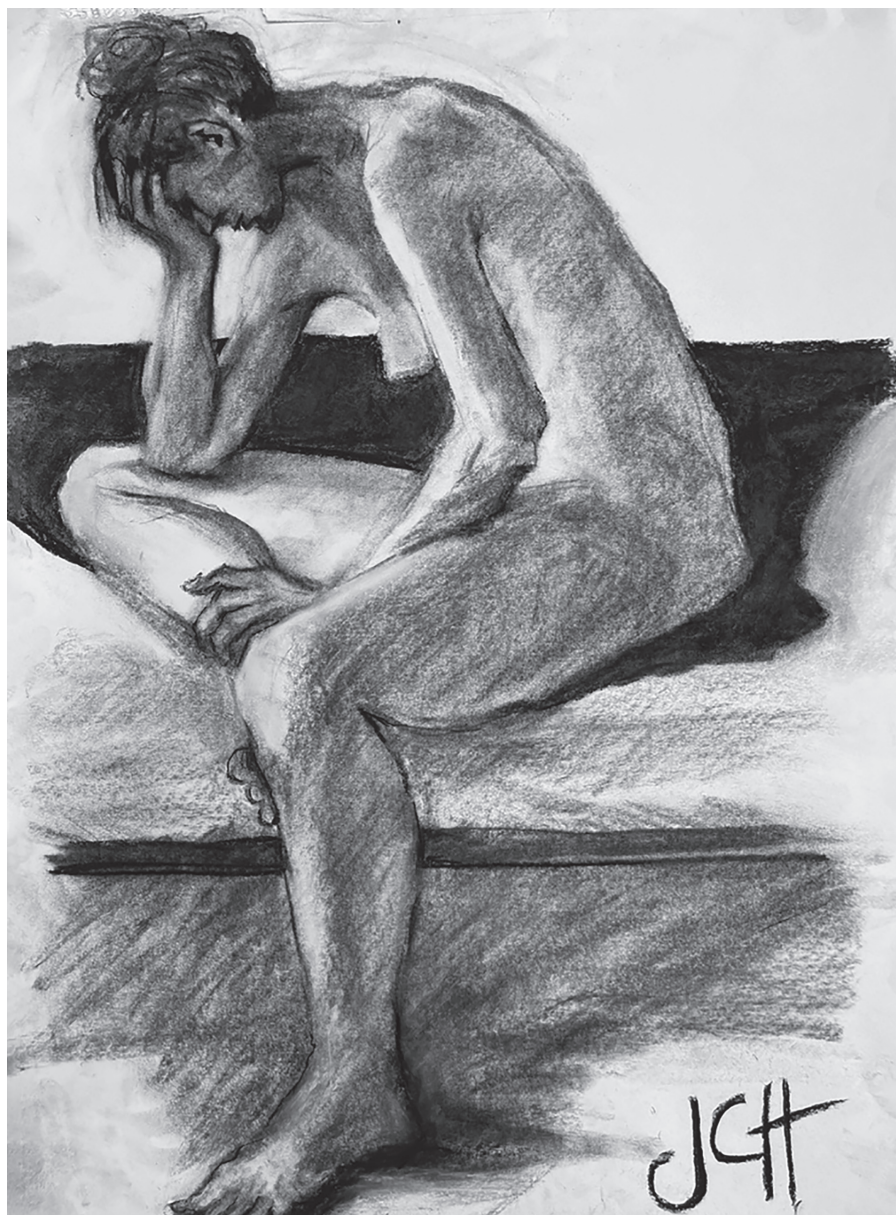


DECEMBER 2023 VOLUME 21 ISSUE 4

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



The Body in Pain Series untitled #3 .© Julia Hollander

ISSN 2050-4497

TIME IS
PRECIOUS

THINK
OUTSIDE
THE BAG

Who has time
for buffering,
dilution and
slow-infusion?

- No reconstitution
- No buffering
- No dilution
- No slow infusion
- Reaches C_{max} in 3 minutes¹



Akis[®]
diclofenac sodium 75 mg/1 mL
solution for injection

READY WHEN YOU ARE

Intravenous bolus injection for treatment,
or prevention, of postoperative pain
in hospital settings

AKIS[®] (DICLOFENAC SODIUM) 75mg/mL SOLUTION FOR INJECTION

PRESCRIBING INFORMATION: Please refer to Summary of Product Characteristics before prescribing. **ACTIVE INGREDIENT:** Each 1 mL ampoule contains 75 mg diclofenac sodium. **INDICATIONS:** By intravenous bolus injection for treatment, or prevention, of post-operative pain in hospital settings. By intramuscular and subcutaneous injection in acute forms of pain, including renal colic, exacerbations of osteo- and rheumatoid arthritis, acute back pain, acute gout, acute trauma and fractures, and post-operative pain. **DOSAGE AND ADMINISTRATION: Adults:** by intramuscular, subcutaneous or intravenous bolus injection. Not to be given by i.v. infusion. Use the lowest effective dose for the shortest duration necessary. For severe pain a dose of 75mg may be needed. Exceptionally, and in severe cases, a second dose of 75mg can be administered after 4-6 hours. Lower doses may suffice for mild and moderate pain, where freedom from the usual side-effects of NSAIDs is a priority and in the elderly particularly if frail or underweight. Maximum daily dose 150mg. Maximum treatment duration two days. **Elderly:** Maximum daily dose 150mg. Monitor regularly for GI bleeding. **Children and adolescents:** Not recommended. **CONTRAINDICATIONS:** Haemostasis disorders or current anticoagulant treatment (i.m. use only), hypersensitivity to active substance or excipients, active gastric or intestinal ulcer, bleeding or perforation, historic NSAID-related gastrointestinal bleeding or perforation, active or history of recurrent peptic ulcer/haemorrhage, last trimester of pregnancy, severe hepatic, renal or cardiac failure, history of NSAID or acetylsalicylic acid precipitated asthma, urticaria, or acute rhinitis, established congestive heart failure, ischemic heart disease, peripheral arterial disease and/or cerebrovascular disease. **Specifically for i.v. use:** Concomitant NSAID or anticoagulant use (including low dose heparin), history of haemorrhagic diathesis or asthma, history of confirmed or suspected cerebrovascular bleeding, operations associated with high risk of haemorrhage, moderate or severe renal impairment, any cause of hypovolaemia or dehydration. **SPECIAL WARNINGS AND PRECAUTIONS FOR USE:** Avoid use with systemic NSAIDs or COX-2 inhibitors. Caution in the elderly particularly if frail or underweight. Monitor for anaphylactic/anaphylactoid reactions and signs and symptoms of infection. Adhere to instructions for intramuscular injection to avoid adverse events at injection site including injection site necrosis and embolia cutis medicamentosa (Nicolau syndrome). Caution and close medical surveillance with symptoms indicative of gastrointestinal disorders or with a history suggestive of gastric or intestinal ulceration, bleeding

or perforation. Consider combination therapy with protective agents for these patients and those requiring concomitant medications likely to increase gastrointestinal risk. Discontinue immediately if gastrointestinal bleeding or ulceration occurs or at first appearance of skin rash, mucosal lesions, or other signs of hypersensitivity. Close medical surveillance and caution in patients with ulcerative colitis, Crohn's disease, after gastro-intestinal surgery, impaired hepatic function, hepatic porphyria, impaired cardiac or renal function, history of hypertension, the elderly, patients receiving concomitant treatment with diuretics or medicinal products that can significantly impact renal function and patients with substantial extracellular volume depletion from any cause. Monitor for fluid retention and oedema in patients with history of hypertension and/or mild to moderate congestive heart failure. Caution in patients with significant risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking). Careful monitoring in patients with defects of haemostasis. Monitor haemoglobin and haematocrit levels if symptoms of anaemia are detected. Risk of hyperkalaemia in diabetic patients or those taking potassium-sparing drugs. Special precaution recommended in patients with asthma, seasonal allergic rhinitis, swelling of the nasal mucosa, COPD, chronic infections of the respiratory tract, and patients allergic to other substances. Increased risk of aseptic meningitis in patients with SLE and mixed connective tissue disorders. **INTERACTIONS:** Lithium, digoxin, diuretics, ACE inhibitors, angiotensin-II antagonists, other NSAIDs, corticosteroids and acetylsalicylic acid, anticoagulants and heparin (administered in the elderly or at curative doses), thrombolytics and anti-platelet agents, SSRIs, antidiabetics, methotrexate, pemetrexed in patients with normal renal function, calcineurin inhibitors (e.g. ciclosporin, tacrolimus), deferasirox, quinolone antibacterials, phenytoin, colestipol and cholestyramine, potent CYP2C9 inhibitors, (e.g. sulfapyrazone and voriconazole), mifepristone, tacrolimus, zidovudine. **PREGNANCY, LACTATION AND FERTILITY:** Avoid during first and second trimester of pregnancy unless clearly necessary. Consider antenatal monitoring for oligohydramnios resulting from foetal renal dysfunction and ductus arteriosus constriction after exposure to diclofenac for several days from week 20 onward; discontinue if found. Contraindicated during the third trimester of pregnancy. Not to be administered during lactation. May impair female fertility. **DRIVING:** May cause visual disturbances, dizziness, vertigo, somnolence or other central nervous system disturbances. Driving or use of machines

should be avoided if affected. **UNDESIRABLE EFFECTS: AKIS Post-marketing experience: Very common:** injection site reactions. **Common:** nausea, limb discomfort. **Serious:** hypersensitivity reaction, ischaemic colitis, Nicolau syndrome. **NSAID class effects: Common:** headache, dizziness, vertigo, nausea, vomiting, diarrhoea, dyspepsia, abdominal pain, flatulence, transaminases increased, rash, injection site reaction, injection site pain, injection site induration. **Serious:** Thrombocytopenia, leukopenia, anaemia (including haemolytic and aplastic anaemia), agranulocytosis, anaphylactic and anaphylactoid reactions, psychotic disorder, convulsion, aseptic meningitis, cerebrovascular accident, cardiac failure, myocardial infarction, Kounis syndrome, hypertension, vasculitis, asthma, pneumonitis, gastrointestinal haemorrhage, haematemesis, diarrhoea haemorrhagic, melaena, gastrointestinal ulcer, colitis (including haemorrhagic colitis and exacerbation of ulcerative colitis or Crohn's disease), stomatitis, diaphragm-like intestinal strictures, pancreatitis, hepatitis, hepatic necrosis, hepatic failure, bullous eruptions, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome), acute renal failure, haematuria, proteinuria, nephrotic syndrome, interstitial nephritis, renal papillary necrosis. Prescribers should consult the summary of product characteristics in relation to other adverse reactions. **PHARMACEUTICAL PRECAUTIONS:** Store below 25°C. Do not refrigerate or freeze. Store in the original packaging to protect from light. Do not use if crystals or precipitates are observed. **DATE OF REVISION OF PRESCRIBING INFORMATION:** March 2023 **LEGAL CATEGORY:** POM. **BASIC NHS PRICE:** £24.00 (5x75mg/1 mL ampoules). **MARKETING AUTHORISATION HOLDER:** IBSA Farmaceutici Italia Srl, Via Martiri di Cefalonia 2, 26900 Lodi (Italy).

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Flynn Pharma Ltd. Medical information: Tel 01438 727822

MARKETING AUTHORISATION NUMBER: PL 21039/0042. Marketed in the UK by Flynn Pharma Limited, Hertlands House, Primett Road, Stevenage, Herts SG1 3EE, Tel: 01438 727822, E-mail: medinfo@flynnpharma.com. Information about this product, including adverse reactions, precautions, contraindications and method of use can be found at <http://medicines.org.uk/emc/>. AKIS is a registered trademark of IBSA Farmaceutici Italia Srl.

contents

The opinions expressed in PAIN NEWS do not necessarily reflect those of the British Pain Society Council.

PAIN NEWS DECEMBER 2023

Officers

Professor Roger Knaggs
President

Dr Rajesh Munglani
Vice President

Dr Cathy Price
Vice President

Dr Ashish Gulve
Vice President

Dr Tacson Fernandez
Honorary Treasurer

Dr Neil Collighan
Honorary Secretary

Elected

Dr Tacson Fernandez

Mr Martin Hey

Dr Sumit Gulati

Dr R Krishnamoorthy

Ms Celia Manson

Dr David Pang

Dr Mahindra Chincholkar

Dr Manojit Sinha

Pain News Editorial Board

Dr Rajesh Munglani
Editor

Dr Margaret Dunham
Associate Editor

Co-opted Members

Ms Victoria Abbott-Fleming MBE
Chair, Patient Voice Committee
Patient Lead, National Awareness Campaign

Ms Felicia Cox
Editor, British Journal of Pain and
Representative, RCN

Dr Andreas Goebel
Chair, Science & Research Committee

Elsje de Villiers
Representative, Physiotherapy Pain Association

Dr Patrick Hill
Representative, British Psychological Society

Dr Lorraine de Gray
Representative, Faculty of Pain Medicine

Dr Martin Johnson
Representative, Chronic Pain Policy Coalition

Dr Rajesh Munglani

Editor, Pain News

Dr Edmund Keogh

Chair, Scientific Programme Committee

Secretariat

Matthew Hall
Executive Director

Ester Zorova
Association Manager

Editorial

106 Pain News round up: Christmas 2023 – Margaret Dunham

President's message

108 President's message – Roger Knaggs

Articles

- 110 Pain and music 2: composers – Julia Hollander
- 112 'How can we improve primary care management of MSK pain?' – Jonathan Hill
- 114 Implementation of a new musculoskeletal multidisciplinary pathway and reduction in pain intervention waiting lists – J Smith, J Jack and S Bustamante
- 119 Prescribing of modified-release opioids at hospital discharge – Michael Wilcock, Neil Roberts, Sarah Medicott, Kerry Elliott, Bernie Booker, Kayley McGuffie, Liam Bastian, Ann Cardell, Josh Holloman, Joseph Oates and Keith Mitchell
- 122 Opioids and surgery: a Massive Open Online Course (MOOC) – an innovative approach to education in perioperative opioid stewardship – Dr Fausto Morell-Ducos, Dr Dermot McGuckin, Dr Jamie Smart and Dr Brigitta Brandner
- 124 The problem with pain scales – Chris Bridgeford

Lives Remembered

- 126 Colonel James McEwan OSJ MB CHB FFARCS L/RAMC (1927–2012) – Dr Charles A Gauci
- 128 Andrew Diamond: pioneer and visionary in anaesthesia and pain medicine – Dr Gareth Greenslade

End piece

- 130 The prescription: a view from general practice
- 132 The art of Sir Michael Bond
- 134 The Fool's way with pain – Julia Hollander

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

Neil Cheshier, Sage Publications,
1 Oliver's Yard, 55 City Road,
London EC1Y 1SP, UK.

Tel: +44 (0)20 7324 8601;

Email: advertising@sagepub.co.uk

Disclaimer:

The Publisher, Society and Editors cannot be held responsible for errors or any consequences arising from the use of information contained in Pain News; the views and opinions expressed do not necessarily reflect those of the Publisher, Society and Editors, neither does the publication of advertisements constitute any endorsement by the Publisher, Society and Editors of the products advertised.

The Editor welcomes contributions including letters, short clinical reports and news of interest to members.

Material should be sent to:

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

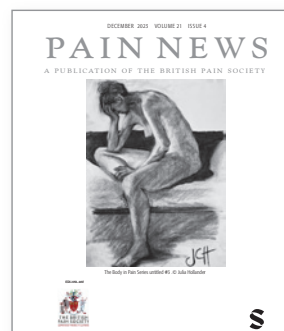
Email rajeshmunglani@gmail.com

ISSN 2050-4497 (Print)

ISSN 2050-4500 (Online)

Printed by Page Bros., Norwich, UK

At Sage we take sustainability seriously. We print most of our products in the UK. These are produced using FSC papers and boards. We undertake an annual audit on materials used to ensure that we monitor our sustainability in what we are doing. When we print overseas, we ensure that sustainable papers are used, as measured by the Egmont grading system.



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

Pain News round up: Christmas 2023

Margaret Dunham *Associate Prof in Nursing & Pain Management*

Associate Editor Pain News

As you read this at Christmas, or nearly, here is my Christmas wish. I hope for an idealised future world where we can identify and prevent lots of diseases and healthcare research and researchers continue to be ambitious for a world with less disease. Yet chronic pain still accounts for a massive amount of sickness within the workforce globally and its deleterious effects have consequences for society as a whole. Hence, any research in this area is always very welcome, but my particular plea is that anybody looking at large datasets could they please identify the age populations within them and stratify the results so that we have some idea of the different effects within the range of ages of the adult population including the young old, and the oldest old.

At the University of California, San Francisco (UCSF), researchers in the Departments of Anaesthesia, Neurology and Neurosciences have combined efforts to explore the origins of neuropathic pain by studying brain biomarkers in humans. Shirvalkar et al.¹ and team implanted intracranial electrodes into the frontal brain regions of four volunteer participants. The study was intended to try and identify some of the physiological processes associated with developing chronic pain. All four participants had established chronic neuropathic pain and the researchers report this as the first in vivo study of its kind. Changes in the cortex signals were identified as predictors of pain experience. This is clearly a burgeoning area of research and is particularly welcome after so many years of animal studies being used to model human experience, and who knows where this development may lead . . .

One of the major manifestations of chronic pain in ageing global populations is though osteoarthritis. Joint replacement of knee or hip is frequently the final resort but that does not mean the cause goes away, and prevention is always better. A major study,² combining data from 43 centres in Australia and the Netherlands, considered the effects of colchicine low dose compared with placebo for people with co-existing coronary disease and osteoarthritis of the knee or hip. Interestingly, this lower dose of colchicine was associated with subsequent lower incidence of joint replacement in this population.

Chronic fatigue (CF) or myalgic encephalomyelitis (ME), both pre- and post-Covid, is a debilitating condition for the individual

experiencing it. It is also a challenging one to get treatment for. The exhaustion and cognitive effects that people with ME/CF experience can be transitory, which makes it challenging to even get a diagnosis. Hence, a blood test or similar would be extremely helpful. Researchers³ at the National Heart, Lung, and Blood Institute (NHLBI) in the United States have identified a particular protein called WASF3 in both human and mouse cells. In humans, they studied people with existing ME/CFS and with the mice toxins were used to induce stress in cultured cells. This particular protein may be the result of cellular stress within muscles but is potentially a biomarker, a biochemical signature associated with CF, the effect of which requires further research.

The potential of cannabis has yet to be fully realised. It has long been lauded as one of the ways forward for the management of chronic pain. However, to establish the safety concerns for the UK population, it is important that any drug trials represent the diverse ethnicity and genetics of the population through inclusive recruitment of UK representative populations. The under-representation of the UK Black and Asian minority populations in trials for vaccinations and drug development is a major concern for UK researchers. A London-based team led by Dr Marta Di Forti⁴ is trying to gather a cohort of existing cannabis users. This is proving challenging at multiple levels. However, we need these data not only for cannabis use but also to support much medical care. Studies like this are so valuable as in the United Kingdom, we lack particular data that relate to people from diverse cultural and genetic backgrounds to support effective practice, whether it relates to drug development or effective health management/promotion.

All of these insightful and important pieces of research evidence are absolutely no use to the NHS if we do not have the workforce to deliver. There is a recruitment crisis across the United Kingdom for health professionals, partially due to the reducing number of young people in our ageing population. At societal level, as expressed in the mainstream media, and within the NHS, we appear to be experiencing a level of post-Covid fatigue and disquiet about healthcare provision in general which is perhaps putting people off, alongside the pay . . .

However, once these recruits are obtained do we keep them, and how do we keep them? GPs are becoming an endangered species, when fewer than half of the trainee GPs translate into full-time working within the UK NHS. Alarming, given the 70 million-plus population of the United Kingdom, only 2,267 doctors joined the GP part of the Medical Register in 2020, only 63% of the trainees. We are now in 2023; let us hope at some point soon this trend is reversed.

Pain services, and the roles of the Multi-Disciplinary Team (MDT) members within these, are continually having to justify their existence and re-establish themselves. One particular concern of mine in this evolving landscape is the advance of the 'advanced practitioner' role or generalist alongside that of the specialist. Within Scotland, the pain service delivery framework implementation plan⁵ is very much still in the process of realisation but shows a high-level commitment to supporting chronic pain services. The ScotGov Phase 2 report⁶ affirms the need for people with a lived experience of chronic pain to be part of ongoing developments. However, the need to acknowledge the specialism of pain management for all

members of the pain MDT and the importance of a clear career pathway to attract new recruits and retain them is an ongoing concern across the four nations of the United Kingdom.

Here is to a bright and better 2024 and

Merry Christmas !

Email for contact. m.dunham@napier.ac.uk

References

1. Shirvalkar P, Prosky J, Chin G, et al. First-in-human prediction of chronic pain state using intracranial neural biomarkers. *Nat Neurosci* 2023;26:1090–9.
2. Heijman MW, Fiolet AT, Mosterd A, et al. Association of low-dose colchicine with incidence of knee and hip replacements: Exploratory analyses from a randomized, controlled, double-blind trial. *Ann Intern Med* 2023;176:737–42.
3. Wang PY, Ma J, Kim YC, et al. WASF3 disrupts mitochondrial respiration and may mediate exercise intolerance in myalgic encephalomyelitis/chronic fatigue syndrome. *Proc Natl Acad Sci U S A* 2023;120:e2302738120.
4. Cannabis brain effects study struggles to attract black UK users. *The Guardian*, September. Available online at <https://www.theguardian.com/society/2023/sep/24/cannabis-brain-effects-study-struggles-attract-black-uk-users>
5. Pain management – Service delivery framework: Implementation plan. Available online at <https://www.gov.scot/>
6. Available online at <https://www.gov.scot/publications/scottish-government-pain-management-panel-report-phase-2-engagement-panel/>

President's message

Roger Knaggs



Welcome to the final issue of *Pain News* for 2023. My first few months as the President of the British Pain Society have been productive, and time has flown by very swiftly. It is always interesting to hear about your successes, and I hope that we can celebrate more of them through the new monthly e-newsletter over the coming months.

Provision of education activities has always been highly valued by members. It is so pleasing to see the return of our popular face-to-face study days over recent months. Both the Headache and Interventional Pain SIGs have held very successful events that have had positive reviews. These study days have provided opportunities to hear about latest developments on these topics from national and international experts. Very recently, there has been an interesting webinar on nutrition and pain. We have already planned a programme of webinars for the first few months of 2024, so I hope that you will find some that will be of interest to you. If you have ideas for future topics and potential speakers, do let us know.

First, some practical issues. The observant among you will have seen some substantial changes to the look of The British

Pain Society (BPS) website over the last few weeks. This is the first stage of a programme of activities to refresh and update the Society's communications. The changes should make easier to navigate content on smaller devices, such as phones and tablets which are used much more commonly to access the Internet since the website was last updated. We are now beginning to review the website content and will update information and add new content where appropriate.

Following conversations with some members, it is apparent that they have not been receiving our regular e-newsletter. These updates are usually sent during the third week of each month. Please check your junk and spam folders to ensure that they are not being diverted. However, it is also important that the BPS has the correct contact details for you. So please ensure that they are up to date. This can be done quickly on the 'account login' tab on the top of the home page of the website. Alternatively, please contact the Secretariat (info@britishpainsociety.org) with the best contact details to update them.

Pain is a universal experience, and we are all familiar with experiencing 'everyday' pain. Typically, it will resolve and not require any treatment, and we each know the sorts of strategies that may be helpful for ourselves. Most pain is managed either without requiring support from a health care professional or in primary care. Multidisciplinary specialist pain management services are only able to see a small proportion of the many people living with chronic pain. Specialist services typically see patients who require more intense support or more complex interventions than are available in non-specialist settings. Throughout the health service, we need to work collaboratively and ensure a more seamless transition between different care settings to ensure the best outcomes for our patients.

One of the biggest differences between consultations for pain in primary care and specialist services is that more time is available in the latter. People want someone to listen and acknowledge that their symptoms are real in the context of an empathic and therapeutic relationship. It is neither possible nor indeed appropriate use of resources for every person living with chronic pain in the UK to be seen by a specialist service.

Instead we must consider how we can use our specialist expert knowledge and skills to educate and empower the wider health and social care professional workforce, including our colleagues in other specialties and in primary care, so that they are better able to support people living with pain within a biopsychosocial framework. Furthermore, the ultimate aim for the vast majority of people living with pain is in behaviour change and the adoption of self-management strategies. As we all know, this is not an easy process, and people need to be supported as we encourage them to better manage their ongoing pain and related symptoms.

The last issue of *Pain News* contained a reflective and thought-provoking article on managing chronic pain in primary care written by Professor Tony Avery. In his article, Professor Avery identifies some of the challenges as a general practitioner and cites several examples of changes in service provision in an attempt to provide better patient care and which have led to a blurring of the historical divide between primary and secondary care pain services. It can only be a good thing in generously sharing with primary care services some of the more specialist pain management skills and techniques and so ultimately benefitting a larger group of patients. I am sure that there are many more examples of such novel transformative practices elsewhere. It would be good to share these novel

solutions more widely so that we can learn from each other. *Pain News* would be an ideal forum for us to hear about each other's good work. So, if you are willing to share your innovations, contact the editor, Dr Raj Munglani (rajeshmunglani@gmail.com), who would be happy to discuss your initiatives further with you.

The recent approval of the GMC credential for the pain medicine specialist, led by the Faculty of Pain Medicine, available to all medical specialties and general practitioners, will be a good start. However, there is much more to do. In collaboration with the Faculty of Pain Medicine, the BPS is exploring the most effective ways to support the empowerment of the entire health and social care workforce in all settings to improve pain management for all.

I trust you and your families can enjoy a break over the festive period and that the New Year is both prosperous and healthy for you all.

With best wishes,



(Email: roger.knaggs@nottingham.ac.uk)

Pain and music 2: composers

Julia Hollander

Take a look at the lives of the great Classical and Romantic composers, and they seem to have suffered more than their fair share of chronic ailments.

Frederic Chopin, for example: a fragile man, he was often bedridden with migraines, laryngitis and bronchitis. Modern doctors have conjectured that perhaps he had cystic fibrosis; for sure he had bouts of serious depression. Through less than four decades of life, he is thought to have consulted as many as 50 physicians, and self-medicated with everything from blood-letting to belladonna. I remember spending hours during my adolescence nailing his piano music, finding a profound emotional outlet in the beauty of his harmonies.



Frederick Chopin Daguerrotype. Circa 1849.

These days I love to watch my young piano students unlock Chopin's very distinctive sound world: discovering how it can transport them from deep introspection to reckless abandon, from anguish to tenderness. We talk about how Chopin's

suffering seems to have intensified his creativity, his sensitivities made more acute by his vulnerabilities. His is the voice of frail and suffering humanity.

Top of the list of composers famous for their pain must surely be Ludwig van Beethoven. His whole adult life, he suffered from debilitating stomach ailments along with encroaching deafness. It began in his twenties with a distressing buzzing that soon developed into a whine and then complete deafness (though still with the tinnitus shrieking inside his head). As Beethoven lamented, of all the senses for a composer to lose, what could be worse than his hearing? When he was 32, Beethoven wrote a long letter to his brothers, describing a torment so unbearable that he longed for death; the only reason he had not killed himself was his commitment to his art. This piece of writing became known as 'The Heiligenstadt Testament' and is now regarded by scholars as a turning point in his creative life: from that moment on, his compositions show a renewed energy.



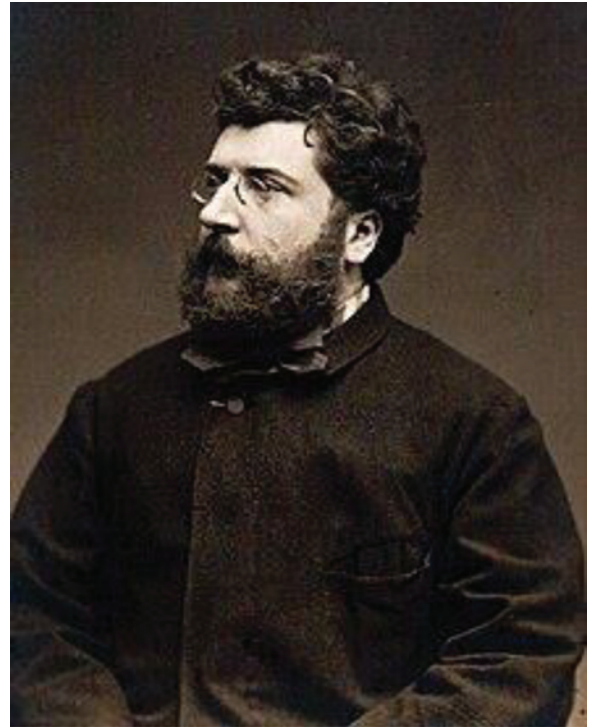
Ludwig van Beethoven 1820 portrait.

It was in this period that he wrote his most famous pieces: the *Eroica Symphony*, the *Moonlight Sonata* and his mesmerising last quartets. Having consciously chosen to bear his pain for the sake of his work, cut off from the rest of the world by his condition, his music became all the more defiant, all the more vivid.

Listening to music is a well-known balm for physical and mental agony: by expressing something of what we are going through, it can offer us solace or reassurance. On the other hand, music also has the power to distract us from our suffering, especially if it is light-hearted and joyful. This seems to have been the case for composer Georges Bizet. A heavy smoker, he suffered from what he termed ‘throat angina’ – abscesses on his windpipe, and recurrent swellings and lesions throughout his vocal system.

It seems a terrible irony that, commissioned at the age of 35 to write for some of the greatest voices of his time (at Paris’ *Opéra Comique*), his condition became all the more acute. To make matters worse, during this period his marriage was also failing. When his opera *Carmen* opened, the Parisian public didn’t think much of it and Bizet fell into a terrible depression. He died of a heart attack 3 months later, on his wedding anniversary.

These days, *Carmen* is one of the world’s best loved operas, full of colour and delight. The tunes of the *Habanera* and the *Song of the Toreador* have become part of popular culture, endlessly repeated in everything from advertising jingles to dance tracks. Who would guess what personal suffering lies



Georges Bizet 1875.

behind those melodies? What might Bizet have written had he not been in such a terrible state? Indeed, what if all three of these composers had had access to 21st-century medicine, to surgery or antibiotics or pain killers? Would their mighty music ever have come into existence?

‘How can we improve primary care management of MSK pain?’

Jonathan Hill *Professor of Physiotherapy, Director for Research for the School of Allied Health Professionals, School of Medicine, Keele University, UK*

56th Annual Scientific Meeting of the British Pain Society – opening plenary talk

In *The Primary Care Stocktake Report*, written by Claire Fuller on behalf of NHS England and NHS Improvement, the findings echo what we hear in the news about primary care teams being stretched beyond capacity, with staff morale at a record low. Any changes made in this setting in relation to MSK pain need to be aware of this context. However, the report also speaks positively about the opportunities the new Integrated Care Systems (in total, there are 42 of them across England) can play in providing a momentum to reshape the way in which health and social care is delivered. New ways in which primary care needs to change to deliver better integration for the above areas include reshaping the primary care workforce, using data and digital resources, investing in estates to create spaces/buildings that are fit for purpose and through ICSs ensuring that primary care is truly at the heart of our healthcare systems. The report suggests three key areas for integration, including (a) helping people to stay well for longer through a joined-up approach to prevention, (b) streamlining access to care and advice for those who use services infrequently and (c) providing more proactive personalised care with support from a multi-disciplinary team (MDT) for those with complex needs. It is important to look at these three key areas in relation to managing MSK pain in primary care.

Helping people to stay well for longer through a joined-up approach to prevention

How well do you know your local contextual, public health information about the specific population you serve? I urge you to look at online public health dashboards such as Public Health England’s ‘Fingertips’ dashboard. The Office for Health Improvement and Disparities’ 2022 report on long-term musculoskeletal health shows that the prevalence of long-term MSK pain is increasing and is particularly higher for women in our most deprived communities, among those who are overweight, and among those who are not achieving 30 minutes of moderate vigorous physical activity per week. My colleagues at Keele University have produced this map which shows estimated MSK health inequalities across the

Staffordshire region, including a fivefold difference in the prevalence of high-impact chronic pain, which can be as low as 5% of the population in some areas, and up as high as 30% to 35% in other neighbourhoods. We cannot expect two GP practices who are working among very different patient populations to have the same referral rates to secondary care services (such as a pain clinic), and we need to target our healthcare interventions much more specifically, to better support communities with MSK inequalities using maps with this information.

Streamlining access to care and advice for those who use services infrequently

Ivan Linn et al. (2020) have produced a systematic review which identifies 11 consistent recommendations for good primary care management across MSK pain conditions. These focus on (a) effective communication using shared decision-making tools, (b) screening patients for red flags, (c) assessing psychosocial factors and addressing them early, (d) discouraging inappropriate imaging, (e) high-quality physical examination, (f) monitoring progress with outcomes, (g) providing good quality information, (h) supporting physical activity/exercise, (i) only providing manual therapy as an adjunct to exercise and advice, (j) only using surgery after conservative care has failed, and (k) facilitating work continuation or resumption.

Keele University has a programme of research funded by the Nuffield Foundation called MIDAS, which is using integrated data to measure MSK care quality across 30 GP practices for all 11 of these MSK care quality indicators. Some of the data are collected via patient surveys, with further data on the treatments patients are given being collected through bespoke medical record searches. In addition, it is important to note that we consider any variation seen between GP practices alongside contextual data about the local population each practice serves. We are pleased that the learning from the MIDAS research programme is being extended into 40 other regions through a national MSK audit in primary care funded by the British Rheumatology Society, led by a team at Keele. While the MIDAS data are not yet analysed, there are national data from the GP Patient Survey which clearly shows that the

‘How can we improve primary care management of MSK pain?’

experience of people with MSK pain is substantially behind those with diabetic conditions, particularly in relation to (a) having a care plan and (b) having conversations which discuss what is important to the patient. It is worth considering what is working well in the area of diabetes and emulating their approach for those with MSK pain. Two examples of this are the role of diabetic health reviews performed during GP annual health checks, and having practice nurse-led diabetic review clinics. In order to better support long-term MSK conditions, particularly in communities with MSK inequalities, we should seek to investigate whether MSK clinics that operate similar to GP practice diabetic review clinics are effective.

It is vital to ensure that high-value care options are readily available to GP practices and that consistent MSK pathways are developed across integrated care systems to reduce care variation. As part of the MIDAS research project, data from a recent survey of 23 GP practices suggest that GPs locally have low access to four high-value primary care treatment options, including escape pain, MDT pain management, vocational support, and yoga for back pain. Similar data show that GP practices are currently not using digital pathway tools for MSK pain patients. Even the digital provision of self-management information was only available to 50% of GP practices surveyed at the time (2022). It is important to note that innovative new digital tools such as ‘OrthoPathway’ are being developed and tested, and these are digitising the MSK primary care pathway. The advantages of digital pathways are that evidence-based guidelines can be implemented at scale, with clinicians better supported to provide high-value treatment options and self-management advice.

Providing more proactive, personalised care with support from an MDT for those with complex needs

The third area is to identify processes to better differentiate people consulting with complex MSK needs from those who

use services infrequently in primary care. An example of this is the use of risk stratification tools (e.g. STarTBack) together with assessments of social and lifestyle factors like obesity, low physical activity and deprivation. The recent RESTORE trial by Peter Kent, published in *The Lancet* (2023), provides strong, high-quality evidence that upskilling physiotherapists with appropriate psychosocial skills can have life-changing benefits for people with severe chronic low back pain, as well as being incredibly cost-effective. The treatment was delivered over seven sessions, with a booster session after 6 months to signal to patients that they are not alone and to review their MSK management plan. In the trial physiotherapists were upskilled to deliver holistic treatment using three key components: (a) helping patients make sense of their pain through a biopsychosocial perspective, (b) graded exposure to feared movements to re-build confidence and (c) attention to areas of lifestyle change including adopting healthy sleep and dietary habits, stress management and social engagement, where relevant.

This evidence confirms that it is possible to upscale the primary care workforce to better manage long-term complex MSK conditions by prioritising communication, rapport, continuity of care, booster sessions to review management plans and through approaches that address psychosocial and lifestyle factors. The major challenge, however, is to find ways to provide the training and upskilling needed. It is crucial that chronic pain experts integrate and collaborate with primary care teams to provide this training to colleagues.

In conclusion, Claire Fuller’s *Primary Care Stocktake Report* is incredibly valuable in providing a useful blueprint for the ways in which we can improve primary care management of MSK pain. The answer for all three areas is integration, integration, and integration!

Email for contact j.hill@keele.ac.uk

Implementation of a new musculoskeletal multidisciplinary pathway and reduction in pain intervention waiting lists

J Smith *Epsom and St Helier University Hospitals NHS Trust*

J Jack *Epsom and St Helier University Hospitals NHS Trust*

S Bustamante *Epsom and St Helier University Hospitals NHS Trust*

Low back pain (LBP) is the largest cause of disability worldwide and is projected to impact over 800 million people by 2050.¹ The majority is non-specific (NSLBP) and associated with high healthcare expenditure (£12.3 billion in 2009) and poor quality of life.^{1,2} This presents a challenge to musculoskeletal (MSK) and pain management services, leading to long waits for consultations, investigations and interventions. In June 2023, there were a record 7.57 million patients awaiting elective treatment in England.³ Ensuring patients are referred quickly for appropriate management is vital to minimise pain and disability.

NICE Clinical Guideline 59 de-escalated medical management of LBP, discouraging routine imaging, prioritising exercise and psychological therapies and reserving invasive interventions for non-responders.⁴ As diagnosis of NSLBP is clinical, pain resistant to conservative measures may result in referrals to a variety of specialties before definitive treatment, prolonging patients' suffering.

In recent years, our trust experienced a significant increase in poor quality referrals for non-emergency back pain.⁵ This led to a high discharge rate from first pain clinic appointments, low conversion to interventions and 55% of patients undergoing spinal radiofrequency denervation (RFD) reporting unsatisfactory pain relief.⁶ In response, a virtual spinal pain MSK multi-disciplinary team (MDT) was established, involving Consultant Orthopaedic Surgeons, Consultant Pain Physicians and Advanced Physiotherapy Practitioners (APP) to allow appropriate assessment and triage of cases. However, the MDT was frequently bypassed by consultant-to-consultant referrals, so in July 2022 a new referral pathway was introduced (Figure 1).

Patients enter via a single point of access, assessed by a first-contact practitioner or APP, who decides on further investigations, conservative management or virtual MDT assessment. Cases are discussed and directly triaged to the most appropriate management. Following pain interventions, patients are followed up by their APP, empowering these practitioners to have greater agency in patient management. General Practitioners or non-orthopaedic consultants could still directly refer to pain clinic for non-MSK related pain.

Following implementation, a retrospective audit was undertaken to determine the effect on referral-to-treatment (RTT) times and the wider impact upon the pain management department.

Method

Clinically relevant standards were discussed within the department and listed below. Periods investigated were June to August 2021 (prior to pathway introduction) and November 2022 to January 2023 (following implementation). Data were obtained from numerous sources including previous departmental audits, trust surgical performance dashboards, clinic/theatre lists, patient surveys and South-West London Pain and MSK network data.⁵

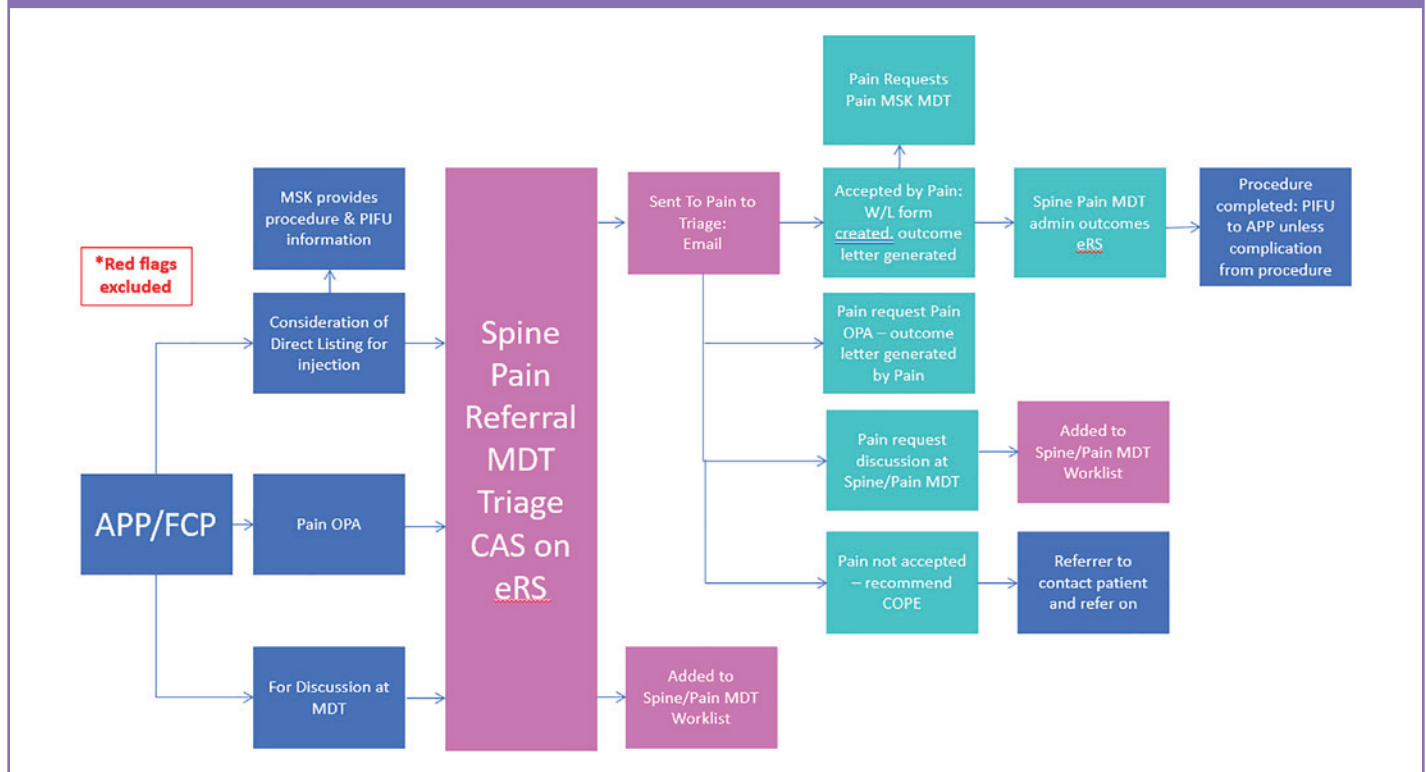
Results

See Table 1.

Discussion

Introduction of the pathway dramatically improved waiting times within the pain department for both average RTT wait

Figure 1. Musculoskeletal MDT pathway.



(decreased 58.6%) and the percentage of patients achieving the 18 week RTT target (Figure 2). Factors underlying the initial large waiting list size have been discussed above, but of interest is the initial increase in the number of patients for clinic appointments in 2021 (Figure 3). This could reflect late presentation of patients who may otherwise have presented while national COVID-19 measures were in place. Alternatively, physical inactivity during this same period may have resulted in an increase in de novo patients due to deterioration of chronic conditions.

Post-pathway introduction, the significant reduction (94.5%) in clinic wait list size (Figure 3) and intervention wait list size (55%) may be due to more efficient triage (as per the average RTT wait decrease). Patients who previously may have seen multiple specialties now have a rapid treatment decision processed via the MDT.

Despite the reduced waiting list size, total referrals increased by 17.8%. Total procedures conversely decreased by 29.5%. However, peripheral nerve injections, which includes medial branch blocks (MBB), increased by 60%, epidural injections increased by 8% and radiofrequency denervation to facet joint

(RFD FJ) decreased by 17%. The discrepancy between increased referrals and fewer procedures may be for several reasons. First, a backlog of cases created during COVID restrictions was cleared due to improved triage efficiency, facilitating faster patient transit through the service.

Second, the new pathway introduced patient-initiated follow-up (PIFU), whereby patients would return for radiofrequency procedures following successful diagnostic blocks when their pain returned. If more appropriate patients are initially selected for procedures via the MDT, this results in greater benefit and prolonged pain relief from diagnostic procedures. Although direct outcomes were not investigated, this is possibly reflected in increased patient feedback and positive satisfaction scores for the department. This may also explain the decrease in RFD FJ compared to MBB, as there is a longer interval between the procedures that was beyond the timeframe of the second data collection period (4–7 months after pathway introduction). As a result, these patients may not yet have initiated APP follow-up, or if via pain clinic, physicians adopt a less-invasive approach and delay RFD if patients are still comfortable. Therefore, there may be a delay in intervention numbers increasing. Other explanations are multifactorial and

Implementation of a new musculoskeletal multidisciplinary pathway and reduction in pain intervention waiting lists

Table 1. Standards and results.

No.	Standard	Target (if applicable)	Pre-pathway result		Post pathway result	
			Median	Range	Median	Range
1	Percentage of patients achieving national target RTT time of <18 weeks (%)	92%	58.9	(52.7–75.0)	91.7	(86.5–94.2)
2	Mean patient RTT time (weeks)	18 wks	20.3	(16.6–22.2)	8.4	(7.1–9.0)
3	Clinic (non-admitted) waiting list size (no. of patients)	n/a	383.5	(349–502)	21	(18–28)
4	Intervention (admitted) waiting list size (no. of patients)	n/a	379.0	(296–509)	168.5	(149–187)
5	Comparison of total referrals and source (no. of referrals)	Referral source				
		General medical practitioner	64		35	
		eRS referral	216		334	
		Referral management centre (GP)	12		18	
		Referred from other clinician (internal)	74		54	
		Referred from other clinician (external)	26		35	
		Referred from primary care (other)	23		31	
		Referred from A&E	1		1	
		Not specified	10		1	
		Other	6		0	
		Total	432		509	
6	Comparison of total procedures and procedure type (no. of procedures)	Procedure type				
		Radiofrequency denervation to facet joint (RFD-FJ)	147		56	
		Pulsed radiofrequency (PRF) to peripheral nerve (PN)	15		11	
		PRF to spinal nerve root (NR)	1		0	
		Injection to PN	205		202	
		Injection to FJ	5		0	
		Injection to Spinal NR	18		2	
		Epidural (all)	34		26	
		Intramuscular injection of local anaesthetic	15		17	
		Injection into joint	18		2	
		Injection of sympathetic nerve	1		6	
		IV infusion	9		9	
		Other	7		4	
		Total	475		335	
7	Comparison of total patient satisfaction survey scores (no. of responses)	Rating				
		Very good	26		39	
		Good	5		5	
		Neither good nor poor	0		0	
		Poor	0		2	
		Very Poor	2		0	
		Don't know	0		0	
		Total	33		46	

Data for standards 1–4 reported on weekly basis, result presented as median of each investigation period. Standards 5–7 are totals for each period.

Figure 2. Percentage of patients achieving 18-week RTT target. Comparison of pre- and post-pathway introduction.

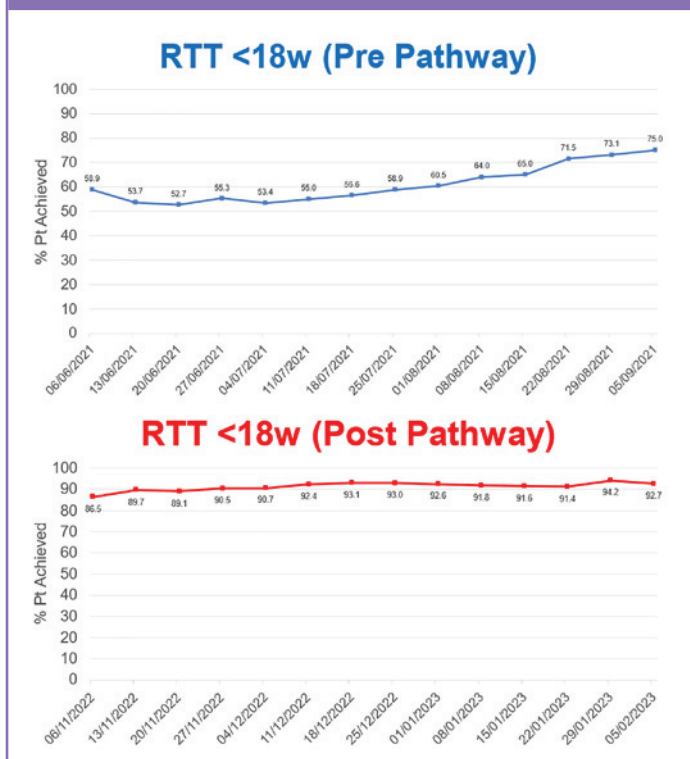
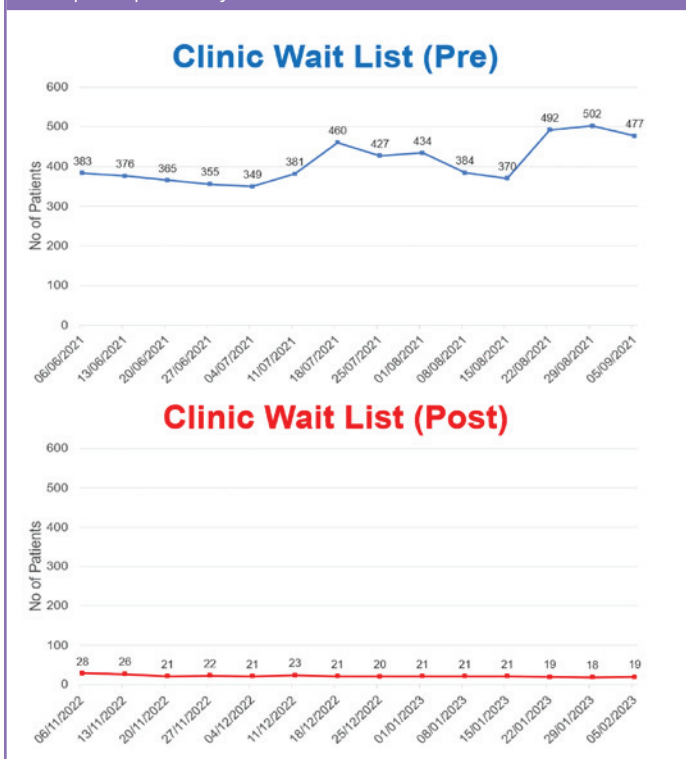


Figure 3. Waiting list size for Pain Clinic. No. of patients awaiting outpatient appointment. Comparison of pre- and post-pathway introduction.



beyond the scope of this audit, including waiting time to see community APP, or ineffective MBB not suitable for RFD.

Direct GP referrals decreased proportionally compared to those via the electronic referral system (ERS), which increased (reflecting greater use). The pathway was not fully implemented across all services until April 2023 so this trend may have continued if re-audited.

Additional effects upon the pain service were identified during data analysis related to staffing structure and requirements. Nursing requirements for clinics were reduced (absorbed somewhat by consultant activity), and there were increased referrals to the department's Pain Management Programme (PMP), so nurse activity was redirected to this area. Acupuncture referrals from pain clinic also increased; despite the single acupuncture practitioner in the department increasing their number of sessions to accommodate this, waiting times have increased. Long-term nursing staff vacancies have also reduced the inpatient acute pain service capacity.

Limitations

Due to the wide range of data sources and this being the first collection of such a data set, it is possible some sources may have been missed. This has been mitigated by keeping the sources across both investigated periods consistent. Data parameters did not allow for determination of wait list/RTT time for specific clinics/interventions, and coding terminology meant multiple procedures were covered by one term. Increased referrals via ERS made determination of the source more difficult. The post-pathway period covered the festive season, so there may have been reduced activity in this period.

Recommendations and further study

Recommendations included use of an existing ERS feature to differentiate non-MSK from MSK pain clinic referrals for faster processing. The Pain Service management reviewed staffing distribution which would reduce nursing staff demand and expenditure in already difficult-to-fill positions.

Regular re-auditing, including outside of December/January, would reduce variance from seasonal changes in clinic or

Implementation of a new musculoskeletal multidisciplinary pathway and reduction in pain intervention waiting lists

intervention activity and determine long-term trends in wait times due to the pathway. The decreased number of RFDs and intervention activity overall could also be confirmed. Including post-procedural outcomes such as patient-reported change in pain scores, physical function or analgesic use would determine if the pathway facilitated improved patient selection or greater efficacy for interventions. Recording triage/clinic outcome would quantify the number and proportion of referrals that are redirected to PMPs.

Practice points

- Real-time multidisciplinary discussions around cases facilitate rapid and effective management decisions, following the principles of Getting It Right First Time.
- Empowering physiotherapists to have greater ownership of patients in the community can help to improve appropriate access to secondary care by ensuring the foundations of NSLBP management are undertaken before more invasive measures are considered.
- With appropriate safety-netting and guidance, PIFU may improve a patient's sense of autonomy, control and satisfaction with their treatment, while reducing pain clinic

workload for follow-up. This can ultimately increase the volume of patients moving through a Pain Management department's RTT pathway.

References

1. GBD 2021 Low Back Pain Collaborators. Global, regional, and national burden of low back pain, 1990–2020, its attributable risk factors, and projections to 2050: a systematic analysis of the Global Burden of Disease Study 2021. *Lancet Rheumatology* 2023; 5(6): 316–29.
2. Donaldson L. 150 years of the annual report of the chief medical officer: on the state of the public health 2008. Department of Health. Available online at: https://webarchive.nationalarchives.gov.uk/ukgwa/20130105021744/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206 (accessed 6 Sept 2023).
3. NHS England. *Referral to treatment (RTT) waiting times data 2023–2024*. London: NHS England & NHS Improvement. Available online at: <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/> (2023, accessed 25 August 2023).
4. National Institute for Health and Care Excellence. *Low back pain and sciatica in over 16s: Assessment and management* (Clinical guideline [CG59]). London: NICE. Available online at: <https://www.nice.org.uk/guidance/ng59> (2016, accessed 1 July 2023).
5. Shah S, Dawes T and Bustamante S. A review of the appropriateness of referrals for chronic pain services at Epsom & St Helier NHS Trust [Abstract]. In: *British Pain Society annual scientific meeting 2023*, vol. 17, 8–11 May 2023.
6. Sud N. Audit on 12 to 15 months outcomes after RFD procedures. Unpublished audit presented to Pain Management Department, Epsom & St Helier NHS Trust. Available from Pain Management Department, Epsom & St Helier NHS Trust via sara.bustamante@nhs.net (2022, accessed 25 August 2023).

Prescribing of modified-release opioids at hospital discharge

Michael Wilcock *Royal Cornwall Hospitals NHS Trust, Truro, UK*
Mike.wilcock@nhs.net

Neil Roberts *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Sarah Medlicott *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Kerry Elliott *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Bernie Booker *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Kayley McGuffie *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Liam Bastian *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Ann Cardell *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Josh Holloman *Medical School, University of Exeter, Exeter, UK*

Joseph Oates *University of Exeter Medical School, Exeter, UK*

Keith Mitchell *Royal Cornwall Hospitals NHS Trust, Truro, UK*

Introduction

The problems associated with the opioid crisis have been well described.^{1–3} Opioids are effective and appropriate for acute nociceptive pain yet can cause harm if used or continued inappropriately.⁴ The United States of America has seen a significant rise of prescribed opioids for acute pain, with the prescription of opioid analgesia exceeding the patients' need for this, thus contributing to their opioid epidemic.⁵ In the United Kingdom, data from 1998 to 2016 looking at primary care prescribing reported a 34% increase in opioid prescriptions, and 127% increase in total oral morphine equivalence although there was wide variation between regions and practices.⁶ However, more recent data show the number of opioid items prescribed has decreased every year since 2016/17.⁷ International guidance in particular advises that modified release (MR) opioids should only be used to treat severe and persistent pain in exceptional circumstances^{8,9} Compounding this problem of apparent opioid use, patients are still prescribed MR opioids in acute hospitals with minimal communication to ongoing care providers such as general practitioners (GPs).^{4,10}

In support of national and international guidance^{8,9,11} and recent recommendations in a regional clinical report¹² we sought to understand the number, characteristics of, and the reasons for, patients being discharged from an acute hospital (750 beds) in the south west of England on new or escalated MR opioids or opioid patches.

Method

Patient data were identified from the hospital electronic prescribing system (Careflow Medicines Management), electronic notes and patients' GP summary care records. The electronic prescribing system was used to identify all patients discharged on MR/patch opioids during September 2022 and any relevant notes attached to them. Patients receiving these drugs for cancer pain or breathlessness were excluded. Electronic notes were reviewed for demographics, discharging team, opioid type/dose, risk factors for opioid misuse,¹³ any documented weaning plan in the discharge summary for primary care, or any in-patient pain team advice. The summary care record for these patients was reviewed for any continued opioid prescribing 3 months later.

Results

There were 83 patients discharged on MR/patch opioids during September 2022, and we excluded 32 who were receiving the opioid for cancer pain (25) or breathlessness (7), leaving 51 patients (median age 73 (33–92), 47% male) for further analysis. Eighteen (age 39–92, 50% male) of these 51 patients had the opioid newly commenced while in hospital. These 51 patients were under 14 different specialities though trauma and orthopaedics, geriatrics, and acute medicine accounted for 49% of the patients.

Prescribing of modified-release opioids at hospital discharge

Opioids at discharge were buprenorphine patch (19, 37%), MR morphine (14, 27%), MR oxycodone (13, 24 %), fentanyl patch (3, 6%), and MR tramadol (2, 4%). Opioids that had been started in hospital and continued at discharge were buprenorphine (8), MR oxycodone (8), and MR morphine (2). In-patient pain team advice was provided to 8 (16%) of all 51 patients, five of whom also received opioid weaning advice in the discharge summary. A further six patients received opioid weaning advice at discharge only.

In relation to risk factors for opioid misuse disorder for the 51 patients, a history of depression was documented in five instances, a history of alcohol abuse in four, and one each of a history of illicit drug use and a history of prescription drug use. No patient had more than one risk factor recorded. For all patients, central sensitisation syndromes, for example, fibromyalgia was recorded for 16 (31%) and pre-existing antineuropathic usage in 7 (14%).

Follow-up of all 51 patients at 3 months revealed that 25 (49%) were on an equivalent dose to that at discharge, 15 (29%) had stopped the opioid, 6 (12%) were on a decreased dose, and 5 (10%) had increased the dose. Interestingly, and though the numbers are small, patients who received pain team input and/or a discharge weaning plan were more likely to have decreased or stopped opioids at 3 months.

Discussion

Our trust discharge four to five patients per week on new MR/patch opioid for non-cancer pain. It is not routinely documented if patients have a diagnosis of chronic pain among patients who are on long-term opioids. We note about a third of our small sample of patients on long-term opioids have central sensitisation syndrome diagnoses. In relation to postoperative management, recent national best practice guidelines and international guidance advise against the use of MR opioids due to well-documented adverse effects.^{8,9,14,15} Yet MR opioids are still being prescribed postoperatively and also for other acute pain or acute on chronic pain syndromes in acute hospitals. This was supported in our small study where the prescribing of MR opioids/patches was scattered across multiple specialists with trauma and orthopaedics, geriatrics, and acute medicine accounting for almost half of the total.

Although there is international evidence-based guidance^{8,9} regarding the use of MR opioids for acute pain, national safety advice in the United Kingdom has not specifically mentioned MR opioids.¹⁶ We are still limited to best practice statements from professional bodies such as the Faculty of Pain Medicine.¹⁵ The NICE guideline on prescribing and managing withdrawal from dependence-forming medications in primary and secondary care does not cover opioids prescribed for acute pain.¹¹

One of the ways to reduce this risk in the United Kingdom, locally, regionally, and nationally is education.¹⁷ Despite pain being a major component of hospital admissions, it accounts for only a small amount of medical training. Education of relevant staff (and patients) can contribute to appropriate, effective and safe opioid prescribing, including the implications of commencing such medications, deprescribing practices, patient expectations, and ensuing all opioid prescription have ongoing management advice. However, education provision is not without challenges or resource demands, as medical prescribers are only one layer of hospital prescribers: we have previously introduced dedicated F1 and F2 teaching and a grand round presentation for consultants; we are also planning physician associate education and non-medical prescribing sessions, and we need a strategy to educate nursing staff who lead the discharges.

Opioid stewardship is not a new idea, but uptake remains patchy nationally and internationally.^{18,19} Stewardship activities need to operate at multiple levels from the individual prescriber, the organisation and nationally. For acute hospitals, obvious steps include monitoring and feedback to individual prescribers to improve opioid prescribing practice, standardising the quantity of discharge opioids, and improved communication with the GP. The use of 'Managing pain after your surgery' information leaflet has a very useful pain management plan to guide the ongoing use and discontinuation of analgesics including opioids following discharge,²⁰ yet the number of information leaflets given to surgical patients can lead to information overload and the information being lost in the wealth of literature. Collaboration with hospital pharmacy staff is required to identify a way for this information to be provided with the discharge prescription, and education of nurses regarding information given at discharge is required.

Complete, timely, and accurate discharge communication is essential. Yet discharge communication between acute hospitals and GPs remains poor despite the introduction of electronic discharge summaries.²¹ Such poor quality of communication between hospital, and GP has been identified as leading to medication-related harm.²² Our small study adds to the growing evidence that effective communication and documented weaning plans decrease the risk of inappropriate ongoing MR opioid use and persistent post-discharge opioid use. The documentation within our small study was added as a note on the electronic prescribing system to be incorporated into the discharge summary, which appeared to be successful. Further developments are required to improve the standard of communication on discharge. Utilising hospital electronic prescribing systems, not only as a way for specialist teams to record changes to MR opioid prescriptions since admission, but also to initiate a proforma to be completed for opioid weaning advice for primary care, would be helpful.

We acknowledge that our study is a small subset of patients prescribed opioids during hospitalisation from just one hospital, and hence we do not know to what extent it reflects overall current practice in the United Kingdom. As this was retrospective data collection, the prevalence of recorded risk factors is unlikely to be totally accurate, and we would expect the real prevalence to be much higher because some of the questions are not standard medical clerking questions. There is also uncertainty as to the critical risk factors for opioid-related misuse.^{23,24} We recognise the limitation of using prescribing data extracted from an electronic prescribing platform and summary care records as a proxy for actual drug consumption.

Conclusion

If our findings are reflective of hospital practice elsewhere, then organisational engagement²⁵ is imperative to achieve a successful change of practice. Locally we are beginning with the provision of a discharge leaflet informing patients that they should be trying to wean off these opioids after an appropriate amount of time; Grand Round presentation of audit results and other opioid information (for education and discussion among medical staff); development of protocols/guidelines to support pharmacists and prescribers for complex pain patients e.g. flare of acute-on-chronic pain, and mandatory referral or discussion with the Acute Pain Team for higher risk patients. Our plan is to reaudit again in the near future to identify if our changes have had an impact which will support future more widespread behaviour change.

A key message for prescribing medical teams should be that MR opioids for acute pain should only be prescribed in exceptional circumstances, under the explicit guidance of the acute pain team and with a clear weaning plan in the discharge summary. Patients should instead go home with a limited doses of immediate release opioids and a plan for review of this prescription if further medication is needed. Crucially, there needs to be drive at national level to bring the United Kingdom into line with international drug safety bodies in the United States and Australia, and we would therefore call on the MHRA to re-appraise the evidence for use of MR opioids in acute pain and consider drafting such guidance to improve practice.

References

1. Roberts AO and Richards GC. Is England facing an opioid epidemic? *British Journal of Pain* 2023; 17(3): 320–4.
2. Bailey J, Nafees S, Jones L, et al. Rationalisation of long-term high-dose opioids for chronic pain: Development of an intervention and conceptual framework. *British Journal of Pain* 2021; 15(3): 326–34.
3. Higgins C, Smith BH and Matthews K. Incidence of iatrogenic opioid dependence or abuse in patients with pain who were exposed to opioid analgesic therapy: A systematic review and meta-analysis. *British Journal of Anaesthesia* 2018; 120: 1335–44.
4. Kent ML, Hurley RW, Oderda GM, et al. American Society for Enhanced Recovery and Perioperative Quality Initiative-4 joint consensus statement on persistent postoperative opioid use: Definition, incidence, risk factors, and health care system initiatives. *Anesthesia and Analgesia* 2019; 129(2): 543–52.
5. Chua KP, Kimmel L and Brummett CM. Disappointing early results from opioid prescribing limits for acute pain. *JAMA Surgery* 2020; 1155(5): 375–6.
6. Curtis HJ, Croker R, Walker AJ, et al. Opioid prescribing trends and geographical variation in England, 1998–2018: A retrospective database study. *The Lancet Psychiatry* 2019; 6(2): 140–50.
7. NHS Business Services Authority. Dependency forming medicines England 2015/16 to 2022/23.2023. Available online at: https://nhsbsa-opendata.s3.eu-west-2.amazonaws.com/dfm/dfm_summary_narrative_2022_23_v001.html#4_About_these_statistics
8. US Food and Drug Administration. FDA drug safety communication 04-13/2023 FDA updates prescribing information for all opioid pain medicines to provide additional guidance for safe use. Available online at: <https://www.fda.gov/media/167058/download?attachment>
9. Therapeutic Goods Administration Australia. Prescription opioids: What changes are being made and why. 2021. Available online at: <https://www.tga.gov.au/products/medicines/prescription-medicines/prescription-opioids-hub/prescription-opioids-what-changes-are-being-made-and-why#fn2>
10. Allen ML, Silva AP, Braat S, et al. Post-surgical discharge opioid prescribing, use and handling after introduction of a stewardship program. *Anaesthesia and Intensive Care* 2023; 51(4): 239–53.
11. National Institute for Health and Care Excellence. Medicines associated with dependence or withdrawal symptoms: Safe prescribing and withdrawal management for adults. NICE guideline NG215. 2022. Available online at: <https://www.nice.org.uk/guidance/ng215>
12. South West Clinical Senate. Recommendations from the South-West Clinical Senate Council on how to support people in the region to live well with pain whilst reducing and preventing harm from opioids. 2023. Available online at: https://www.swsenate.nhs.uk/wp-content/uploads/2023/05/20230209_-_Senate-Council-Recommendations_REPORT_Pain-mgmt_opioid-prescribing-V1.3.pdf
13. Webster L. Opioid risk tool (ORT) for narcotic abuse. Available online at: <https://www.mdcalc.com/calc/1757/opioid-risk-tool-ort-narcotic-abuse#evidence>
14. Quinlan J, Levy N, Lobo DN, et al. No place for routine use of modified-release opioids in postoperative pain management. *British Journal of Anaesthesia* 2022; 129(3): 290–3.
15. Faculty of Pain Medicine. Surgery and opioids: best practice guidelines. 2021. Available online at: https://fpm.ac.uk/sites/fpm/files/documents/2021-03/surgery-and-opioids-2021_4.pdf
16. Drug Safety Update. Opioid medicines and the risk of addiction. Medicines and Healthcare Products Regulatory Agency. 2020. Available online at: <https://www.gov.uk/guidance/opioid-medicines-and-the-risk-of-addiction>
17. Gliszczynski K, Hindmarsh A, Ellis S, et al. Online education for safer opioid prescribing in hospitals-lessons learnt from the Opioid Use Change (OUCH) project. *Postgraduate Medical Journal* 2023; 99(1167): 32–6.
18. Levy N, Lord LJ and Lobo DN. UK recommendations on opioid stewardship. *BMJ* 2021; 372: m4901.
19. Ardeljan LD, Waldfogel JM, Bicket MC, et al. Current state of opioid stewardship. *American Journal of Health-System Pharmacy* 2020; 77(8): 636–43.
20. British Pain Society. Managing pain after your surgery. 2022. Available online at: https://www.britishpainsociety.org/static/uploads/resources/files/pain_management_print-ready_atwork_2.pdf
21. Kattel S, Manning DM, Erwin PJ, et al. Information transfer at hospital discharge: A systematic review. *Journal of Patient Safety* 2020; 16(1): e25–33.
22. World Health Organization. Medication safety in transitions of care. 2022. Available online at: <https://www.who.int/publications/i/item/WHO-UHC-SDS-2019.9>
23. Weiner SG and Hoppe JA. Contextualising opioid-related risk factors before an initial opioid prescription. *BMJ Quality & Safety*. Epub 27 July 2023. DOI: 10.1136/bmjqs-2023-016336.
24. Nestvold HH, Skurtveit SS, Hamina A, et al. Socioeconomic risk factors for long-term opioid use: A national registry-linkage study. *European Journal of Pain*. Epub 27 July 2023. DOI: 10.1002/ejp.2163.
25. Simpson AK, Levy N and Mariano ER. Opioid stewardship. *BJA Education* 2023; 23: 389–97.

Opioids and surgery: a Massive Open Online Course (MOOC) – an innovative approach to education in perioperative opioid stewardship

Dr Fausto Morell-Ducos *Consultant in Anaesthesia & Pain Medicine, University College London Hospitals*

Dr Dermot McGuckin *ST7 Anaesthesia & Pain Medicine, University College London Hospitals*

Dr Jamie Smart *Consultant in Anaesthesia & Pain Medicine, University College London Hospitals*

Dr Brigitta Brandner *Consultant in Anaesthesia & Pain Medicine, University College London Hospitals*

There is increasing evidence that surgery is a risk factor for persistent postoperative opioid use¹ and that pre-operative opioid use is associated with an increased risk of perioperative complications.² However, opioids continue to play an important role in facilitating recovery and return to function after surgery.

Perioperative opioid stewardship is a practical approach providing a systematic framework aimed at minimising the risks associated with perioperative opioid use, while allowing their safer administration to those patients most likely to benefit. It is increasingly regarded as one of the approaches which will help to mitigate the problem of prescription opioid-related harm but there is a lack of structured curriculums to develop healthcare professionals' skills in competent opioid management.

To address this, the Department of Anaesthesia at University College London Hospital (UCLH), in collaboration with University College London (UCL) and FutureLearn, have developed *Opioids and Surgery*, a Massive Open Online Course (MOOC).

The MOOC concept has grown in availability and popularity since 2012. Delivered completely online, free to access and open to all, MOOCs allow education to be delivered flexibly and at scale.

Learning objectives:

- Explain the reasons for persistent postoperative opioid use and its contribution to the development of the international opioid epidemic.
- Engage in a discussion on global variation in perioperative opioid use with healthcare professionals from around the world.
- Justify the reasons for using different opioid and non-opioid analgesics for the management of acute pain in the perioperative setting.
- Summarise the basic pharmacology of opioids and the mechanisms associated with their therapeutic and harmful effects.
- Evaluate the component parts of opioid stewardship which are aimed at reducing persistent postoperative opioid use and its subsequent harms.
- Reflect upon the challenges of managing perioperative pain in patients with opioid tolerance and/or dependence.

Opioids and Surgery has been designed for a global, multidisciplinary audience. Over 3 weeks, participants will spend 3–4 hours per week learning about the advantages and disadvantages of perioperative opioid use, opioid pharmacology and opioid stewardship via a mixture of

peer-reviewed articles, video interviews with clinicians and experts, patient stories, interactive case discussions and quizzes.

Week 1: opioids in the perioperative setting

In this week, we set the scene by examining the causes and extent of the opioid crisis in North America and beyond, and the role-played by perioperative opioid use. We discuss the importance of managing perioperative pain, and how inadequate pain management can lead to poor patient outcomes. We then focus on the challenges of balancing the utility of opioids against the risks of prescribed opioid-related harm.

Week 2: opioid pharmacology

In week 2, we explore the specific pharmacokinetic and pharmacodynamic properties of different opioid drugs, and how these are responsible for both their desired analgesic actions and adverse drug-related patient outcomes. We examine the mechanisms of opioid tolerance, opioid use disorder and non-opioid responsive pain, as well as the concept of persistent postoperative opioid use.

Week 3: solutions and best practice

In the third and final week of the course, we focus on opioid stewardship. We discuss the practical approaches and interventions which can be taken to promote appropriate opioid prescribing and to minimise adverse drug events and persistent postoperative opioid use. We also explore the concepts and practical application of opioid-free and opioid-sparing anaesthesia and analgesia, as well as the way in which

different legal frameworks affect the clinical use of opioids around the world.

Developing the *Opioids and Surgery* MOOC has required a collaborative approach with an international, multidisciplinary faculty of educators, as well as input from patients and lived experience experts. The collaboration with UCL Digital Education has ensured high-quality pedagogy and quality assurance review throughout the course. We have also benefitted from the collective knowledge and experience achieved through UCLH's successful teaching portfolio, which includes the distance learning MSc programmes in Perioperative Medicine and Pain Management, as well as the successful UCL/FutureLearn Perioperative Medicine in Action, Airway Matters and Transfer Medicine MOOCs, commended for their high learner retention and completion rates, so far attracting over 50,000 healthcare professionals from over 120 countries.

The *Opioids and Surgery* MOOC will launch on Monday 29 January 2024. To find out more details about the course and to register your interest, please visit: <https://www.futurelearn.com/courses/opioids-and-surgery>.

Conflict of Interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

References

1. Srivastava D, Hill S, Carty S, et al. Surgery and opioids: Evidence-based expert consensus guidelines on the perioperative use of opioids in the United Kingdom. *British Journal of Anaesthesia* 2021; 126(6): 1208–16.
2. Quinlan J, Levy N, Lobo DN, et al. Preoperative opioid use: A modifiable risk factor for poor postoperative outcomes. *British Journal of Anaesthesia* 2021; 127(3): 327–31.

The problem with pain scales

Chris Bridgeford

Whenever I ended up in hospital or a clinical appointment (which happened far more than I would've liked), I was asked 'How would you rate your pain on a scale of 1-10?' When I began to seek help for my chronic pain in the late 1970s, I never saw a problem with the question. However, as time and my own knowledge has moved on, it is clear now that the question is really inconsequential for gauging how the never-ending pain affects me and my circle of loved ones. I'm certainly not unique in my dissatisfaction with the overly used 1 to 10 pain scale or, even worse, the 1 to 4 scale I came across in Accident and Emergency the other month.

Everyone is unique in how their pain affects them. Even people with the same condition or label for the pain do not experience the same pain levels. Some people tolerate more pain than others all the time, or dependent on how long they have lived with their pain, and so their pain score will be lower.

Although I am always in pain (and I do literally mean always – which in itself seems hard for the non-pained to comprehend), the pain levels can change immensely day by day and even hour to hour. This is caused by many things such as the weather, my mood and my stress level at the time. During an appointment, for example, I could be stressed and tired out by travelling to the appointment, especially if it is many miles away from home. This happens a lot if, like me, you live in a rural area. Travelling for about 3 hours is pretty common in my part of Scotland. At the time of the appointment, my pain could be a 5 on their scale, but when I get home, it could be an 8 for the next couple of days as I recover from the journey.

Many people will be guilty of being influenced by how desperate they are for help by increasing or lowering the score. Some patients can be worried that they will not be taken seriously if they are having a good day and their pain level is low at the time. The clinician's own perception of the scale can also influence things. They may think that 4 is very low and not worth bothering about. Dangerously, all this misinterpretation could lead to an inadequate amount of pain relief or even the wrong treatment being given.

During an appointment you normally get the chance to discuss your chronic pain issues after you've rated your pain level. However, when the pain scale is used on a questionnaire,

it becomes even more unhelpful. With no chance to discuss what you mean by picking a '3', it does not give you an opportunity to make it clear how the pain makes you feel, what sort of pain you are experiencing, or how it affects your ability to cope.

In the 1970s, McGill University in Canada developed the McGill Pain Questionnaire which is now used world-wide. It has questions about the type and quality of pain that a sufferer may be experiencing. The university also produced a pain scale which shows different conditions on a line that ranges from the least to most painful conditions. This scale starts at 0 (no pain) and ends with 50. It gives a relative idea of pain severity, such as a bone fracture to childbirth, cancer pain and many in between. Incidentally, this widely known Pain Scale was utterly dismissed by the main instructor at the Glasgow Residential Care Treatment Course some 3 or 4 years ago, run by the Scottish National Health Service, where Pain Clinics in Scotland can send their patients for 3 weeks. She said she had never heard of it and I vividly remember her stating the scale was dangerous by comparing different pain conditions with each other.

The Wong-Baker Faces Pain Rating Scale, which features a series of faces representing what different levels of pain 'should' look like, is a wee bit more helpful. Under each face is a number, ranging from 0 (*no pain*) to 10 (*the worst pain imaginable*). Patients are asked to look at the faces and circle the number which best represents how their pain makes them feel.

Despite living with chronic pain since 1978, I do not really have a definite diagnosis – which is not that unusual for someone my age. It started off as ankylosing spondylitis (and is proven by x-rays), then labelled as 'neuropathic pain', 'complex neuropathic pain syndrome', 'complex regional pain syndrome' following serious surgery in 1995, with 'fibromyalgia' now appearing to cover my symptoms. Whatever label you give it – it is devastating and has seriously affected two-thirds of my life.

After 1995, with CRPS being described by 'the worst pain imaginable' on the McGill Pain Scale, I was not shy about giving my pain score a high 8–10. Then, a few years ago, 'the worst pain imaginable' for me was changed when I needed to

be put into a coma to cope with a serotonin syndrome-induced headache which had left me incoherent on the floor at home for my wife to find.

What I've learned over four decades of pain is that it truly is subjective. Your pain is unique to you. No pain scale can reveal that without some sort of description of how it affects your ability to get through the day.

Not that I'm likely to be attending a pain review anytime soon, but in future, I will bring along my own pain scale to try to get over what a day in chronic pain is like. Something like the following:

10	Unable to Move	I am in bed or trapped in a room due to my pain. I need to be taken to hospital to get help.
9	Severe	I can barely talk, move or think of anything because of the pain.
8	Intense	Talking and listening are difficult. My pain is so bad it's hard to think of anything else.
7	Unmanageable	I am in great pain all the time. It keeps me from doing most things.
6	Distressing	I think about my pain all of the time. I've given up many activities because of my pain.

5	Distracting	I cannot do some of what I need to do each day because of the pain. I think about my pain most of the time.
4	Moderate	I am constantly aware of my pain but I can continue most activities.
3	Uncomfortable	My pain bothers me but I can ignore it most of the time.
2	Mild	I have a low level of pain. I am aware of my pain only when I pay attention to it.
1	Minimal	My pain is hardly noticeable.
0	No Pain	I have no pain.

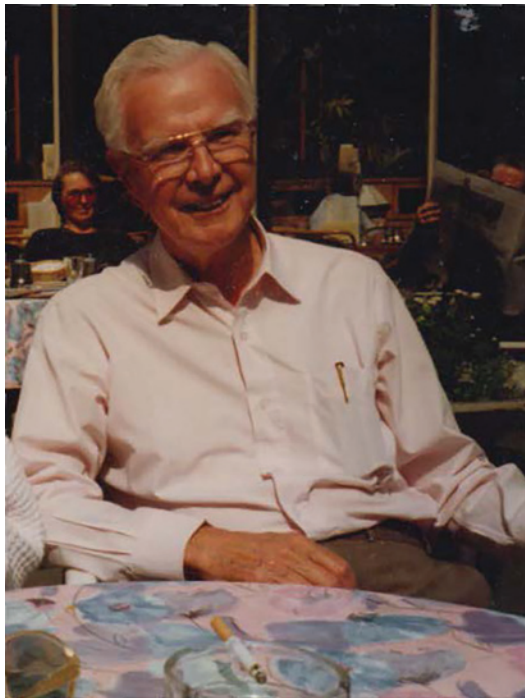


Chris Bridgeford is Chairman of the Scottish Charity – Affa Sair – Scots for 'awfully sore'. They currently have over 680 members, an information-filled website at www.affasair.org and a well-used private Facebook group where most member interactions take place.

Affa Sair is one of the charities on the Scottish Government's new Pain Management Framework. The charity has taken part in many consultations, surveys and webinars from universities and health organisations in both Scotland and England.

Colonel James McEwan OSJ MB CHB FFARCS L/RAMC (1927–2012)

Dr Charles A Gauci *Lt. Colonel RAMC (Retd)*



One of the great unsung British heroes in the field of chronic pain management is my ex-Army boss and mentor, the late Colonel James ('Jimmy') McEwan. He took me under his wing shortly after I was appointed Consultant Anaesthetist in the Royal Army Medical Corps in 1979 and encouraged me to become actively involved in the specialty of chronic pain therapy as it used to be called in those far-off days!

Jimmy, based at the then Queen Elizabeth Military Hospital in Woolwich, S.E. London, founded the first chronic pain relief clinic for the Armed Forces in the mid-seventies and was also involved in teaching John Wedley, Consultant Anaesthetist who then ran the Pain Clinic at Guy's Hospital.

He was close friends and often co-operated with John Lloyd, Sam Lipton, and Mark Mehta who all occupy a special place in the pantheon of our early British chronic pain heroes.

It was Jimmy who insisted that I join the Intractable Pain Society, which I did in 1980. I remember those early IPS meetings very fondly, especially the joint meetings held with the Dutch Pain Society, which Jimmy and I used to attend on a regular basis. It was then that we both formed a lasting friendship with the late Dr. Menno Sluiter, another 'great' in pain management. Jimmy encouraged me to carry out research on the use of radiofrequency in lumbar facet joint pain and to present my results to the British Back Pain Society.

I distinctly recall the both of us, in the early eighties, implanting a 'home-made' spinal cord stimulator, constructed to Jimmy's specifications, by our medical physics department, before the technique became widely accepted. He pioneered the use of thermography for chronic pain diagnosis and taught many young consultants the techniques of the then in vogue, trans-sphenoidal pituitary alcohol injection, of cervical cordotomy, various radiofrequency procedures, cryotherapy, acupuncture as well as the safe use of neurolytic agents. Those were the days where *any* consultant could receive paperwork-free, hands-on teaching, from *any* experienced colleague in *any* hospital he or she cared to visit.

He was actively involved in the development of the early RF machines and in the testing and perfecting of TENS machines for various companies. He delivered a seminal presentation on TENS at the very first IPS meeting I attended in Oxford, which earned him a standing ovation. He was also a pioneer in the computerisation of pain relief records and indeed taught me how to use a computer in those far off days of green screens, blinking cursors, and floppy discs! I remember him also being very involved, together with a biochemist whose name now escapes me, in attempting to locate blood markers as an indication of the measurement of pain. He always preferred intervention treatment as opposed to filling patients with strong opioids. When it came to musculoskeletal pain, he advocated a system of close cooperation with both the orthopaedic and physiotherapy departments. He was always full of energy and brimming with ideas. With Jimmy, there was never a dull moment!

Colonel James McEwan OSJ MB CHB FFARCS L/RAMC (1927–2012)

The Chronic Pain Clinic at the Queen Elizabeth Military Hospital rapidly acquired both a national and international reputation with doctors coming from all over the world to be taught by Jimmy. We had a very large civilian patient intake as many patients preferred to be treated in a military rather than in an NHS hospital.

He was very interested in the psychology of pain and taught all to respect this concept but *always* to remember that it was not the be-all and end-all of pain management. We had several ex-FEPOWs (Far Eastern Prisoners of War) as our patients. They had suffered heavily at the hands of the Japanese in WW2 and many still carried the physical and psychological scars of their ordeals with somatised chronic pain problems. It was not easy to get them to talk, but Jimmy managed to persuade them to open up to him. He was a very compassionate human being and instilled this sense of compassion into all the many doctors he taught.

He was also an excellent Consultant Anaesthetist, who eventually became the Head of Anaesthetics in the British Army. (*Consultant Advisor in anaesthetics to the DGAMS*). He was, for a time, a co-opted member representing the Armed Forces on the Council of the Association of Anaesthetists, which he had joined as a member in 1973.

Due to an unfortunate falling-out with the powers that be, he was denied the well-earned rank (and pension) of *Brigadier*, then customary for the position of Consultant Advisor in anaesthetics. He left the RAMC in 1986 on reaching the compulsory retiring age of 60 years, handing the running of the Pain Clinic over to me. Jimmy then promptly went off to the

British Military Hospital in Hong Kong as a civilian practitioner to continue his work in both anaesthesia and chronic pain management! He returned to the United Kingdom and finally retired from clinical practice in 1990. Together with his wife he moved back to Scotland, settling in Fife, in 2006.

Born in Glasgow on 5 January 1927, he qualified in Medicine from the University of Glasgow in 1949. After completing his national service, he received a regular commission in the RAMC in 1962 and obtained the FFARCS in 1973. He was an accomplished organist, a member of the Order of St. John, an active member of the Church of Scotland and very devoted to his wife, Dorothy, whom he married in 1953, and to his two daughters, Joan and Gillian, both of whom became nurses in the NHS.

When, in 1994, John Wedley and I jointly published our book 'Handbook of clinical techniques in the management of chronic pain', we dedicated it to Jimmy, with these words . . .

'To Colonel J. McEwan, who taught us both so much during the early years of our careers in the field of pain relief therapy, we dedicate this book'.

We both received a letter of thanks from him for this dedication.

He passed away on 24 December 2012, in Scotland at the age of 85. His wife predeceased him by just under a year.

Our specialty owes him a great deal. Those of us lucky enough to be taught by him will never forget him.

Andrew Diamond: pioneer and visionary in anaesthesia and pain medicine

Dr Gareth Greenslade



Andrew William Diamond had a tragic start to life, marred by the death of both parents during his early school years. His mother suffered from rapidly progressing multiple sclerosis, which caused her early death. His father was a general physician in Devon. He died suddenly after Diamond's sixth birthday.

After leaving Aldenham School, he entered St Thomas' Hospital Medical School, graduating in 1961. He specialised in anaesthesia and was appointed as a consultant in anaesthesia at Frenchay Hospital, Bristol, in 1968. He enjoyed a year working in Denmark before taking up his consultant post in Bristol.

He had considered a career in intensive care medicine, but his main interest was the control and management of pain. He was skilled in the use of regional anaesthetic blocks, following

his experience in Denmark. At the time, regional anaesthesia was uncommon in the UK, with very few patients being comfortable with the idea of being awake during their surgery.

The opposite was true in Denmark and the other Scandinavian countries, where patients were more concerned about the risks of having general anaesthesia. Diamond was soon identified as the doctor who could help patients suffering from intractable pain.

His interests remained broad, and in 1973, he published articles on prehospital intensive care for victims of traffic accidents.

Diamond was an advocate for a separate college of anaesthetists, instead of just being a Faculty of the Royal College of Surgeons. He was a signatory to a letter to the BMJ in April 1979, criticizing '... the comfortable view that anaesthetists are better off firmly tucked under the surgeons' wing [...] and basking in the prestigiousness of their splendid building – the Royal College of *Surgeons*'.

The letter was signed by other consultant anaesthetists at Frenchay Hospital, including Drs Peter Baskett, David Cochrane, Ronnie Greenbaum, Robin Weller, David Wilkins, John Zorab and the only female consultant at that time, Dr Sheila Willatts.

The same group supported the advanced training of ambulancemen (as they were called in the 1970s), and in 1976, Diamond was a co-author, with Dr Peter Baskett and Dr David Cochrane, of an article in the *British Journal of Anaesthesia* describing a pilot study of an urban mobile resuscitation service which could include the out-of-hospital deployment of an anaesthetist.

In 1975, 1976 and 1982, he published articles that aimed to improve the management of burns. In addition to the resuscitation of burns victims, these articles pushed for the

Andrew Diamond: pioneer and visionary in anaesthesia and pain medicine

provision of good analgesia, particularly when changing burns dressings – a procedure that was dreaded by many patients. Another study, published in 1975, examined the feasibility of providing postoperative extradural analgesia after thoracic surgery.

Diamond was now more tightly focused on pain. Without getting formal permission from the hospital's management, he established a chronic pain service. At first, this was with a theatre recovery nurse helping out with procedures, such as steroid epidural injections, in her lunch break.

Demand for Diamond's pain service quickly soared, and space was found in a spare building for a pain consulting room, minor treatment room and staff accommodation. He was fortunate to be working in a hospital built by the US Army, for D-Day and the European land war. Getting space was simply a matter of spending a weekend with cleaning materials and some tins of emulsion paint to open up a mothballed building. Soon, he had a full-time pain nurse, a secretary and dedicated pain block lists in an operating room.

At one point, a National Health Service (NHS) turf war threatened to derail the pain management programme, when the managers from outpatient services, anaesthetic services and therapy services could not agree on which budget would fund physiotherapy time in the new programme. Diamond resolved the issue by paying out of his own pocket, which got the recruitment underway, before getting the Chief Executive to arrange NHS funding.

The pain service at Frenchay Hospital became the largest chronic pain service in the Southwest of England, with clinical psychologists, specialist physiotherapists and an occupational therapist. Diamond recruited a clinical psychologist, Dr Nick Ambler, who had been a fellow with the Seattle group, to develop an outpatient pain management programme. He later attracted Dr Stephen Coniam and Dr Cathy Stannard as consultant colleagues.

Diamond was the president of the British Pain Society from 1991 to 1994. During that time, he drove the remodelling of the

society's constitution to allow full membership not just for doctors but also for members of the allied professions.

When he finished his term as president, the society's membership reflected the composition of a well-run pain service, with nurses, physiotherapists, occupational therapists, pharmacists and clinical psychologists having full membership rights.

Back in Bristol, Diamond set in motion plans to have a joint pain clinic and palliative care facility. This was designed by his colleague, Dr Coniam, in partnership with Macmillan Cancer Support. The centre was housed in a purpose-built building in the grounds of the hospital. The adjacency of the two services made it possible to provide regional pain relief techniques for those palliative care patients whose pain could not be controlled by normal hospice methods without causing cognitive impairment and other complications.

Diamond developed informal training pathways for anaesthetists in training who wished to pursue a career in pain medicine. His clinical teaching method was a combination of permissiveness and an eagle eye. He was ready to intervene before things started to unravel. The trainees learned a lot, but not at the patient's expense.

When he retired, he told me, as his successor in the NHS clinic, to keep anything in his office that would be useful and put the rest in a skip. He believed in a clean break!

Before retiring, he and his wife, Patsy, commissioned a steel canal boat, with which they sailed to France. After his retirement, in 1998, they navigated France's inland waterways before settling near Béziers. Diamond suffered a stroke after emergency cardiac surgery for bacterial endocarditis. They moved back to Somerset in 2016 where he lived, with Patsy, until his death. He leaves Patsy, a son and a daughter from a previous marriage, plus four grandchildren and one great grandson.

Andrew Diamond, Consultant in Pain Medicine and Anaesthesia at Frenchay Hospital Bristol (b 03 May 1938; q London, 1961; FRCA), died from heart failure on 02 April 2023.

The prescription: a view from general practice

The receptionist note on the consultation screen said, *'Just needs pain killers for knees'*. Edna, now sat before me, arms crossed, eyes me expectantly. My starter for 10, co-codamol, has been batted away with a *'tried that, made me constipated'* dismissal. My mind chugs through the alternatives and a mental image accompanies each one. Tramadol; Edna hunched over toilet bowl, wrenching. Co-dydramol; Edna, sat on same toilet bowl, straining. Naproxen; Edna staring down in horror at the blood in the toilet pan. Buprenorphine patch. Edna lying unconscious in the toilet while ambulanceman tries to force the door.

When I first became a GP partner in 1990, we were doing our own night and weekend calls; prescriptions and medical notes were all handwritten; and the GP I took over from gifted me his obstetric bag containing (among other things) forceps, ventouse and neonatal laryngoscope to equip me for all of the home deliveries I would be attending.* I inherited his patient list, and among all of the patients being repeat prescribed benzodiazepines and sleeping tablets, there was even a lady being repeat prescribed slimming pills. Fast forward to 2023 and General Practice is very different. And yet . . . some things do not seem to have changed at all.

Save for a few of the newer drugs, the consultation with Edna could have taken place in 1990 rather than 2023. Prescribing for pain is generally seen as an unsexy and mundane task but boy, is it tricky to get right. The possibility of dependence and addiction added to the usual considerations of side effects and interactions make for a heady concoction of variables to juggle with. It boils down to whether I am prepared to take Edna down the well-trodden, but potentially perilous, path of prescribing morphine analogues. As I have gone through my career, I have become less and less inclined to tread this path. Now I hardly ever initiate them because it usually ends badly. I received no formal training in the subject of opioid prescribing as a medical student and, until recent years, have seen very few postgraduate GP update courses specifically covering the subject. In my darker moments I dwell on how many patients, over my career, I have set on the path of addiction to prescribed drugs.

17.55. I thought I'd finished but another patient has been added on. The receptionist note on the consultation screen says *'Just needs pain killers for wrist'*.



A small wiry man in his 30s with a pale complexion, bad teeth and a large tattoo that covers one side of his neck and face walks in when I call him. He casually looks around my room before sitting down. He is an unregistered patient so I have no notes.

'Thing is Doctor, I've run out of my Ventolin . . . for my Asthma'. He says. 'Oh, and the brown one, Beco . . . something?'

' . . . tide'. I say, finishing it for him.

I write up the drugs on the computer and just before pressing the 'print' button I look at him expectantly.

'Oh. And while you're writing the prescription Doctor I need some more of my Pregabalin. For my wrist'. He waves it for emphasis. 'Broke it years ago. Now there's arthritis.' A pause. He gives his wrist a massaging rub. 'I take Dihydrocodiene as well, but I'm Ok for them at the moment, unless you could just give me a few, a top-up like?'

I have little chance of corroborating his story in any way. Pretty much all I have to go on is what he tells me and my instincts.

I ask where he is from and who issued his last prescription. I also ask where he cashed that prescription. I get the name of his registered doctor who I quickly Google and ring. But it is 6.10 and I get the answerphone. I do the same for the pharmacy he mentioned. This time I speak to someone. I am told he was given a prescription for the two inhalers and the pregabalin and dihydrocodeine 6 weeks ago, 2 weeks supply of the pregabalin and dihydrocodeine on that occasion. I also noted that the postcode of the pharmacy was not in the vicinity of his registered surgery. Maybe he has visited other doctors and other pharmacies in the meantime? While carefully avoiding any hint of accusation I gently suggest that there is a gap.

He gets defensive. 'Well doctor, I've had to make them last. I can't work 'cause of my f***ing wrist and I lost my flat 'cause I was EVICTED'. The last word spat out with particular venom. 'So, I am sleeping on my sisters sofa. Every time I try and get more of my painkillers I get given the third fucking degree'. I remain silent and his temper seems to settle a little.

I tell him I need to chat to his registered doctor in the morning and then I'll ring him on his mobile.

His temper flares again. 'What about tonight. My wrist is f***ing agony'.

I agree to issue a prescription for two pregabalin pills, one for tonight and one for tomorrow morning.

He becomes more conciliatory, 'What about some Dihydrocodeine as well, doctor, just for tonight?'

At this point I know it's all a ruse to get more pills. To take? To sell? To give to a dealer in part payment for a debt? Who knows?

I explain I will only be prescribing the pregabalin. He angrily snatches the prescription and walks off. He leaves behind the separate prescription for the inhalers.

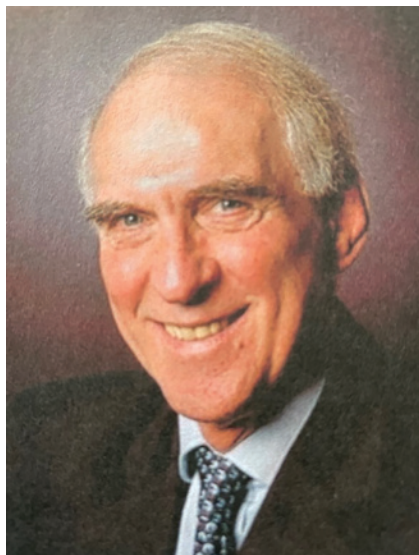
I phone his GP surgery the next day to be told they only ever give a maximum of 2 weeks supply and that they are often rung by other GPs asking whether his request for more pills is genuine. They last issued a prescription 5 days ago . . . for 2 weeks supply.

I know how this will play out. When I ring the mobile number he gave me, I will say my name and the phone will go dead. I will try the phone again and be cut off before I can say anything.

Prescribing pain killers. Like I said. Sounds straightforward but damned tricky in practice. In fact one of the most complex, time-consuming and important roles a doctor does. And, to this day, a scandalous paucity of any sort of training in the subject.

*I've never opened the bag other than to take a curious peek!

The art of Sir Michael Bond



Sir Michael is a graduate of Sheffield University (1961). His interest in pain began in the early 1960s when he was involved in cancer chemotherapy research in the Department of Surgery in Sheffield for which he was awarded an MD.

For health reasons, a diagnosis of chronic glaucoma, he transferred to the University Department of Psychiatry where he continued his research into pain and personality for which he was awarded a PhD. In 1966, he and Issy Pilowsky, also in the department, published the first article on the use of the analogue scale for pain measurement.

In 1967, the glaucoma diagnosis having been corrected, he moved to Glasgow to join the University Department of Neurosurgery and to train as a neurosurgeon. In 1972, he was appointed Professor of Psychological Medicine given his training in both psychiatry and neurosurgery.

In Glasgow, Sir Michael was a founder member of the short-lived Glasgow Pain Group. In 1979, he was a Founder Member of the Intractable Pain Society, which later became The British Pain Society. He has been a member of International

Association for the Study of Pain since 1976, a member of its council twice and was its President from 2002 to 2005. Throughout his clinical life, Sir Michael's interest was in the psychosocial aspects of pain.

Sir Michael has had a lifelong interest in art but began to paint seriously only after he retired in 1998. He is productive and sells his work with all proceeds going to charities.



A View Across Loch Lomond from Inchcailloch. © Michael Bond. Sold.



A Spanish Villa. © Michael Bond. Sold.



Looking North Across Loch Venacher. © Michael Bond. Sold.



Fruit and Flowers. © Michael Bond.

The Fool's way with pain

Julia Hollander



Sir Michael Gambon 2013 Public Domain.

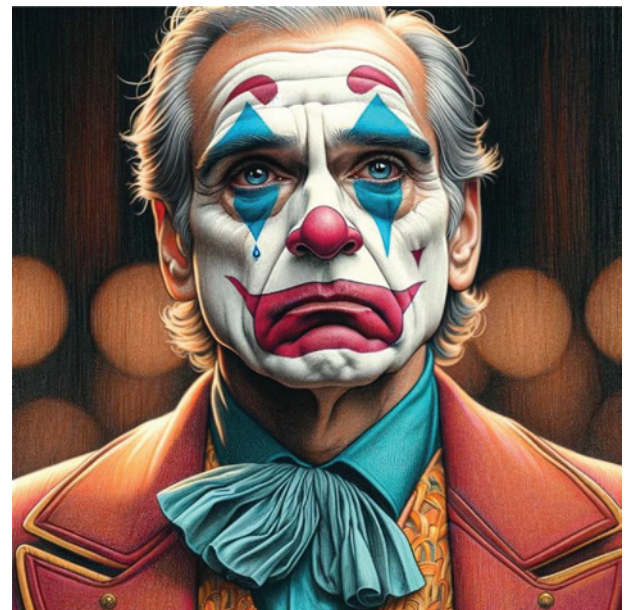
If you were lucky enough to see the late Michael Gambon play King Lear at the RSC in the 1980s, you will also have witnessed a landmark performance from Anthony Sher as his Fool. Wearing a clown's nose, he opened the show in high spirits, tumbling all over the place, chattering like a chimpanzee, only to end up perched on Gambon's lap like a ventriloquist's doll. Sher's extraordinary physicality in the role was also the thing that floored him. Literally. One night, he made one tumble too many and snapped his Achilles tendon. Not that anyone noticed, least of all him. Only when he left the stage at the end of the show did he actually start to feel the pain, leading to 6 months with the leg in plaster, his Fool consigned to staggering about the stage on crutches.

I tell his story not as a lesson in actorly hubris, but as an example of how laughter and suffering, pain and ecstasy are inextricably linked. All of it neatly symbolised by the blob of colour on the front of his face.

Have you ever wondered about the clown's red nose? With such a simple addition to his features, we know how he will

behave: overly eager to please, his body too skinny to keep his trousers up; shoes so oversized that inevitably he will end up tripping over his own feet. The nose gives us permission to laugh, not with him but at him.

Meanwhile, outside the theatre or the circus ring, it is quite a different matter. If you see someone with a red nose on the street, you don't laugh. You assume they've got a drinking problem or dangerously high blood pressure, a bad cold or (these days) a deadly virus. In real life, that nose is a sign that someone is in pain.



When I studied theatre performance in the 1990s, I got to work with a master of French clowning, Philippe Gaulier. Unlike Marcel Marceau with his artful mannerisms, or Jacques LeCoq with his strict set of skills, Gaulier was in search of the clown he maintains is at the heart of everyone: our human essence. Many famous British actors discovered themselves in his classes, from Helena Bonham Carter to Sacha Baron Cohen. What Gaulier says is that clowns (or their French cousins, the bouffons) are the invalids of the performing world. In feudal times, they were the lepers who were banished beyond the city

walls. Once a year the King would give special dispensation for them to return. Their eyes white-rimmed from lack of sleep, their hair unruly as if only just risen from their pillows, into the castle they would trudge, bringing with them their musical instruments, their props and costumes and, most importantly, their latest dramatic take on society's ills.

The clown's job is to satirise everyday social behaviour: the clumsy cruelties family members inflict on one another; the absurdity of power and status; the way we thoughtlessly exploit love or vulnerability or loyalty. These are some of the themes in

Shakespeare's *King Lear*, and perennial to every era. When the clown parodies them, we laugh in recognition. It may feel that we are on the outside, mocking, but on a deeper level, our laughter signals a form of respect for the leper who, exiled from the mainstream, is able to stand witness to our truths.

So the next time you are at a circus or a panto, rolling in the aisles as the clown performs his silly songs and ludicrous physical feats, spare a moment for his nose. It is a warning that they are in pain, and that pain grants them insight into who you are and what you are doing with your life.

