and patients are often reluctant to report pain unless directly asked about it. Pain assessment was rarely or never carried out. It was also interesting to discover that Rwandans often assume pain is a normal part of healing. In the past, these issues, and the understandable emphasis on solving problems such as high infant mortality and tuberculosis, have meant that pain management has not been made a priority.

It was a welcoming environment, but to influence change, I realised that I needed to be accepted as a functioning member of the team. I therefore tried to build my credibility immediately by supporting acute pain management: promoting regional anaesthesia in theatres and using and teaching a number of simple blocks such as wrist block for the resection of a large lipoma in a 6-year-old boy.

Understanding and embedding myself in the day-to-day life at the hospital was critical to supporting the change necessary. A start had been made, but often a service disintegrates without the constant input of foreign aid doctors. I kept asking myself, 'how will the service continue after you have left?' To sustain change, the culture of pain management needed to be owned and prioritised by staff and leadership themselves.

To make this happen, I focused my limited time on four things:

1. Selection, training and empowering of Rwandan Pain Champions;
2. Enabling better pain management through improved access to the right drugs;
3. Demonstrating the value of chronic pain management through facilitating Rwanda's first pain clinic;
4. Negotiating the buy-in at the leadership level so that this work will be protected from competing priorities going forward.

Rwandan Pain Champions

Despite my initial training, the nurses' documentation was very poor, and pain scores were not regularly recorded. Doses of analgesia were often missed, leading to terrible breakthrough pain. To ensure the service could become self-sustaining, it was essential for me to inspire champions for pain management. The chronic shortage of doctors meant that supporting a multidisciplinary team was essential, so I therefore chose nurses as the Pain Champions.

The pain champions included Didier, Jean-Claude, Denyse and Josephine – four nurses from paediatric, surgical and internal medicine wards. Also in the team were Bernadine, Liliane, Nepo, Chantal, Ruben and Deo – a mix of physiotherapists, anaesthetic technicians and clinical psychologists. It was an inspiring experience to work with such dedicated people, and I am happy to say we are still in touch. They were able to share the vision for a pain service and facilitate interaction and teaching with both patients and staff. This was especially important as my *Kinyarwanda*, the native language of Rwanda, was very basic at best!

We took acute pain ward rounds and chronic pain clinics together. These included regular pain assessments using validated tools such as the numerical rating scale and Wong-Baker faces – even more important than normal given Rwandan *kwihangana*. This also



The pain champions teaching other staff about pain at the RMH



demonstrated the unacknowledged pain being suffered on their watch. One of the champions was so shocked at the level of pain felt by one patient, he said that the lack of attention was 'an abuse of her human rights, which the staff should almost get court-martialed for!' We supported them with intensive small group training using problem-based learning, which was scaled up by the week-long visit by a team from SPIN,



Author, Dr Sian Jaggar (from the charity SPIN) and the pain champions



With Rachel one of the paediatric nurses – using posters to teach basic pain assessment

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which included both doctors and nurses. Critically for the sustainability of our vision, they also received training in how to teach the other people in their department, and it was agreed that each would hold a departmental teaching session in pain in the future.

I observed that the hierarchical dynamic between the doctors and the nurses was part of the challenge. Sometimes, even if the nurses knew the patients were in pain, unless the doctor directly asked, which was very rare, the nurse would not feel confident enough to flag it up as a problem and encourage analgesia to be prescribed. As well as empowering the nurses with knowledge, it was also important to motivate doctors to take pain management seriously by explaining that effective analgesia would help prevent future complications such as deep vein thrombosis, poor wound healing and bronchopneumonia. We also used a weekly doctors' meeting to introduce Didier and Jean-Claude, the nominated acute pain nurses, and explain they would be carrying out twice-weekly ward rounds accompanied by an anaesthetist if available.

Nepo and Chantal, the two anaesthetic technicians on our team, covered the service in theatres. They are currently running a quality improvement project in recovery to ensure that no patient returns to the ward without appropriate analgesia being prescribed.

I realised that my Pain Champions needed to feel empowered to lead the service on my departure. So before I left, we discussed intensively, as a team, how the pain service should function after I had left. We were able to set realistic goals and assign roles to individuals so people would be accountable.

Improving patient access to the right drugs

When I arrived, the RMH only had parental preparations of morphine, pethidine, fentanyl and ketamine. Tramadol was available in oral and



intravenous formulations, and there were relatively consistent supplies of oral paracetamol, ibuprofen and diclofenac. Despite this, doctors often failed to use a multimodal approach to treat pain, and often, the doses and timings of analgesics were inappropriate. This led to many patients with severe pain put solely on intravenous pethidine as required. I ran teaching sessions with doctors emphasising the use of the WHO analgesic ladder and a multimodal approach.

There was no oral morphine at the RMH, and if patients required it, their family would have to travel to the neighbouring palliative care hospital 20 minutes drive away. Notably, the supply of morphine from the International Narcotic Board had radically increased in recent years, but this has not translated into increased availability. I liaised with central government to ensure the first supply of oral morphine for the RMH. For patients with neuropathic pain, there was a good supply of amitriptyline, and I was also able to secure the first stock of gabapentin for the RMH.

I gave Flavia, the deputy head pharmacist, a list of drugs in varying doses and formulations that would need

to be made available if possible. Just after I left, the first supply of morphine elixir became available, and this could benefit many more patients. Hopefully, as the routes of distribution become more established, morphine will become readily available to more patients.

Demonstrating the value of chronic pain management

As it was a new service in Rwanda, it was essential to publicise the pain service. We advertised at local and national level for patients via word of mouth, flyers, email and a radio announcement. The Rwandan government health insurance, 'Mutuelle', covered most of the cost of the clinic visit, meaning that it was affordable for most.

Initially, there were two clinics a week. These were carried out with my trusty nurse translator Jane, in an outpatient department setting. Amazingly, there was a very well-developed department of clinical psychology at the RMH – larger than I have seen in most hospitals in the United Kingdom! This is due to the high level of post-traumatic stress and its recognition by the government following the genocide. Health professionals were therefore already familiar with techniques such as cognitive behavioural therapy. We took the opportunity to build on this in the context of chronic pain so that as the clinics became more established, we were able to run them in a



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Poster used to advertise the new pain service at the RMH

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multidisciplinary manner with psychologists and physiotherapists.

The aetiology of chronic pain in the patients who attended clinic varied enormously. Trauma was common due to the high incidence of road traffic accidents and the after effects of the genocide. One 40-year-old woman had suffered from chronic headaches since her parents were killed in front of her, and she herself had received a skull fracture. There was also a man who had suffered a gunshot to the spine, which had caused paraplegia as well as chronic pain. Despite this, he remained optimistic, and on further questioning, we found out he had adopted 10 orphans from the genocide despite his disability, and they were now able to support him. I found out that following the genocide, this was not a rare occurrence and it shows the resilience of the Rwandan people despite massive adversity.

There was also a large proportion of cancer pain from osteosarcomas to prostate carcinoma. Despite recent national palliative care policy, one of the first in the developing world, it was often undertreated. I saw a 46-year-old woman who had a pathological fracture of her right humerus with an unknown primary. She was married to a cultivator with five children, and after receiving regular oral morphine, they were able to return home to care for their children and farm.

There were also many patients suffering from similar conditions to those in the United Kingdom, such as sciatica,

lower back pain and headaches. There was a young policeman who had developed piriformis syndrome after being on an assault course, and had now been put on a leave of absence from work. Unsurprisingly, he was very anxious and becoming increasingly depressed. I was able to review him with the physiotherapist, and we were able to reassure him that the condition was treatable and he improved with simple analgesia and physiotherapy. We also took the chance to do simple injections such as a suprascapular nerve block in a 62-year-old woman with a frozen shoulder and a median nerve block in a 65-year-old sea-captain suffering from carpal tunnel syndrome.

We received huge interest for the chronic pain clinic, and towards the end of my visit, it always overran due to the volume of patients. The life expectancy has more than doubled in the last 20 years, and as the population ages, there will be an inevitable rise in the incidence of chronic conditions, similar to the developing world. I can only see the demand for the service increasing.

Negotiating buy-in from leadership

Through my time in Rwanda, I could see that the demands on the health service in this ambitious country are huge set against the resources available. In this hierarchical system, it was critical to ensure the buy-in of leadership so that the service was not swept away by

competing priorities in future. I took the Pain Champions' vision for the service to the Commandant (medical director), Dr Ben Karenzi, and the Chief Nurse. I approached this meeting with some apprehension, but I found overwhelming support. Orders were sent out to the respective departments to ensure we had the multidisciplinary team available for ward rounds on Wednesdays and clinics on Fridays. Before I left, we made an announcement at the weekly doctors meeting, introducing Didier and Jean-Claude and explaining their roles.

Since I left, Dr Christian Mukwesi and Dr Jerome Muhizi are continuing the clinics and acute pain ward rounds on a weekly basis with physiotherapists, nurses and psychologists. Both myself and the SPIN team remain in contact with the team via email and social media and hope to return next year.

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The assumption dilemma: do healthcare professionals have the teaching skills to meet the demands of therapeutic neuroscience education?

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Introduction

The contemporary paradigm shift from a biomedical understanding of pain to a more comprehensive biopsychosocial

model comes with many personal and professional challenges for both sufferers and clinicians.¹ When we consider the rising epidemiological nature of persistent pain within the Western world,² and the poor clinical outcomes resulting from conventional, passive interventions,³ the need for such a fundamental paradigm shift becomes clear.

Recent epidemiological data bring our need to meet these challenges into alarmingly sharp focus. Van Hecke et al.⁴ found that persistent pain affects over 14 million people in England alone. It also accounts for 4.6 million general practitioner (GP) appointments per year. Butler and Moseley⁵ suggest that by reframing pain as an epidemic, we may begin to draw useful comparisons with other epidemics.

Historically, epidemics from measles to cholera have been contained through education and communication.⁶ Therefore, for clinicians to adequately meet the demands of the biopsychosocial model, it is imperative that they develop their knowledge and

skills as practice-based educators. Dreeben⁷ (p. 4) argues that patient education forms 'a significant component of modern health care'. However, most clinicians have a limited educational toolkit.⁸ As the pain epidemic continues to grow, we must ensure that all clinicians feel equipped to guide their patients through the complexities of therapeutic neuroscience education (TNE).

As a sufferer, an inability to make sense of the often worrying and persisting uncertainties of pain forces many to retreat from life's pleasures. As a clinician, it is therefore vital to ensure a collaborative facilitation of meaning in those who live with pain. Bolton⁹ argues that educational skills are merely assumed in both practice and research, while Briggs et al.¹⁰ found that, in many disciplines, pain education accounted for less than 1% of undergraduate programme hours within the United Kingdom.

This persistent undervaluing of our educational role and the need for an increased awareness of facilitatory skills within healthcare places a practical dilemma at the heart of pain education. In his call for a transformative medical education system, Quintero¹¹ states, 'In order to respond to the current needs of society, which is education's main objective, the learning processes of

physicians and their instruction must change'. While highlighting the need for clinicians to gain a greater understanding of educational facilitation within practice, this article will also consider how a greater awareness of collaborative learning and learning styles would better enable practice-based educators when helping people make sense of pain.

Facilitation and collaborative learning

To facilitate an understanding of pain's complexities and the importance of self-determined, sustained self-management, we must first develop facilitatory skills. Facilitation can be defined as 'A technique by which one person makes something easier for others'.¹² (p. 177). Helping and enabling are central to meaningful facilitation. Yet, Knowles et al.¹³ (p. 257) suggest the desire for practice-based educators to ensure efficient and effective learning 'often leads to concentration on what they are doing rather than what the learner is doing'.

This traditional, copy and paste, dualistic approach to education stems from a lack of understanding regarding andragogy and a fear of losing control as an educator within learning environments.¹⁴ The novelist E. M. Forster provides a striking grasp of the dilemma facing contemporary pain education by suggesting, 'Spoon feeding

in the long run teaches us nothing but the shape of the spoon', while Gilmartin¹⁵ suggests healthcare professionals need to develop three key qualities in order to meet the facilitatory demands of practice-based education:

1. An ability to actively listen
2. Best use of peer-learning opportunities
3. An understanding of group dynamics

Whether healthcare professionals endeavour to facilitate a meaningful understanding of pain through either one-to-one clinical interactions or group settings, Fredricks¹⁶ suggests that in order to engage patients in the process of TNE, we must embrace collaborative learning. Cross et al.¹⁷ highlight the distinct differences between cooperation and collaboration within practice-based education. While cooperation involves a superficial level of joint engagement, collaborative learning involves a wholehearted desire and active interest in collectively solving problems.

By moving from more conventional, didactic teaching methods and by embracing collaborative learning activities, both practice-based educators' and sufferers' sense of connection is amplified.^{18,19} However, many practice settings remain implicitly unconducive to collaborative engagement.²⁰ When we consider the diametrically opposed seating arrangements seen within most clinic settings, it is easy to see how something so simple as where we sit in relation to our patients can impact on our ability to facilitate a meaningful understanding of pain. Jaques²¹ suggests that collaborative learning must involve side-by-side, close positioning, not the more traditional, dualistic stance of sitting opposite one another where the implicit, physical metaphor is one of division.

The move away from an expert model of teaching is considered by Turner-Bisset²² to be a reaction against the technical rationale paradigm.²³ Schon²⁴

argues professional practice is chaotic and requires ongoing reflection. To adequately explore the cluttered complexities of biopsychosocialism, the learning environment must seek to promote reflective engagement.

Learning styles and gaining interest

As practice-based educators aiming to deliver patient-centred care, it is crucial that we understand the undoubted differences between how people learn. Ewan and White²⁵ argue that educators must become acquainted with each individual's learning needs in order to optimise learning. While learning styles questionnaires (LSQ) provide some insight and promote discussion,²⁶ research suggests that they don't stand up to peer review. Coffield et al.²⁷ found that Honey and Mumford's²⁶ questionnaire failed to meet most of the minimum criteria for validity, while Rayner²⁸ argues LSQ risk labelling learners and therefore must be viewed in context.

Our ability to adapt our educational delivery and tailor meaningful pain education to individual needs is vital. Silvia²⁹ suggests this process must begin with a better understanding of interest. Interest is an emotion that serves two main functions: motivation and performance.²⁹ Without an ability to actively facilitate an interest in TNE, patients will likely remain disengaged, and practice-based educators will miss opportunities for sustained cognitive and behavioural change towards self-efficacy.

As practice-based educators, we must understand what lies behind the emotion of interest. Silvia²⁹ states, 'Finding something understandable is the hinge between interest and confusion'. Through an appreciation of an individual learner's coping potential and an understanding of the dynamic relationship between challenge and support,³⁰ clinicians would feel better equipped to respond to the ever-changing demands of contemporary pain education.

Conclusion

As the multifaceted and complex demands of persistent pain continue to mount on Western healthcare systems, we must stop assuming that our understanding of how to educate others is merely reached through our professional status. Instead, it is vital that we wake up to our obligation to expand our educational toolkits.

Daloz³⁰ summarises our educational duties by suggesting, 'Like guides, we walk at times ahead of our students, at times beside them, and at times we follow their lead. In sensing where to walk lies our art'. While there is an undoubted art to practice-based education,⁹ an appreciation of the theoretical models that underpin TNE and an active and continued development of facilitatory skills will enable healthcare professionals to meet the demands of contemporary pain education.

Although this article aims to explore whether healthcare professionals possess the teaching skills to meet the demands of TNE, it can only offer a brief insight into how an appreciation of andragogy and adult learning theories would better equip clinicians for the challenges of contemporary pain education. Further research is needed to develop our understanding of how the integration of established educational knowledge and skills within practice might impact on clinical outcomes and the experiences of both sufferers and healthcare professionals.

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Focusing on humanity in health and social care – some suggestions

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First a little about my approach to ethics. Shortly after I completed my degree in philosophy, I came across the book *Principles of Biomedical Ethics* by Beauchamp and Childress,¹ which proposes the four well-known principles – respect for autonomy, beneficence, non-maleficence and justice – and this is an approach I have found helpful ever since. These rather simple *prima facie* principles are both useful and can be acceptable to any moral agent who espouses a universalisable ethics – an ethics that is claimed to apply to all moral agents. The four principles approach, although widely accepted, has its denigrators, who claim sometimes, with inexplicable hostility and among a host of criticisms, that it is simplistic and useless. I have responded at length to such criticisms elsewhere but will not do so now. I will simply ask everyone, as I always do, which if any of these *prima facie* principles do you reject in your own ethical framework and why? And which additional moral principle do you think is needed in your own ethical approach that cannot be derived from one – or from a combination of more than one – of these four basic principles? As I see them, these *prima facie* principles are pretty obvious moral commitments about which moral agents and especially health workers can agree and use as a framework for thinking about the moral issues that arise in healthcare.

Nevertheless, there are two acknowledged problems with the approach, the scope of each principle (to whom or to what does the principle apply) and how to deal with conflict



between the principles when this arises, which it often does. These two issues often require exercise of that mysterious capacity, judgment. For which ultimately we can have no rules, as Immanuel Kant pointed out, and about which there is continuing debate.

So the four principles approach is not a panacea, certainly, nor a computer programme for getting the right answers. But, it can provide a common set of basic *prima facie* moral commitments, a basic common moral vocabulary and a basic common moral analytic framework. Moreover, the approach is entirely compatible with other approaches, including deontological approaches, based on duties and rights, utilitarian approaches based on good and bad consequences and virtue-based ethics including those based on humanity, compassion care and caring. In our context, it helps people like doctors and healthcare workers to make decisions in practice without having to agree to start with on their basic moral approach.

Compassion and humanity

I do not much like the term compassion because it has too many connotations of ‘lady bountiful’. I prefer *humanity* which is much less specific but includes the whole cluster of issues that compassion should encompass. That is empathy, and especially in the literal but potentially passive and counterproductive meaning of compassion, ‘suffering with’, respect, dignity, care, responsiveness, kindness, spiritual and emotional comfort, solace and so on.

If you have humanity, you recognise that suffering is bad and harmful and you seek to do something to relieve and prevent it. These are ordinary common human tendencies. I believe that most of us who go into healthcare are indeed motivated by humanity and compassion. Sometimes it is driven out of us, and in our training, we may have to learn to temper our humanity and compassion in order to be beneficial to our patients. Additionally, there is clearly a danger of burnout actually driving out compassion and humanity. Nonetheless, it is a widespread motive for entering medicine and nursing and, in my view, it should be explicitly encouraged as a necessary attribute for entering the caring professions. When I was applying for medical school, we were told not to dare to mention that we wanted to help and care for people or anything like that. Instead, we were advised that we should emphasise our scientific interests and curiosity. I think that has changed, and now students are encouraged to realise that caring for the sick is indeed a fundamental aim of medicine and nursing.

Humanity, compassion and ethics

If we accept the four *prima facie* principles, as outlined, the ethical underpinning of humanity and compassion does not amount to rocket science. Ann Gallagher talks about ‘slow’ ethics and the need for complex analysis. Certainly, many aspects of ethics do need complex analysis; but others just need ‘fast’ ethics. It is simply obvious that compassion and humanity are good things and should be encouraged. In terms of the principles, delivering healthcare with compassion and humanity tends to be more beneficial and less harmful than delivering it without them. In terms of respect for autonomy, there cannot be many autonomous people who prefer their healthcare to be delivered without compassion and humanity. Indeed, compassion and humanity are very rarely in conflict with justice. That is not to say that there are not some pretty awful resource allocation problems in distributive justice that have to be faced. But, if you face and deliver them with compassion and humanity, you will do a better job than if you do so without them. So, it does not need much more than that to provide principle-based ethical support for humanity and compassion in healthcare. And, of course, compassion and humanity, as well as caring, are highly esteemed virtues if one prefers to use a fast version of Virtue Ethics to give ethical support for humanity and compassion in healthcare.

Compassion and humanity in everyday practice

No, the problem is not one of ethical analysis which is straightforward. But of getting the results of such analysis into practice which is by no means straightforward. This article (on which this talk was based and which contains more references for those who wish to follow them up) was an attempt to come up with some suggestions about how to get compassion and humanity into everyday practice.

My first suggestion is to get rid of what I call ‘biomedical machismo’. This is the notion that science is what healthcare is all about and that we must get rid of all these touchy feely things that spoil it and concentrate on the important scientific part of medicine. It seems to me that this is to put the cart before the horse. Science is instrumental to medicine because science helps us to do it better, but it is only a means to an end. The ethos of medicine has swung too far towards not just reifying the scientific component but turning it into a ‘god’. So we need to sit on the biomedical machismo as part of the requirement for getting humanity back (perhaps one of the reasons why humanity functioned much more in earlier times in medicine was that there was not much science, or managerialism, available to interfere with the humanity). Humanity is not just a constituent part of medicine but is or should be its driving force. In my experience, most doctors, nurses and healthcare workers are very benevolent and orientated towards being beneficial. But, I have come across some counter examples who seem to have lost their humanity, who are instead very concerned with numbers and targets, and getting things done with efficiency at the expense of ordinary humanity. When such people get into positions of power, they can have a very malign influence.

But, there is reason for some optimism, as humanity and compassion are increasingly emphasised in the healthcare literature, much of it no doubt as a response to the awful events in Mid Staffordshire.² It is certainly my impression that the Francis report on this has started to get people moving towards actually trying to change things. It has been a long process. The Dignity Commission appointed by the National Health Service (NHS) Confederation, the Local Government Association and Age UK provided an impressive start on the humanity agenda. The Dignity in Care Network hosted by the Social Care Institute for Excellence unsurprisingly

emphasised the dignity aspects of humanity and compassion which are also the focus of the Royal College of Nursing. The Chief Nursing Officer categorises compassion as one of the six fundamental values – all starting with C! – in a vision of the future of nursing. The other values are care, competence, communication, courage and commitment. The General Medical Council (GMC), the Royal College of Physicians and the British Medical Association (BMA) all manifest humanity-orientated concerns in their literature. The King’s fund has a section in their Point of Care Programme devoted to these issues. The Human Values in Healthcare Forum,³ with which I am associated, is focusing on the issue of compassion. Incidentally, it invites membership and so does the Institute of Medical Ethics⁴ with which I am also associated. Perhaps, most importantly, the recent version of the NHS Constitution, which was revised partially in response to the Francis Report, has taken up the theme of compassion. It tells all NHS staff that they

‘should aim to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility ... also for your wider contribution to the aims of your team and the NHS as a whole’. ... ‘Patients come first in everything we do ... we value every person as an individual, and seek to understand their priorities, needs, abilities and limits... We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person’s pain, distress, anxiety or need ... We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care’ ... [We acknowledge] the right of all ‘to be treated with dignity and respect, in accordance with your human rights’.

Focusing on humanity in health and social care – some suggestions

The Secretary of State for Health has sent a ‘mandate’ to Health Education England – these words are now built into the very constitution of the NHS, and people can be required to meet these obligations. Everyone ‘from ward to board’ is required to implement the NHS constitution.

Implementation

So what about the ways in which it might be done? My first suggestion is to create a high-level task force to propose practical ways of implementing the humanity objectives in that constitution, and to constantly monitor the implementation of that aspect of healthcare. Without such monitoring, I fear that it will rapidly disappear as it is squeezed out by the other more ‘scientific’ objectives.

High on my list of structural proposals is provision of more *time*: time to interact with patients, clients and colleagues in an unhurried, un-harassed, friendly and human way. I do not know how this is to be done, but I do not think it is beyond the wit of managers, informed by the NHS constitution, to work out ways. A simple outline of four priorities which are ‘preventable mortality, long term conditions, “being caring”, and dementia’ and requiring that

recruitment, education, training and development results in patients, carers and the public reporting a positive experience of services consistent with the values and behaviours identified in the NHS Constitution.

You may well say that is a lot of hot air, what about the action? What is important? An example is appointment time. We could devise a method that would take account of the different speeds at which people consult, partly by letting people choose who they are going to consult and whether they are prepared to wait longer for a longer consultation. You could also

build in ‘buffers’, as general practices often do, so that a couple of time slots are there to compensate for over-running appointments.

Good communication skills are obviously a tremendously important part of being human, and these can be taught. There are lots of courses on these in medical education, including using scenarios and actors playing the parts of patients or doctors. This can be particularly useful when teaching medical ethics by helping people to become involved in the assessment of a difficult issue. I wonder whether there might be an ‘improve your interpersonal skills’ module introduced into such teaching; it might be a bit threatening to say ‘how to make yourself a nicer doctor or social worker’ but that would be the objective. This also might include self-assessment.

There is no doubt that structural and institutional changes are essential to bring in a more humane approach to healthcare, but it is also important to remember personal responsibility. This is not to advocate the blame game or the threat culture; it is to advocate the responsibility game. We are all moral agents. We can look at our own behaviour and apply a little checklist:

- Does my practice manifest a human face?
- Am I friendly, helpful, kind, considerate?
- Do I listen enough, do I talk too much? Or too little?
- Do I interrupt too much?
- Do I smile enough?
- Do I make eye contact, or at least appropriate eye contact? (Of course some people are shy and avoid eye contact, and in some cultures, it is discouraged, but in general, it is a very helpful component of communication.)
- Do I ‘blank’ people out? There is a horrible tendency in the NHS to do this especially if people have been critical and we feel under threat. Am I perceived as arrogant or patronising

or overbearing or frightening?

- Do I ask my patients or clients about their concerns and if I do, do I wait for answers?
- Can I be trusted?
- And if I have a managerial role, what do I do and what can I do to encourage this human face in the people that I manage? I wonder if this should be included in assessments and appraisals for revalidation or even 360-degree feedback

Research

This seems to be an area where it is worth doing some research into what methods actually improve communication with patients and they find helpful. In order to get funding for such research, we need to point out that humanity, caring and compassion are part of the very concept of *healthcare*, otherwise research which purports to be about health or social care is simply scientific research. Any funding agency, researcher or research body which purports to be doing healthcare or social care research should obviously commit itself to both health and care. Integral to the notion of health is wellbeing. You might not accept the World Health Organization’s (WHO) definition of health as ‘a state of *complete* physical mental and social wellbeing’, but you could replace the word ‘complete’ with ‘adequate’, which expressly builds in an evaluative component. Once you accept the notion that wellbeing is part of the concept of healthcare, then you have an argument to convince the providers of research funding that humanity and care research should be part of their commitment. The Wellcome Trust, which got round to recognising ethics in the 1970s or 1980s, could well be persuaded to back wellbeing research (and is the only source of grant money for this special interest group (SIG)). Perhaps, when any scientific proposal in the area of healthcare is made, there ought to be an added question about how much does this add to wellbeing

and of whom, with the explicit condition that those projects which include an aim to improve wellbeing would get preference over those that do not.

One could go on to wider research themes such as what sort of components in assessing applicants for healthcare jobs are likely to improve patient care. An Australian research project showed that students who had studied the humanities as well as sciences before entering medical school performed better as interns than those who did not. My own suspicion is that later entry into medical, nursing and social care schools might improve patient care. We could at least look into the possibility that a broader life experience before going into these caring

professions may be better for your patients when you grow up, as it were.

In sum, the healthcare experience should be, for all involved, compassionate, kind, supportive, respectful and humane as the NHS constitution now says it should be. In too many cases at the moment, it isn't. The various practical suggestions I have offered may help to achieve these objectives. Perhaps the most important of these suggestions would be the creation of a high-level task force within NHS England whose remit would be to monitor and promote the humanity objectives of the NHS Constitution.

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compassion in healthcare held at the Royal Society of Medicine in November 2012 and on my subsequent article of this title published in 2013. The final, definitive version of this article has been published in *Clinical Ethics* Volume 8 Issue 4 (page 105–110; DOI: 10.1177/1477750913502618) by SAGE Publications Ltd.

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Aide-memoire for treating chronic pain – making more of a meal out of it

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The late Professor Patrick Wall used to explain that pain is a complex sensation comparable to thirst and hunger rather than simple sensations such as touch, heat or cold. Integral to these complex sensations is the innate need to find relief. This analogy can be pushed further when we consider how to treat someone with chronic pain. We think that when a clinician sees a patient, chronic pain management should be planned in similar ways to satiate hunger and thirst.

When planning a meal, it is important to take into account your guests' particular preferences and food intolerances. Some of these may be real but many are just perceived 'allergies'. This is similar to treating chronic pain. All previous treatment methods should be recorded in their history and why they were abandoned. Many patients, for example, will avoid taking tricyclic or serotonin–norepinephrine reuptake inhibitor (SNRI) drugs because they are not 'depressed'. One can regard these prejudices in

patients similar to the snobbish 'Anything But Chardonnay' and lose the (ABC) pronouncements made by misguided wine drinkers. It is always worth pointing out that 'Blanc de Blanc' champagne, and some of the greatest white wines in the world (Puligny and Chassagne-Montrachet), are made exclusively from the Chardonnay grape. It may be possible to alter their views and reacquaint them with supposed treatment 'failures'.

The next question is whether there should be one course or multiple. Apart from some very rare conditions, a single treatment or medication is unlikely to completely alleviate pain. So, we will end up with a meal with multiple courses.

After this, the question is in what order the dishes should be served. The traditional method of having starters, a main course and dessert, usually followed by cheese, is widely accepted in the United Kingdom (the French have cheese before dessert). The analogy for this is, which medication should be prescribed

first for treating chronic pain. Recent guidelines have only outlined a list of medications without giving any guidance on what order they should start.¹ In someone with post-herpetic neuralgia, for example, it may seem sensible to start off with topical treatments such as a lidocaine 5% patch. This can then be followed by a small dose of amitriptyline at night to aid sleep, and if that fails to work, then to add in a gabapentinoid. However, we are not sure if there is sufficient evidence to offer firm guidelines. There are simply not enough combination trials that have been done or reported. When one looks at the available data, there is some suggestion that starting with an opioid may lead to a less favourable outcome than using a gabapentinoid.^{2,3} We simply need to think more carefully about these questions and how to acquire the data to inform us.

If one is contemplating multiple courses, then the question is which method of serving is to be employed. For food, the two main methods are *à la russe* and *à la française*. The 'methode française' is the most common format when you eat in a Chinese restaurant – multiple dishes are placed in the centre of the table and everyone helps themselves. The *à la russe* way is to apportion food for each individual diner: fixed servings of protein, carbohydrate and vegetables. Similarly, when it comes to treating

Table 1. Questions on diet that clinicians should consider and discuss with the patient

Dinner plan	Clinical analogy
Food preferences	History of all previous therapies
Laying the table	Clinician's approach to the patient and how to introduce suggested therapies
Menu planning:	Pharmacotherapeutic agents to try:
How many courses	How many drugs?
What order	What to start?
How much to serve for each course	Maximum doses of each drug?
What drinks?	Should medications be combined with
	Physical therapies – TENS, physiotherapy
	Psychological
	Invasive: facet injections, nerve blocks
Remember your etiquette as the host	Take your patient's problems and concerns seriously

TENS: transcutaneous electrical nerve stimulation.

chronic pain, the question is whether we allow the patients to take variable combinations of different medications as they wish or whether we stress fixed amounts. Is it, for example, acceptable to add in gabapentin only if patients are taking at least 50mg amitriptyline a day? When would it be correct to add in a third medication? Should we aim for serial monotherapies or allow variable combinations? Is it acceptable to use medications in excess of licenced amounts? There is simply no evidence to guide us, and it is likely that individual patients may respond best to different regimes. We think that at the very least, these questions should be considered by the clinician and discussed with the patient as far as possible (Table 1).

Apart from food, drinks are also important for the enjoyment of a meal. A glass of Sauvignon Blanc goes well with asparagus, while beef steak is delicious with a robust Malbec. Unfortunately, when it comes to treating chronic pain, we simply do not know what other adjunctive medications are beneficial. Will transcutaneous electrical nerve

stimulation (TENS) work much better when someone is on gabapentin or tricyclic drugs? Will acupuncture be more effective when added on to gabapentinoid compared to tricyclic or an SNRI? Once again, these are questions we should be thinking about. It is likely that patients seek a number of therapies. This can also extend to the other more invasive treatments such as nerve blocks and joint injections. There may indeed be no difference, but we simply do not have the evidence. Most of the time, no one has thought about this.

The analogy between serving up food and pain management also extends to how it is done. Uninterested clinicians, eager to get patients out of their clinic room, will dish out treatment without much enthusiasm. This is similar to doling out 'slop'. A well-presented plate of food will be more palatable and is more likely to be eaten. Clinicians should bear this in mind when counselling patients about which therapy to choose for alleviating pain.

If the reader will bear with us further, we can stretch this analogy between food and pain management a little further

when it comes to new therapies. Among those who take a great interest in food, there are always new and novel foodstuffs for which we do not initially know their value. The sun-dried tomato was widely used, now much derided, but can still add greatly to certain dishes. Similarly, we really do not know the utility of high-frequency spinal cord stimulation for treating chronic leg and back pain. There probably is a role for this, but it ought to be assessed carefully and assimilated within current accepted forms of treatment rather than being splashed about like truffle oil.

Similar to the cult of super-chefs for food, we have our super-specialists in pain as well. Some of them will come in and out of fashion. At present, there is still a debate regarding utility of differential patterns of spontaneous and evoked pain as predictors of response to certain anti-neuropathic pain agents.⁴⁻⁶ However, like the recipe for snail porridge, it may eventually be quietly forgotten. There is simply far too much work for very little gain. We should be aware that our practice is also subjected to certain fashions.

The one thing which we would not like to happen is that of poor Mr Creosote in the Monty Python's film 'Meaning of Life'.⁷ An indiscriminate amount of gorging finally led to Mr Creosote exploding on screen after swallowing one small wafer thin mint. Some of the patients referred to us in clinic have been allowed to 'gorge' in a similar way on different pain medications in a very indiscriminate fashion. This then gives rise to secondary complications, particularly when they are taking large amounts of opioids. We all know the effects of opioids on the immune and endocrine systems. In headache clinics, many of them are seen with chronic daily headaches. For some of these patients, it would seem that medications are prescribed without much thought: a completely chaotic 'meal' no better than serving up pigswill. Everything is thrown

Aide-memoire for treating chronic pain – making more of a meal out of it

together, in the hope that it will be found satisfying and palatable.

We hope that our analogy is useful to illustrate how clinicians think about treating patients. It will also give rise to a number of questions we should be asking. Will it make a difference which medication is started first for our patient? Should different treatment modalities be used concurrently? This applies to pharmacotherapy as well as physical and psychological treatment. Psychologists may think that it is premature to start treatment until all invasive intervention techniques are exhausted. Is this fundamentally correct? At present, evidence is usually gathered on a single treatment regime, without proper combination studies. Evidences for unimodal therapies from small studies do not inform clinicians faced with a patient with complex pain in their clinics. The concept of non-inferiority is now used when trying to compare different treatments. Coming back to our analogy, 'is apple pie "non-inferior" to vanilla ice cream for dessert?' This method has been used, for example, to compare the 8% Qutenza capsaicin patch versus pregabalin.⁸ The practical question should be, 'would combination of the two be better than either one alone?'

In our everyday clinical practice, we could probably collect information to answer some of these questions. We also recognise that clinicians themselves can only do a certain amount. Some of it will have to come from the regulators, particularly when new treatments are licenced. There should be an absolute requirement to obtain and provide data on combination treatment rather than licencing drugs as if they are only ever going to be used in isolation. Indeed, some of the data may already be available,

only needing to be reanalysed. When drug trials are done in hundreds of patients, it could be useful to know whether the maximum benefit comes from different combinations of treatment and whether patients have been on pre-existing drugs. This is better than having no data at all.

Similarly, clinicians should have the curiosity to plan and do more trials of combination treatments, although we all appreciate what a difficult task this can be.

The clinician–patient interaction is, of course, a two-way process. We have chosen to emphasise the clinician's point of view in our analogy. In reality, patients seek relief from various sources. They may be selective as well as inconsistent when it comes to choosing treatment they will accept. These are dinner guests who snack between courses and hide food in napkins. However, we hope you will find this a useful perspective to explain the importance of patient engagement, the benefit of experience and the logic of multi-disciplinary pain management. More importantly, it reminds clinicians to construct a suitable treatment strategy for each and everyone of their patients.

In summary, starting someone on the treatment pathway depends on many things:

- Find out what has been tried and what treatment is acceptable for the patient
- Consider how many treatment methodologies to employ and in what way are they are going to combine
- Think about how much to give and how long should to try each individual treatment before abandoning one or adding in another. We do not even know whether it would be sensible to

come off the previous medication if this appears to be partially effective or not at all

- Be wary of indiscriminate prescribing when the risk of harm outweighs any good we hope to achieve

Finally, in all clinical interactions with patients, take their problems seriously: remember, they are our 'guests' who have taken up the 'invitation' to come and see you.

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The power of invalidation in consultations for chronic pain

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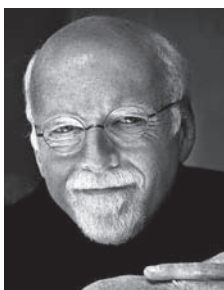
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and to relate this understanding to the patient. As a result, patients sometimes describe feeling stigmatised and misunderstood by healthcare professionals³ and rejected, ignored and blamed for their condition.⁴

Given both the importance and the difficulty of communicating understanding in the context of chronic pain, applying the constructs of ‘validation’ and ‘invalidation’ may be useful. Validation is a therapeutic strategy⁵ used to communicate acceptance and understanding of another’s thoughts, feelings, actions, desires or experiences.⁶ In contrast, invalidation communicates non-acceptance and non-understanding of another. While validating behaviours

include attentive listening, acknowledging another’s disclosure and treating them as equal or competent, invalidating behaviours are the opposite, for example, dismissing what the other person says, telling them what to think or feel or showing inattentiveness to their emotions.⁷

Recent research suggests that there are strong detrimental effects of receiving invalidating (non-understanding) feedback⁸ and found that individuals were less willing to repeat experimental tasks, were more socially withdrawn, reported more negative mood and were more physiologically aroused during stressor tasks when they received invalidating feedback rather than validating or no feedback. Thus, communicating non-understanding can have powerful negative effects.

While the detrimental effects of invalidation have been shown experimentally, invalidation within the chronic pain setting is less well understood. Therefore, we interviewed patients and providers about their experiences of invalidation during their chronic pain consultations. We asked, (a) what are patients’ and providers’ experiences of feeling invalidated during their consultations and (b) what impact does feeling invalidated have?

Background

Although the need to communicate understanding to patients during their consultations is integral to effectual patient care,^{1,2} in the context of chronic pain, this need is not always met. It is difficult both to understand chronic pain

The power of invalidation in consultations for chronic pain

Methods

Participants

Recruitment packs were sent to 40 patients and seven healthcare providers from two National Health Service (NHS) hospital clinics in South West England. Five patients and four healthcare providers were recruited. Patients were females (aged 40–61), diagnosed with chronic widespread pain. Providers were two pain management consultants, one pain management specialist and one consultant rheumatologist (two males, two females).

Procedure

Patients' initial consultations were video recorded and live-streamed, and selected excerpts from the consultation were played back and discussed with the patient during their interview. Excerpts were selected where patients disclosed, or providers delivered, difficult information, or where providers used a clear validation/invalidation strategy. The researcher interviewed patients directly after their initial consultation. Patients were asked to describe their experiences during pain consultations generally, and then to discuss the video excerpts from their consultation, particularly exploring experiences of validation/invalidation. Semi-structured interviews were then carried out with four healthcare providers, where provider's experiences of validation/invalidation were discussed. Interviews lasted 30–45 minutes.

Thematic analysis was carried out based on Braun and Clarke's framework⁹ using NVivo software (v9). Four transcripts were cross-coded by a second coder, and inconsistencies in coding were resolved in discussion. Themes were defined using concept cards, and theoretical memos documented theme development. A thematic map of themes was then developed.

Reflexivity

M.G.H. carried out the interviews and analysis for this study. In order to ground the analysis in the data, the literature review was not carried out until after the thematic



analysis had taken place. Efforts were made to ensure that the themes were based on the most prevalent and enduring themes in the data, using concept cards and memos to focus on themes that most reflected the patient/provider experience and were most relevant to the research questions. The thematic analysis, while including elements of grounded theory to ensure that the analysis was data driven, was somewhat phenomenological, focusing in particular on the experiences and 'life world' of the patient.

Findings

Although patients did not describe feeling invalidated during their video-recorded consultation, both patients and providers described many experiences of feeling invalidated during pain consultations more generally. Four themes were identified, each comprising three subthemes (see Table 1 and Figure 1).

Experiences of invalidation

Patients described how healthcare providers invalidated them in several ways: (a) by showing a lack of insight into their condition; (b) through lack of investment, not taking time to listen, explain, discuss alternatives or hear about the patient's experiences; and (c) by disbelieving and dismissing the patient by communicating that 'there is nothing there' to physically mark their pain.

Interestingly, for healthcare providers too, their pain consultations were sometimes invalidating. Because of the uncertainty around diagnosis and cause, providers discussed the difficulty of encountering patients who had different ideas from theirs, and who did not

accept their advice. Patients sometimes held unrealistic expectations about their recovery, disbelieving that there was no 'magic bullet'. Providers described feeling invalidated by patients when they encountered: (a) conflict and criticism, (b) disbelief and denial or (c) patients with seemingly entrenched views who did not listen, engage or comply.

The impact of invalidation

Both parties described the detrimental impact of encountering invalidation during their consultations. Patients discussed reacting to invalidation (a) by becoming angry and feeling the need to justify their illness; (b) feeling hopeless, losing confidence in providers, in themselves or in the legitimacy of their illness; and (c) battling on their own, refusing to consult a provider again or even avoiding treatment altogether.

For providers too, receiving invalidation from their patients had negative repercussions. Providers described reacting to invalidation by (a) avoiding discussing difficult issues or potentially inflammatory statements; (b) feeling hopeless and helpless, feeling inadequate at not having anything left to offer except advice; and (c) learning to 'be realistic' about the limits of what they can offer and thus dismissing the patient and moving on.

Discussion

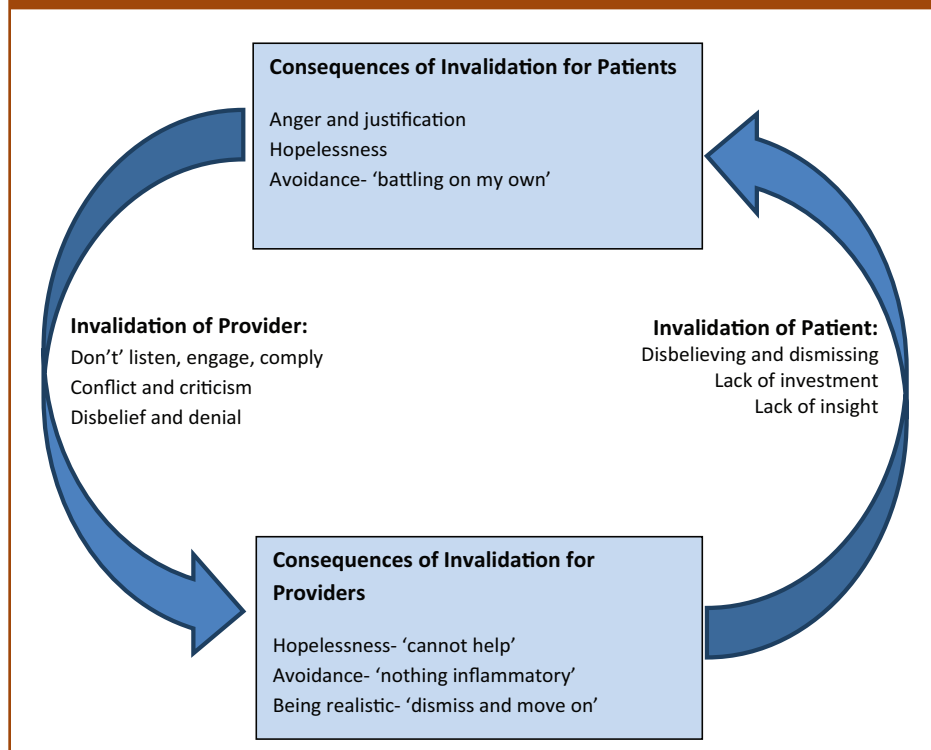
Patients and providers in this study described feeling invalidated during their chronic pain consultations, and discussed the consequences of these exchanges. Although the sample size for this study is small, this research and previous work^{10–14} suggest that feeling misunderstood is a pervasive problem within the chronic pain setting for both patients and providers, and thus, understanding the invalidation construct is useful in this setting. While the detrimental effects of invalidation have been examined experimentally,^{5,8,15} we suggest that invalidation during the chronic pain

Table 1. Themes and subthemes identified for patient and provider interviews

Themes and subthemes	Example quotations
Invalidation of patients by providers	
Disbelieving and dismissing – ‘there’s nothing there’	<i>‘That doctor ... really ... like the condition didn’t exist ... there are some people that think it’s all in your-well yeah it is all in your head isn’t it but it doesn’t mean it’s not there’. Patient 1</i>
Lack of insight	<i>‘She said ‘well you need to go to the gym that will make you feel better’ ... and I ... thought ... I’m crawling up the stairs to go to bed. I can’t go to the gym. ... what planet are you on?’ Patient 1</i>
Lack of investment – no time to listen or explain	<i>‘He recognized all the symptoms that I’d got and matched them accurately with fibromyalgia, but in that respect that was it ... he didn’t explain it to me’. Patient 2</i>
Invalidation of providers by patients	
Conflict and criticism	<i>‘It’s very wearing working with them at times ... especially the people who ... seem to think it’s ... all your fault ... to be so personally criticized by somebody and you think ‘all I’m doing is trying to help you move on’ it’s it’s very difficult’. Provider 1</i>
Disbelief and denial	<i>‘It’s breaking down the ... fixed concrete ideas that patients have that medicine is going to get them better ... it’s shattering the illusion that ... medicine can cure all. That some people have that very fixed idea that there is going to be something that makes this go away’. Provider 2</i>
Entrenched – don’t listen, engage, comply	<i>‘... the guy is probably going to die of a side effect of his medications if nothing else, because he’s doing everything ... that he shouldn’t be doing but any attempts by all the various clinicians who’ve seen him ... we can’t move him out of his entrenched way. ... A lot of people ... choose to be where they are. They don’t want to move on’. Provider 1</i>
Consequences of invalidation for patients	
Anger and justification	<i>‘I remember him saying ‘I don’t bowl a cricket ball as well as I used to’ and if I’d had one there I might have quite like to have thrown one at him because he just sat there so supercilious and you know ‘there’s nothing wrong with you go away’. Patient 3</i>
Hopelessness	<i>‘I was pretty much told that because they couldn’t see anything on the tests that actually I probably wasn’t really experiencing things the way I thought I was and ... that made me feel awful because it made me feel like I was being seen as somebody that was using up time and money and space ... that was always being needed ... what was I going to do if the pain and everything else carried on and what if everybody else that I saw ... were all of the opinion well if we can’t find it on a test then there’s nothing wrong with you and that’s ... when you think I don’t know what I’m going to do then?’ Patient 4</i>
Avoidance – ‘battling on my own’	<i>‘You’re being told that there’s nothing wrong with you so go away and stop complaining ... having that type of consultation I went away and tried to sort of battle on with it on my own’. Patient 3</i>
Consequences of invalidation for providers	
Avoidance – ‘nothing inflammatory’	<i>‘Sometimes during the consultation you can get that feeling and you get some responses that say okay this is this patient is not going to be able to hear this. I mean I have to try a different tack or I’m just going to have to give a very easy simple explanation and leave it to someone else to deal with all those other things’. Provider 3</i>
Hopelessness – cannot help	<i>‘The patients become frustrated and ... you feel inadequate as a doctor which is not a nice feeling ...’ Provider 2</i>
Being realistic – dismiss and move on	<i>‘You get 30 minutes with a patient and by the time someone’s shouted at you for 15 minutes so you’re 15 20 minutes over ... people outside can hear what’s going on often, and then someone comes out and makes a fuss and then you’ve got ... the waiting area with your next three patients some of ... whom don’t know you, thinking ‘Oh god am I going to go and see some shit’ (laughs) ... you’ve just got to you know certainly in medicine you are just trained to ‘okay next one’ and move on to the next one’. Provider 3</i>

The power of invalidation in consultations for chronic pain

Figure 1. Thematic map of patient and provider experiences of invalidation during the chronic pain consultation



consultation may be a nocebo-related effect (i.e. a non-specific negative effect of an intervention) that is largely overlooked.

Chronic idiopathic pain is difficult to diagnose and treat, and patients and providers can have different understandings of it; while patients tend to attribute their pain to physical causes, providers tend to rule out any possibility of underlying physical origin for the pain.^{11,13} Attempts to reassure the patient that there is 'nothing there' can delegitimise the patient's experience by denying 'the reality of the patient's concern'.¹² Providers may be left feeling pessimistic and powerless over their ability to help such patients,^{10,14} labelling them as 'heartsink' and 'difficult'.

Invalidation within the consultation may be a vicious cycle; receiving invalidating feedback is more likely to foster invalidating responses, and thus, both patient and providers can fuel and feel non-understanding and non-acceptance from each other. A better understanding of the validation/invalidation construct may be useful for tackling this problem. Efforts by providers to validate their patients (or at least to avoid invalidating them) and strategies to deal with receiving invalidation from patients should be implemented in order to avoid the potentially ricocheting nocebo effects resulting from such invalidating exchanges.

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The Reader Organisation

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I would like to take this opportunity to tell you about the work The Reader Organisation (TRO) does with patients with chronic pain and/or depression.

TRO is an award-winning charitable social enterprise that is pioneering the movement of shared reading as a practical way of improving health and well-being. Our mission is to build a 'reading revolution' connecting people with great literature through weekly shared reading groups. We take books off the shelves and put them into the hands of people who need them – delivering hundreds of shared reading groups all across the United Kingdom each week, in lots of different settings, including hospitals, care homes, prisons, homeless shelters, rehabilitation units, as well as libraries, schools and cafes – working with people suffering from mental or physical health problems, and those experiencing social exclusion and isolation. As its founder Jane Davis MBE puts it, 'This is not just reading. What we do change, and sometimes save, lives', a view shared by Dr David Fearnley, Medical Director of Mersey Care and Royal College of Psychiatry 'Psychiatrist of the Year 2009', who asserted, 'Shared reading is one of the most significant developments to have taken place in mental health practice in the last ten years'.

TRO began 17 years ago, a time when Jane was teaching a literature course at the University of Liverpool. Struck by the wonderful bond the group had forged – people feeling better in themselves by sharing reading and stories and talking



together – she realised that there must be many others who would relish the opportunity to share the same experience:

I wanted to take reading to all sorts of places, so that's what I did, setting up the first two groups for young mothers and adult learners in Birkenhead. And they quickly told me: 'This is good for my health – you should be getting paid by the NHS!'

The reading groups work like this: shorts stories, novels and poems are read aloud by TRO's trained facilitator because we believe that literature comes alive when it is read aloud – this experience is at the heart of what we do. Everything is read slowly, with regular pauses throughout so that the group can share their personal responses. It is a stimulating but non-pressured environment; group members can participate as much or as little as they choose – taking a turn to read, contributing to the discussion, or simply listening – and nothing is read beforehand, with everything being read



live, aloud, slowly and carefully, in the room. Group members discover the joys of reading works by authors such as Shakespeare, George Eliot and Wordsworth, the 'good stuff' in other words! Quite simply, we believe that literature provides us with vital information about being human, opening up our imaginations, so we can connect, share and come to new understandings and awareness. What TRO does is bring books to life – as Jane puts it again,

People need meaning and human connectedness just as they need air and water. That's what we aim to give them with our reading groups. Something happens to you in shared reading, a sudden moment, a feeling of recognition, of seeing written down something you've had as a nameless feeling, and at that moment it takes some form in the visible world, so you can begin to know it. And there's something so important about that – it's a form of consciousness.

One group of people who may especially benefit from our shared

The Reader Organisation



reading groups are those with chronic health conditions, including chronic pain. Recent research conducted by Liverpool University has been undertaken to investigate the effect reading aloud in a group has on the patients' level of pain. A study is currently being conducted through a partnership between researchers from CRILS – the Centre for Research into Reading, Literature and Society and Health Sciences at the University of Liverpool – The Royal Liverpool and Broadgreen National Health Service (NHS) Hospital Trust and TRO.

The study

Participants with severe and chronic pain were recruited from a local NHS Trust pain clinic and attended a weekly shared reading group within a hospital. The study used a mixed-methodology approach – quantitative self-report measures tested the impact of shared reading on participant's psychological symptoms and function, before, during and after attending the group. A qualitative approach explored the participants' experience of the group through semi-structured individual interviews. A year into this 3-year project and initial results are already showing a positive link between attending one of our shared reading groups and the alleviation of pain symptoms.

Kate McDonnell from TRO, who leads a group at Broadgreen, describes how

everyone in the group has a different pain story to tell, but in the session

the focus is on the book or story we share together and on the wider lives and experience of the people who come rather than just the pain. Group members say that the sessions give them something new and interesting to talk about to people who know them – a different conversational currency, that they're able to forget their pain while we're reading and that it gives them a weekly lift.

And Dr Andrew Jones, Consultant in Anaesthesia and Pain Medicine at Broadgreen, confirms that the signs are good:

Early indications are showing that the reading group is making a difference to people in our hospital. People with chronic pain have three times the average risk of developing psychiatric symptoms such as mood or anxiety disorders, and depressed patients have three times the average risk of developing chronic pain. While there is already evidence of the mental health benefits of shared reading, little is known about the benefits for physical health, but the link between chronic pain and psychiatric symptoms indicate it could help.

On the strength of this initial research, The Royal Liverpool and Broadgreen University Hospital NHS Trust has commissioned TRO to run weekly shared reading sessions for the next 3 years, and further research is planned. In fact, a further project is already in operation within the South London area. TRO, along with CRILS and in collaboration with Goldsmith's University, is currently carrying out a 3-year research project funded by Guy's and St Thomas Hospital Trust to continue to explore the benefits of shared reading on patients' sense of health and well-being. Along with other populations, such as dementia/older adults in the community, mental health/addiction and youth groups, we are also investigating the

effect of attending a shared reading group for those individuals living with a physical health condition and/or chronic pain. We will be measuring the impact through questionnaires, interviews and the video-recording of group sessions, with the results helping to inform researchers, clinicians and governmental policymaker as to how non-medical based therapies may be effective in increasing positive mental health in these individuals. As Jude Stanfield, Consultant of Public Health put it,

The Reader Organisation is a great example of how to improve people's mental wellbeing, in an accessible, acceptable, positive and effective way. I would commend this approach to any commissioner or practitioner wanting to improve mental wellbeing. It's exactly the sort of non-medical, non-stigmatising, non-labelling, cost-effective community activity we need to see more of.

Or as one of the participants put it,

One of the problems of having chronic pain is you tend to get depressed ... coming to the reading group is like therapy. When I go home from here I have a spring in my step. (P, participant in Broadgreen reading group)

Having already set up one shared reading group in a general practitioner (GP) surgery in Brixton, we are now looking to recruit a second group of individuals with chronic health conditions and/or chronic pain within the south London area to attend a weekly group as part of this research project. Therefore, we welcome any enquiries from practitioners, clinicians, consultants and support groups working in this sector who would like to become part of this exciting new opportunity. We are available to meet any interested parties and can arrange taster sessions of a shared reading group to give you a flavour of

what we do and how it could benefit your service-users. So please do contact us on the details below and come and join us in our reading revolution! I will, fittingly, leave you with a poem:

The Coming of Good Luck

*So Good-Luck came, and on my roof
did light,*

*Like noiseless snow, or as the dew of
night;*

*Not all at once, but gently, – as the trees
Are by the sun-beams, tickled by
degrees. (Robert Herrick)*

FFI:

For general information about TRO, visit
<http://www.thereader.org.uk>

To read TRO-published research papers/reports, visit <http://www.thereader.org.uk/what-we-do-and-why/research.aspx>
To become involved, or to find out more about the South London Project, please contact Fiona Magee (research assistant) fionamagee@thereader.org.uk/0781-332-4852.

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Evaluation of an email advice service to support pain management by general practitioners in the community

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Introduction

The Oxford Pain Relief Unit (PRU) established an email advice service in June 2011 to provide advice and support to patients and general practitioners (GPs) managing patients with chronic pain in the community. Nurses run the patient email service, and the medical pain

management consultants manage the GP email service.

The email address is present on patient clinic letters, on the trust website and the Primary Care Trust/Clinical Commissioning Group (PCT/CCG) clinical intranet so it is easily accessible for advice for GPs about patients known to the clinic or patients not known to the clinic.

This project comprises (a) a retrospective survey of the queries received by the advice service during its first 3 years and (b) a survey of GPs who used the service to gain feedback.

Aims

The review had two components. The first was to review the usage of the service, the nature of questions being asked and the response times. It also aimed to identify both the frequently asked questions by GPs and areas where GPs felt further information may be necessary.

The second part was to survey GPs who had used the advice service to gauge GP satisfaction and to identify areas for improvement.

Methods

The emails received over the first 3 years since starting the service (June 2011 until May 2014) were reviewed manually.

Additionally, an online survey was sent to all GPs who contacted the service, using the email address with which they contacted the service.

Results

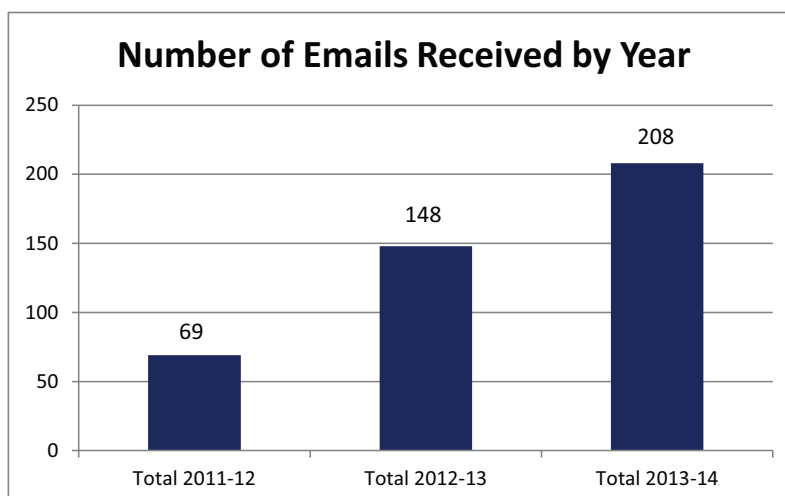
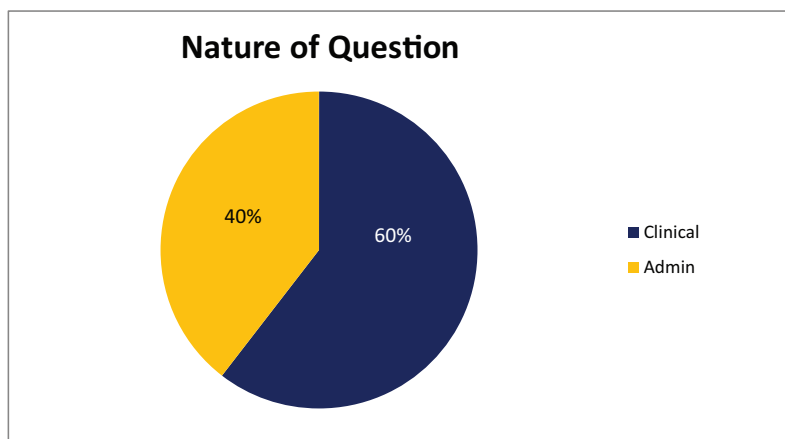
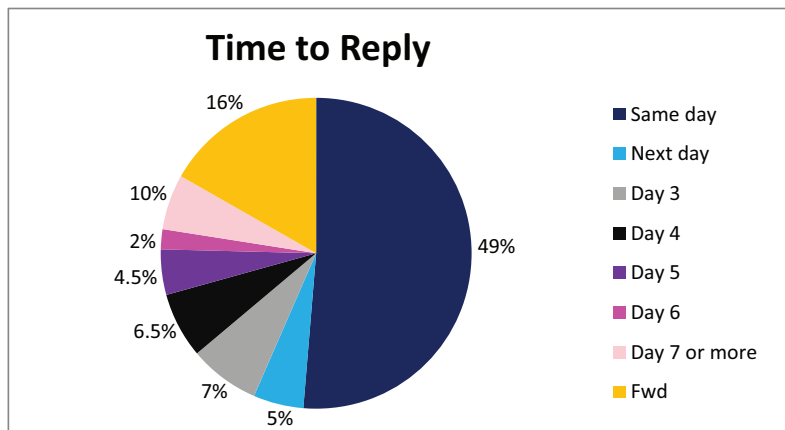
(a) Email audit

Usage: The emails received over the first 3 years totalled 425. The number of emails received increased year on year. A total of 69 emails were received in the first year, 148 in second year and 208 in the third year.

The majority of emails (84% (355)) were appropriate enquiries from GPs or other healthcare professional caring for the patient, for example, psychologist.

In all, 27 emails were from patients directly, which were re-directed to a separate patient advice service. The remaining emails were non-clinical, for example, requests for work experience or from the Patient Liaison Committee asking for information.

Evaluation of an email advice service to support pain management by general practitioners in the community



Response time: 49% of emails were responded to within 24 hours and 92% within 7 days or forwarded as appropriate.

Content of emails: Approximately half of the emails were clinical enquiries (231); 176 were asking clinical advice about a patient who

were either known to the clinic (87), had already been referred to the clinic but not yet seen (20) or not known to the clinic at all (69). In all, 30 emails were GPs providing a clinical update about a patient known to the clinic; 14 were chasing the results of investigations or referrals to other services made by the pain clinic; 11 emails were to confirm that patients would like to go ahead with treatments discussed in clinic but not booked at the time.

Of the other half, 168 were questions related to admin – the majority requesting appointments to be expedited, re-scheduled or confirmed. Advice was also sought about the referral pathway and services provided by the clinic. Complaints, compliments and requests to organise teaching sessions or multidisciplinary team (MDT) meetings accounted for the remaining emails.

A total of 26 emails were concerned with the clarification of clinical responsibility with respect to prescribing off-formulary medications or requesting investigations recommended by the PRU.

Frequently asked questions: The most frequently asked clinical questions were collected.

The majority of clinical queries were patient specific: detailing the patient history and asking for clinical advice or the appropriateness of a referral.

Other clinical enquiries were more generalised. The majority of these were drug related, for example,

- How to start a medication recommended by the PRU
- How to wean a medication recommended by the PRU
- How to wean one medication and start another as recommended by the PRU

Evaluation of an email advice service to support pain management by general practitioners in the community

- Concerns about high opioid doses
- Side effects of medications
- Risks of interventions offered by PRU

(b) Online questionnaire

The online survey was sent to 118 GPs who had directly emailed the email advice service. Seven emails were not delivered and returned to the server. A total of 23 GPs took part in the survey (response rate 20%).

The majority of responders were aware of the advice service from a patient's clinic letter or from a colleague.

In all, 83% rated the service as useful, and 56% found it very or extremely useful. GPs also found the specific advice helpful, with 83% rating it as helpful and 48% very or extremely helpful.

In all, 35% of GPs replying to the survey reported that the advice received prevented a referral to the PRU.

The comments about the email service were generally positive citing it as 'useful', 'helpful', 'excellent' and reporting a 'prompt and authoritative reply'. However, the feedback highlighted that the patients discussed were generally complex, and it would be helpful if the service could include the ability to have case conferences via email for difficult patients.

Discussion

The email advice service is a useful and well-received support service for GPs managing patients with chronic pain in the community. Importantly, the GP survey revealed that referrals to the PRU had been prevented on many occasions.

The majority of clinical questions were patient specific and therefore needed to be assessed on a case-by-case basis. However, several themes emerged from the clinical

questions being asked. GPs frequently requested further information regarding

- The services/interventions provided by the clinic, which patients would benefit from, and the side effects of interventions;
- Access to further guidance about starting, weaning and switching drugs recommended by the PRU;
- The PRU referral pathway and waiting times;
- Advice about prescribing PCT/CCG restricted medications recommended by the PRU.

In conclusion, an email advice service is useful for GPs who appreciate the support when managing patients with chronic pain in the community. It can also reduce pain clinic referrals by supporting GPs to manage chronic pain patients in primary care.



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Attention bias modification: an exciting new possibility for the management of chronic pain

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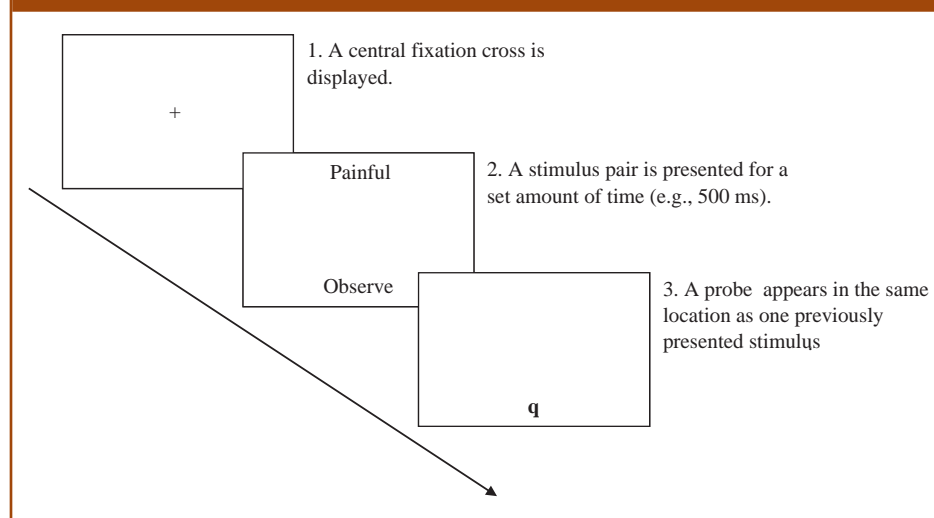
A biopsychosocial conceptualisation of chronic pain is currently accepted,^{1,2} with the onset and maintenance of pain associated with numerous factors including, among others, pathophysiological, cognitive and behavioural.³ In terms of cognition, a number of theoretical models predict the existence of cognitive biases in patients with chronic pain, the most detailed of which is the Schema Enmeshment Model of Pain (SEMP).⁴ A central notion of the SEMP is that self-referent information is preferentially processed, and it is predicted all patients with pain will demonstrate biases for sensory-pain information. After more than a decade of research, there now exists robust evidence for the presence of pain-related attentional biases in chronic pain patients, including studies using the visual-probe task (e.g. Haggman et al.⁵

and Schoth and Liossi⁶) as supported by the results of two meta-analyses,^{7,8} along with recent research exploring patient eye-movement behaviours.^{9–11} The results of such research show patients with chronic pain are more likely to have their attention captured by pain-related words and images relative to healthy, pain-free individuals.

In recent years, the clinical relevance of attentional biases has been increasingly debated.^{12–14} For example, attentional biases for pain and pain-related information may be associated with activity avoidance, which itself has been associated with increases in pain-related disability and maintenance of pain.¹⁵ Investigations of patients with acute back pain¹⁶ and post-operative pain¹⁷ suggest patterns of attentional bias are predictive in the onset of chronic pain. The management of chronic pain can be

notoriously challenging, and in many instances, patients do not achieve total pain relief.^{3,18} Considering this, a number of researchers have therefore explored the potential therapeutic benefits of attentional bias modification (ABM) in chronic pain. ABM is a computer-based therapy which aims to implicitly manipulate attention away from threatening information towards neutral information. A modified training version of the visual-probe task is used (see Figure 1), which on each trial presents one threatening and one neutral stimulus for a specified duration (e.g. 500ms). Immediately following this, a probe appears (e.g. one of two letters, such as *p* or *q*) in the same position as one of the former stimuli, and participants must indicate the type of probe presented as quickly as possible via manual response. In the standard version of the visual-probe task, the probe replaces the threatening and neutral stimulus with equal frequency. As responses are generally faster to probes appearing in an attended region of the display than an unattended region, this provides an indication of attentional bias. In the training version of the visual-probe task, the probe always replaces the neutral stimulus and never the threatening stimulus, which therefore encourages disengagement from threat.

Figure 1. Graphical representation of a typical visual-probe task trial



The majority of ABM research has been conducted in individuals with anxiety, the results of which have been largely supportive of ABM as either an enhancing tool for current treatments or even as a novel standalone treatment.¹⁹ A meta-analysis of 12 studies using ABM revealed significantly greater anxiety reduction in participants receiving ABM than those receiving placebo control interventions.²⁰ This is supported by a more recent analysis including 43 eligible studies exploring the benefits of ABM on different conditions, and which found significant reductions in anxiety but not depression.²¹ Considering chronic pain, to date, three published studies have explored the efficacy of ABM in chronic pain patients. Carleton et al.²² used media announcements to recruit patients with fibromyalgia ($n = 15$ completers; 94% female; mean age = 49.8 years; mean pain chronicity = 12.3 years). Patients were randomised to receive either eight sessions of ABM ($n = 9$ completers) or a control condition ($n = 6$ completers) featuring the standard visual-probe task, with two sessions per week across 4 weeks. Significantly more patients in the ABM group reported clinically significant changes in pain severity compared to the

control group (44% vs 17%, respectively). The ABM group also demonstrated significant reductions in anxiety sensitivity and pain-related fear. This was the first published study to explore ABM in chronic pain, although limitations include a small sample size and a lack of subsequent follow-up data.

Sharpe et al.²³ recruited 34 patients with chronic benign pain ($n = 28$) or arthritis ($n = 6$) via advertisements from pain-related services and also from previous investigations (59% female; mean age = 45.6 years; mean pain chronicity = 9 years). Participants were randomised to either four sessions of ABM or a control condition completing the standard visual-probe task. The first and last sessions were completed in the research lab, and the two intervening sessions completed at home. Participants subsequently completed eight sessions of cognitive behavioural therapy (CBT). The results revealed significant reductions in pain-related disability in the ABM group relative to the control group immediately following attentional training. After both attentional training and CBT at 6-month follow-up, the ABM group showed reductions in pain-related disability, anxiety sensitivity

and fear of (re)injury. A strength of this study was the inclusion of a 6-month follow-up, although a limitation was the small sample size. Most recently, we²⁴ conducted a proof of concept study with a small sample of eight chronic pain patients (4 chronic daily headache, 1 chronic migraine, 1 chronic orofacial pain, 1 chronic abdominal pain, 1 chronic pain resulting from medial patellofemoral ligament reconstruction) recruited from the local Southampton community via press announcements (75% female; mean age = 27 years; mean pain chronicity = 8.3 years). Participants completed eight ABM sessions across 4–6 weeks. Clinically significant reductions pre- to post-ABM were found for pain intensity, anxiety, depression and pain interference. A strength of this investigation included the use of both pictorial and linguistic training stimuli presented at 500 and 1250 ms exposure durations (a decision made based upon the results of empirical findings,⁸ and building upon the two former chronic pain ABM studies which presented linguistic stimuli for 500 ms only^{22,23}). Limitations included a lack of follow-up, no control group and small sample size.

There now exists preliminary evidence supporting the therapeutic benefits of modifying attentional biases in patients with chronic pain, although further research with larger sample sizes is crucial to ascertain the effectiveness and optimal form of ABM to be used. Design questions include the number of ABM sessions to use; the number of trials per visual-probe task to include; whether to train patients with threatening words, images or both; and the duration which to present such stimuli for. It is also of fundamental importance to establish whether beneficial effects are maintained over time. Well-designed double blind randomised control trials (RCTs) are therefore essential. To address many of these issues, we are currently developing an Internet-based ABM intervention using LifeGuide (<https://www.lifeguideonline>).

Attention bias modification: an exciting new possibility for the management of chronic pain



org), a free open-source software package that allows researchers and scientists to create online interventions. Individuals with chronic musculoskeletal pain will be recruited and randomised to receive either the modified training version of the visual-probe task (i.e. ABM group) or the standard version as a placebo control (i.e. attentional control group (ACG)). The intervention includes a number of novel features based on former research findings. First, while biases in chronic pain have been shown towards pain-related words and images due to the comorbidity of pain with emotional disorders,²⁵ patients will be trained to avoid a range of salient linguistic (i.e. sensory-pain, affective-pain, healthy-threat, general-threat words) and pictorial (i.e. musculoskeletal pain images, facial expressions of pain, general-threat and health-threat images) stimuli. Second, as attentional biases have been found towards stimuli presented at 500 and 1250 ms presentation times (i.e. Schoth et al.⁸), both times will be used in this ABM study similar to our proof of concept study.²⁴ Third, dose effects will be investigated in an exploratory manner via the randomisation of participants to either 8 or 16 session training groups, to be completed over 4 and 8 weeks, respectively. The primary outcome measures are pain intensity and pain

interference, and secondary outcome measures include anxiety, depression, pain-related fear and sleeping problems. In order to explore effects of ABM across time, outcome measures will be collected following the intervention and also at 6-month follow-up.

The intervention will be administered via the Internet, with recruitment open to patients across the United Kingdom. This approach allows patients to complete the training in their own homes on days and at times that are convenient to them. Given that 80% of UK households have Internet access (<http://offcom.org.uk>), the intervention will be accessible to the majority of interested patients. We will



use psychological theory and evidence-based methods to maximise patient adherence, which can be low with online interventions. The patients' views regarding ABM training will be collected

via semi-structured interviews at every stage of the intervention, and patients and professionals are currently assisting in the design of the website that will support the intervention (if you are interested in assisting us with this, please email us at abmpain@soton.ac.uk).

Scientific and clinical interest in attentional biases associated with chronic pain has grown tremendously over the past decade. Having established that pain-related attentional biases do exist in patients with chronic pain, research is now turning to the potential clinical implications of such biases, and whether their modification is associated with beneficial patient outcomes. Future research building upon the promising results of recent ABM studies is essential, and in particular, it is important to establish the optimal form of ABM to use, whether the Internet can be used to deliver attentional training with clinical benefits and to also explore the patient's own experiences using ABM. Should positive results continue to be found, the challenge will be for future research to establish how ABM may be integrated in currently existing treatments for pain.

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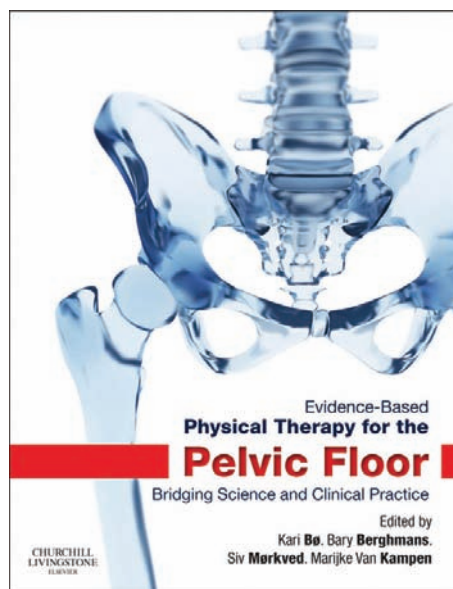
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 **SAGE** journals



Evidence-Based Physical Therapy for the Pelvic Floor: Bridging the Science and Clinical Practice by Kari Bø, Bary Berghmans, Siv Mørkved, Marijke Van Kampen, ISBN 9780443101465

Reviewed by Katrine Petersen, Specialist Physiotherapist in Pain Management (Abdomino-Pelvic Pain), Pain Management Department, University College London Hospitals

There are limited books published specifically about pelvic floor dysfunction for physiotherapists, and what has been written so far often focuses on female dysfunction and women's health physiotherapy. Originally published in 2007, the second, revised edition of *Evidence-Based Physical Therapy for the Pelvic Floor: Bridging the Science and Clinical Practice* covers both sexes and a variety of conditions and patient groups.

The 432-page book's 14 chapters contain contributions from 28 authors from around the world, each displaying their impressive knowledge and research stemming from a variety of specialities.

Aimed at healthcare professionals working in the field of pelvic floor dysfunction, the book includes an overview of physical therapy, a review of randomised controlled trials and the development of clinical practice guidelines. Although these chapters make for interesting reading, it is not clear whether they are targeting students, clinicians or researchers. In their preface, the authors state their hope that the book 'would become the base for postgraduate students in pelvic floor physiotherapy' as well as an informative reference book for any member of the multidisciplinary team involved.

As is often the case with books written by numerous authors, the overall result is somewhat disjointed. Several chapters have excellent up-to-date literature reviews, such as pelvic floor muscle training for urinary incontinence and pelvic organ prolapses; but such quality is not always consistent throughout the book.

Regardless, all chapters profit from a high level of critical evaluation of the evidence base and include recommendations from international organisations such as International Consultation on Incontinence. Each of the chapters' subsections also contains a helpful conclusion and clinical recommendations. This makes it easy for the reader to browse the content and in effect, use it as a reference book.

This publication provides the reader with a very comprehensive review of the evidence surrounding pelvic floor dysfunction, and it covers the biomedical aspects of managing dysfunctions from a non-invasive physiotherapy perspective. Less emphasis is placed on the impact

of the symptoms from patients' point of view, and there is only a relatively brief, 18-page section detailing pelvic floor pain. Although this section is well written and researched, it is trying to cover a very complex area that is likely to be a part of most of the dysfunctions described and probably warrants a multidisciplinary book in itself.

There is mention of the World Health Organization (WHO) classification of health: pathophysiology, impairment, disability and participation. From my perspective, the book focuses mainly on the dysfunction (i.e. incontinence, sexual dysfunction and prolapses) but does not move much beyond the impairment when it comes to looking at patient outcomes. This is not necessarily a criticism, but rather an observation to inform clinicians and students who may want to consider reading this book.

It is very well researched and covers the evidence base of treatment for a wide range of patient types, ranging from children and the elderly to athletes. One caveat is that the book raises more questions than it answers; this may have the positive consequence of encouraging clinicians and researchers to produce more publications in the future to better inform practice.

Although it is very well written and researched, it is important to note that this book does not aim to address the management of complex biopsychosocial issues surrounding chronic pelvic pain. Rather, it would be most useful as a reference for healthcare professionals – mainly physiotherapists working in the field of pelvic floor dysfunction. The content is highly biomedical and therefore unlikely to appeal to specialists trying to manage complex chronic pelvic pain conditions.

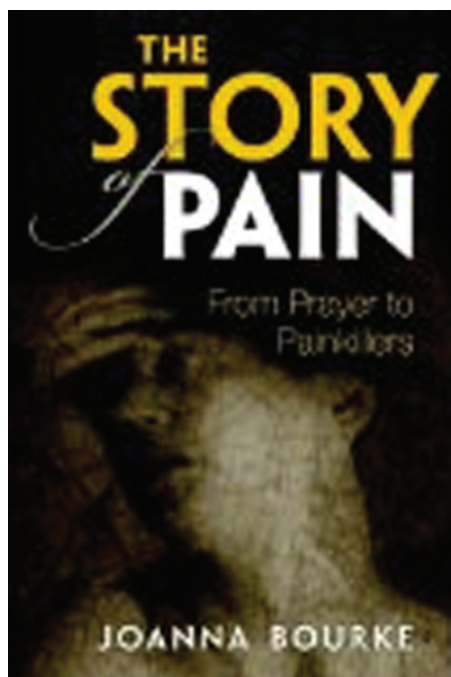


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The Story of Pain: From Prayer to Painkillers by Joanna Bourke, Oxford: Oxford University Press (OUP), 2014, ISBN 0199689423, ISBN 9780199689422

Reviewed by Ethel Hili, Clinical Specialist Physiotherapist (Chronic Pain), Community Chronic Pain, Kent Community Health NHS Trust

In this book, Joanna Bourke, a history professor at Birkbeck, University of London, and a Fellow of the British Academy, explores the history of pain – how we describe it, how we think about it and how we deal with it. The book is a fascinating read, richly researched and very well-written, with extremely striking imagery that transports the reader with a

vivid imagination through the centuries. The book is certainly not one for light reading and needs time and consideration for digesting what is written.

The book is divided into nine chapters that trace the shift in medical, cultural, sociological and historical definitions of pain across the centuries. The preface promises to ‘help us acknowledge our own sorrows and those of others’, and the author bravely takes on the task of writing about pain in the form of what is probably the least common dimension – the historical one. Throughout the book, the terms ‘pain’ and ‘suffering’ are used interchangeably.

The introductory chapter looks at pain as a ‘type of event’ – an event that is historically flexible, but also very complex. Professor Bourke uses several metaphors in order to explore the nature of pain as a significant event in a person’s life, while acknowledging its complexity in terms of this event being what the person says it is, that is, a painful event that causes suffering. She emphasises the discrepancy between particular actions and a person’s experience of pain, as in many chronic pain conditions where pain can be present in the absence of (actual) noxious stimulation. The author believes that evaluating the language choices of people in pain is one of the keys to understanding them better.

The isolating nature of pain is analysed in detail. The author uses the second chapter to explore some of the barriers to communicating painful sensations to oneself, as well as to other people. Another significant theme within this chapter is a reflection on the effect of

pain on significant others and carers. Professor Bourke discusses the fact that one person’s pain can be ‘caught’ by another, and thus almost justifies sufferers’ self-imposed isolation, in an attempt to shield their loved ones from their suffering. However, how social or isolated an individual chooses to be has an impact on their ability to forge social networks, since pain events are inherently social and therefore fundamental to the creation of communities. The author also explores carers’ and professionals’ sense of hopelessness when faced with caring for someone in pain.

Perhaps the most distressing and thought-provoking chapter is the one on religion. This chapter tackles a subject that is often considered taboo within health and social care settings. The author makes use of very vivid descriptions, taken from historical writings, to describe common theological interpretations of pain as a punishment for sin or for neglecting one’s faith. Some writers maintain that pain is a way of making people change aberrant habits, while others view suffering as a preparation for the after-life. In this context, carers and significant others are not spared suffering either, as they are encouraged to learn from witnessing their loved one’s anguish. Hence, for many adhering to this point of view, pain and suffering offer the opportunity for personal improvement and eventual salvation. Consequently, several Christian traditions have also considered pain a gift from God.

The author continues by acknowledging the shift in the religious interpretation of pain in an increasingly

secular world. She emphasises that although secularisation is a feature of contemporary society, there has been a decided resurgence in faith healing, evangelical renewal and prayer in response to suffering. She points out that even the language used by the most convinced agnostic or atheist to express pain is often based on a Christian idea of what it is to be in pain. Professor Bourke also traces the shift from a religious interpretation of pain to a more scientific one, heralded by the invention of anaesthetic and the advances in analgesia.

The author traces the development and sometimes regression of sufferers' pain narratives, as influenced by sociological, historical and anthropological influences throughout the ages. The chapter on diagnosis scrutinises the distress caused by an inability to make a diagnosis of someone's pain. Interestingly, it seems that several authors, both within and outside the medical sphere, have long identified the incongruity between a patient's pain narrative and actual, measurable tissue damage. Professor Bourke highlights the sometimes inevitable disbelief that chronic pain patients face and the consequent (not wholly unwarranted) distrust that they may develop towards medical professionals.

The book features a comprehensive discussion about the world-renowned McGill Pain Questionnaire, the value of the descriptors used in this questionnaire and the value of its use to patients and their clinicians. Professor Bourke's interest in language and metaphor leads into an interesting discussion around the suitability of such a tool for the contemporary multi-cultural and multi-lingual societies we live in.

It is important to note that the book does not fail to acknowledge that paediatric pain can sometimes be even more of a challenge to manage than pain in adults. Perhaps, the lack of development of accurate language and behavioural skills in those of a young age, in addition to the tendency of information being gleaned from the child's parents, plays a part in perpetuating these difficulties. No matter how 'in tune' parents are to their children, their narrative is always a 'second hand' one.

In addition, Professor Bourke does not shy away from discussing the routine underestimation of the sufferings endured by certain groups of people, based on age, sex, ethnicity and class. She considers controversies like whether certain groups of people are physiologically less capable of feeling pain and delves into the highly politicised issue of abortion and the arguments

about whether a foetus or premature infant is capable of feeling pain.

The final chapter is perhaps the most relevant to this particular readership. The chapter tackles two questions: why were anaesthetics not invented earlier and why is contemporary medicine unable to provide effective pain relief for all forms of pain? The chapter provides a highly interesting analysis of interventional pain management and its evolution throughout the ages. It also looks at the under-treatment of pain in certain populations, both with analgesics and anaesthetics.

Professor Bourke makes use of a wealth of historical references from writers and thinkers hailing from all walks of life, who wrote about their lives in pain. She also makes reference to more recent research that is generally based on results from the field of palliative care. This could perhaps exclude that research, albeit limited, originating from chronic, non-malignant pain. This in itself could possibly highlight a certain stigma, associated with this kind of pain, because it does not fit neatly within the 'box' for cancer-related or other 'justifiable' pain. This, however, does not detract in any way from the value of the book and would be appropriate reading for all clinicians involved in the management and support of people with persistent pain.



Spotlight – Meherzin Das



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 Meherzin Das, Chair, ICT SIG



Meherzin Das
Dorset Community
Pain Service, Dorset
HealthCare University
NHS Foundation
Trust

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

I've been a member of the BPS forever, but a chance conversation with Dr Cathy Price in 2011 and later with

Dr Martin Johnson made me aware of the excellent work being done behind the scenes. Several people were generous in sharing their ideas related to the use of Information and Communication Technology (ICT) in pain and with the kind backing of Council and the Secretariat, a new Special Interest Group (SIG) was born.

2. What is your role in the BPS? What excites you about this role?

My role as Chair of the ICT SIG is fascinating because the field itself is infinite! Keeping up with new developments is a full-time task,

thankfully shared by our terrific Committee – working with whom is a privilege and a joy. The enthusiasm generated around the ICT stand at the Annual Scientific Meeting (ASM), 2014, was infectious, and we look forward to doing it all over again this year.

3. What do you feel is the role of the ICT SIG within the BPS?

Over the past year, the ICT SIG has worked with the secretariat and the Communications Committee to support the BPS in various ways: showcasing good practice, helping to enhance our communication with the use of on-line resources, developing guidelines for social media and benchmarking criteria for website inclusion, supporting the development of the BPS' new website under the sterling leadership of Dr John Goddard – our members will really enjoy the new features it provides! ICT brings people together, and our SIG helps to do so in safe and sustainable ways.

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

Our Presidents have provided excellent leadership, and their

considerable achievements make it easier to think of the steps ahead. Given that pain affects one in seven of us, I would like the BPS to reach out more to all instead of expecting people to come to us by creating a pathway so that every person living with pain in Britain can be affiliated to the BPS, if they wish, involving existing members centrally by utilising their considerable skills better, offering professional support to clinicians, commissioners, researchers working with pain, whether they are members or not ... and that's just for starters! While speaking at the EFIC/Societal Impact of Pain (SIP) Symposium in Brussels last year, a colleague from Spain shared my thinking – we need to conduct a media campaign to enhance public understanding of pain – and what better way to do that in this day and age than through social media?

5. What are you known for professionally?

Recognising clinical need and finding innovative solutions ... tiring my long-suffering colleagues with new ideas and irritating bursts of energy,

and ... as a psychologist, following my clients' example by trying out something new every week! And my soapbox: promoting Early Intervention to prevent chronic pain from developing whenever possible, for which we won The Health Foundation's Shine Award for Innovation in Healthcare.

6. What are you most passionate about professionally?

Providing the best pain service our fantastic team and I possibly can for the good people of Dorset ... ensuring their voice is heard and represented well ... setting up multi-disciplinary training for professionals allied to pain ... expanding our Pain Chain (thanks to the most outstanding peer support) so that no one living in pain need ever walk alone ...

7. What do you have a knack for?

Getting groups of people together and generating warmth and positive energy to achieve constructive outcomes.

8. What are you passionate about personally? What do you really enjoy? What can't you stop talking about?

My children.

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

Attending music concerts with my husband – ranging from Iron Maiden to Dylan to Orff – or better still, listening to the kids perform in one of their bands ... day trips when I manage to drag the family out ... catching up with friends over a meal ... falling asleep over that book I just can't put down ...

10. Any other volunteer activities apart from the BPS that you're passionate about?

Supporting Pain Concern and Arthritis Research UK. Fundraising for local events and also for charities in India, where I was born.

11. Any favourite non-profit organisations that you support and why?

We support a number of different organisations, and also our local Age UK and Oxfam shops.

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

Chocolate cake. It's a biological impossibility!

13. How do you want to be remembered?

Shakespeare said it best: ... to thine own self be true.

14. And it must follow, as the night the day ...

Have you developed a new on-line intervention? Heard of one you'd like to share? Please write to meherzin.das@dhft.nhs.uk. Join the ICT SIG and keep abreast of our activities – we would be delighted to hear from you.



Word Search

Pain Assessment and Management

G L T Z Y G E T U C A C J N C E Y L O H
 F B P L D O D N S G E U G F G D Z A P Y
 P G O D H I L H O K G D W T K I Q C J Y
 B B E V A Z R J C H A S H E N S V I C C
 G W V T Z S E X I V O C L U Q A A G E G
 U D I N M B D A O R M B N A X B L O N H
 R V T E A I O R C M A D A W E I I L O S
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 L P E I E A Q N P S Y C U P C W H L V E
 V S K M E L G B T X L E I C U H C K T W

ACUTE
 AGE
 ASSESSMENT
 BEHAVIOURAL
 BIOPSYCHOSOCIAL
 CHRONIC
 COGNITIVE
 COMMUNICATION
 COMPREHENSIVE
 DISABILITY
 EFFECTIVENESS
 MANAGEMENT
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 RELIABLE
 SENSORY
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 SOCIOCULTURAL
 TREATMENT
 VALIDATED

New members

Ratiofied at the November 2014 Council Meeting

Name	Position	Institution
Miss Joanna Quinlan	Pain Management Worker/Counsellor	University Hospital of North Durham
Dr Ramy Mottaleb	ST6 Anaesthesia	St Helier Hospital
Dr Pallam Bhai Desai	ST5 Anaesthetics	York Hospital
Dr Abbie Jordan	Honorary Lecturer in Psychology	University of Bath
Dr Julius Bourke	Clinical Lecturer in Neurophysiology & Clinical Psychiatry	Barts Health NHS Trust
Dr Tomasz Bendinger	Senior Registrar in Anaesthesia and Pain Management	Northern General Hospital
Miss Natalie Wellington	Placement Student (BSc Psychology Degree)	Gloucester Royal Hospital NHS Foundation Trust
Dr Gerard Sinovich	SPR Anaesthetics/Pain Trainee	St Helier Hospital
Dr Giorgio Lambru	Consultant Neurologist with interest in Headache	Guy's & St. Thomas' NHS Foundation Trust
Dr Thomas Selvaraj	Locum Consultant	Warwick Hospital
Dr Norman Kufakwaro	Consultant Neurologist with interest in Headache	Barts Health NHS Trust
Dr Balazs Bartos	Clinical Fellow in Pain Medicine	The Dudley Group of Hospitals NHS Foundation Trust
Miss Karolina Nyitrayova	Placement Student with Pain Management Team	Gloucester Royal Hospital NHS Foundation Trust
Dr Bernat Carner-Bonet	Consultant in Anaesthesia and Pain Medicine	Hopitaux Du Leman, France
Miss Andreia Trigo	Senior Anaesthetic Nurse	The Wellington Hospital
Dr Salmin Aseri	STR	Pennine Acute Hospitals
Mrs Gina Wall	Physiotherapist	Kingsway health centre, Stevenage
Mt Tristan Grey	Nurse in Pain Clinic	UH Bristol

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Pain management in patients with HIV

Pain management in the adolescent/young adult
Peripheral regional analgesia
Pharmacogenomics
Primary care management
Psychology of pain
Service re-design
Sleep and pain
Therapies including lifestyle orientated treatments
Transition between acute and persistent pain

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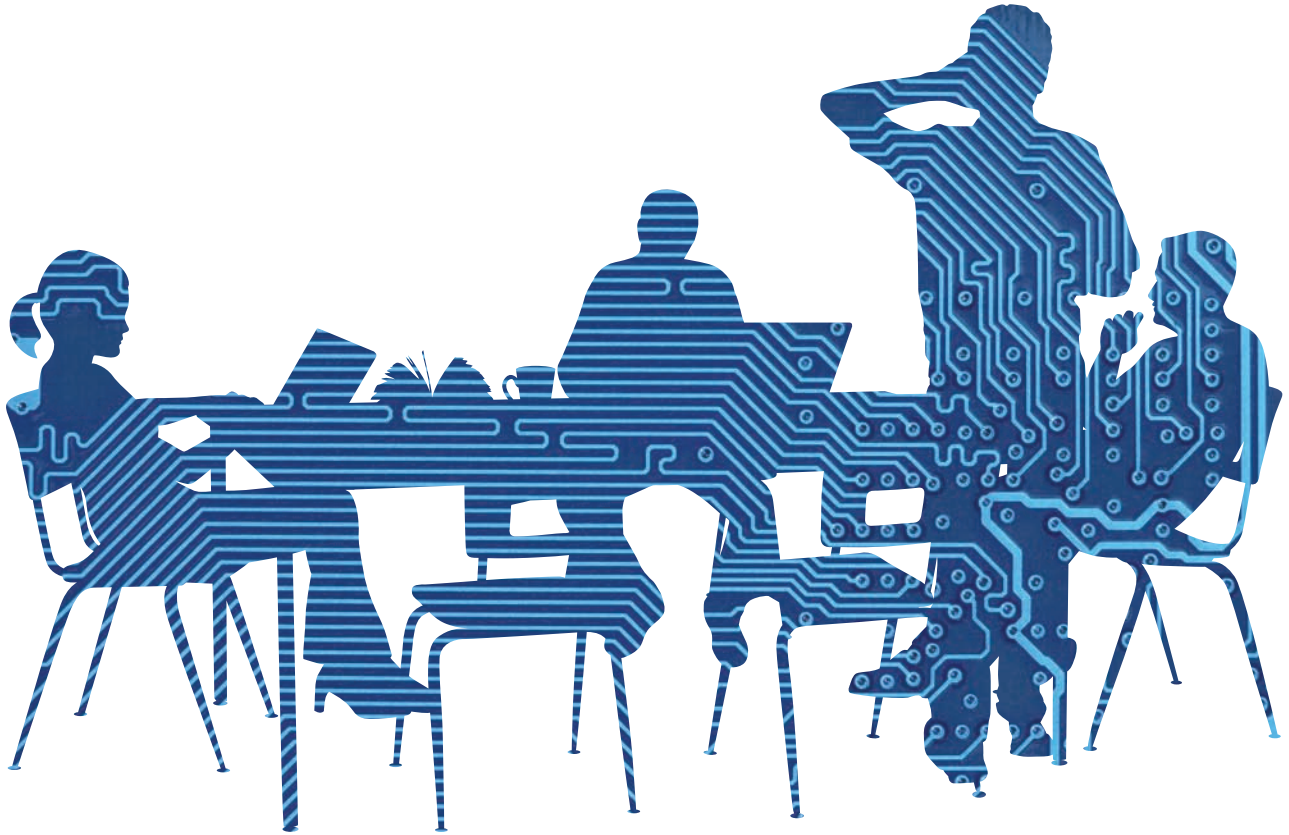
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