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PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

ISSN 2050–4497

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Introducing new Misabri PR (pregabalin)
Once daily pregabalin prolonged-release tablets

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Misabri PR
pregabalin
prolonged-release tablets

The only once-daily pregabalin in the UK

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Reference: 1. Misabri PR prolonged-release tablets Summary of Product Characteristics.

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2025/26 Study Days & Conferences

January 2026	2026
14	Teenagers and Young Adults with Cancer
22-23	Cancer of the Vulva National Symposium and Stakeholder Meeting in Partnership With Lady Garden Foundation
30	An Update on Head, Neck and Thyroid Oncology
February 2026	
5	GI Updates in Oesophagogastric Cancers
6	Paediatric Haemato-Oncology Study Day
11	Progress in the Management of Gliomas Conference
March 2026	
4	Acute Oncology Study Day Part 1
9	Cardio-Oncology Conference
19	GI Updates in Colorectal Cancers
20	Solid Tumours Preceptorship
26-27	Gynaecology Oncology in the UK: Trends, Challenges & Opportunities 2-Day Conference
May 2026	
14-15	The 12th Royal Marsden Conference on Anaesthesia for Major Surgery: What's New?
June 2026	
2	An Introduction to Systemic Cancer Treatments and Cancer Biomarkers
16	Paediatric and TYA Solid Tumour Study Day
17	The Role of Radiology In Cancer Diagnosis and Treatment
30	The Royal Marsden Study Day for Upper GI/HPB: Pre & Post Surgery
September 2026	
28	Senior Adult Oncology Study Day
October 2026	
2	The 19th Annual Royal Marsden Breast Meeting: Hot Topics in Breast Cancer
November 2026	
12-13	Pain Medicine for the 21st Century
26	Adult Palliative Care Update
27	The 16th Royal Marsden Head and Neck Conference: Oropharyngeal Cancer
December 2026	
2	A User Guide to Cancer Immunotherapy
10	Interventional Approaches for Cancer Pain Conference

NHS

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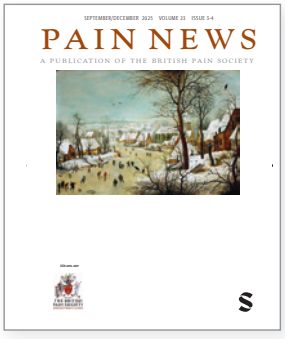

The Editor welcomes contributions including letters, short clinical reports and news of interest to members.

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

President's message

Professor Roger Knaggs

Pain News
2025, Vol 23(3-4) 75–76

As we move approach the end of 2025, I find myself reflecting on the resilience, innovation and collaboration that continue to define our community. Pain management remains one of the most complex and evolving areas of healthcare, and yet, it is also one of the most profoundly human. Every patient we see, every study we conduct, and every policy we advocate for is rooted in the shared goal of alleviating suffering and improving lives.

The BPS brings together professionals from every corner of pain care – clinicians, nurses, psychologists, scientists, physiotherapists, pharmacists and people with lived experience. That diversity is our strength, and it's never been more important. The complex challenges our patients face cannot be solved by any one discipline alone.

Pain News: a new chapter

In the last issue of *Pain News*, we announced that Raj Munglani had decided to retire as Editor of *Pain News* and there was an interesting interview on his reflections. I am very grateful to Martin Hey for working to create a new Editorial team for *Pain News*. It was so pleasing to see the interest from members in contributing to the next stage of the evolution of *Pain News*. A very diverse team has been appointed reflecting the interdisciplinary membership of the Society.

Charles Crawford – Editor (Dentist and orofacial pain)

Deepak Ravindran –Deputy Editor (Pain and lifestyle medicine)

Martin Hey – Associate Editor: Physiotherapy (and Honorary Secretary)

Rajesh Munglani – Associate Editor: Anaesthesia (former Editor of Pain News and Vice President)

Margaret Dunham – Associate Editor: Nursing

Tim Atkinson – Associate Editor: Expert Patient and Carer Committee

Patrick Hill – Associate Editor: Psychology

Graham Dunthorne – Associate Editor: General Practice

Elise Ajay – Early Career Researcher

Isabella Mugerwa – Early Career Medic

Natalia Strzelecka – MSc Psychology & Lived Experience

I thank the new editorial team and wish them well as they work together to take *Pain News* on the next stage of its journey. Do consider what you could contribute and share with your colleagues.

BPS strategy

One of the significant pieces of work that have been undertaken over the last year is the development of a new strategy for the BPS. It sets out a bold and collaborative vision: Together, we will do more for pain. Rooted in the realities of those living with pain and the professionals who support them, the strategy focuses on six key priorities:

- fostering multidisciplinary collaboration,
- enhancing education and training across all career stages,

- advancing inclusive and impactful research,
- driving quality improvement in services,
- embedding person-centred approaches,
- supporting the well-being and development of professionals in pain care.

Underpinning these priorities is a commitment to equity, innovation and lived experience – ensuring that pain care across the United Kingdom becomes more integrated, inclusive and effective for all.

This will be a living strategy and will evolve over time. We will also review achievements and priorities on an annual basis. So, if you have comments or would like to contribute to developing these priorities, please reach out to the Secretariat.

Early career professionals and researchers

Since the introduction of the early career membership category last year, it has been a pleasure to welcome nearly 70 new members. As a community, we must continue to invest in the next generation of pain professionals. This means not only equipping them with the latest scientific and clinical knowledge but also fostering empathy, communication skills and cultural competence. They are now meeting on a regular basis, and I am grateful to Nathan Skidmore who has agreed to support the development and growth of this important network.

Save the date: 21–23 April 2026

Organisation is busy and fast-paced as ever for the **59th Annual Scientific Meeting** of the British Pain Society, taking place between **21 and 23 April 2026 at the Harrogate Convention Centre**. As I write, we are eagerly awaiting submissions for workshops and parallel sessions. By the time this edition reaches you, those will have been selected, but you will still have the opportunity to submit an abstract and secure your place at the meeting. This year's ASM promises a vibrant, multidisciplinary programme showcasing clinical innovation and emerging research. I hope this issue of *Pain News* helps build anticipation, sparks new ideas and brings our community together ahead of what I am confident will be a significant meeting.

2027 – a year to remember

2027 will mark a significant milestone for the BPS; the 60th anniversary of the first meeting of the Intractable Pain Society and the European Pain Federation (EFIC) Congress will be held in Glasgow between 21 and 23 April. The theme of the Congress will be **Building Bridges in Pain: Thriving Through Communication.** We have been some preliminary discussions with EFIC to ensure that there are numerous opportunities to showcase innovations within the United Kingdom. To mark this diamond anniversary, there will be a one day BPS meeting (20th April 2027) preceding the EFIC Congress. Plans are in the very early stage, so keep an eye out for further details.

As President, I am continually humbled by the dedication and creativity of our members. Whether you are working in a busy clinic, conducting cutting-edge research, teaching the next generation or advocating for better services, your contributions are shaping the future for pain management. Thank you for your commitment, your compassion and your courage. Let us continue to support one another, challenge assumptions and strive for excellence in all that we do. Together, we can build a future where everyone living with pain receives the care, understanding and respect they deserve.

I am very keen to hear from you about any pain-related issues or how the BPS can have greater visibility and impact, so do not hesitate to contact to me. I will take the time to read and respond to every e-mail received.

The British Pain Society remains YOUR Society and it needs YOU to flourish.

With best wishes,

Roger Knaggs
Roger.knaggs@nottingham.ac.uk

Charles Crawford Q&A

Pain News
2025, Vol 23(3-4) 77–78

This edition of *Pain News* is the first for a new editorial team headed up by Charles Crawford.

What is your professional background, and how did you become involved in pain management?

I started my career in general dental practice and from that developed a special interest in orofacial pain. I completed a masters in pain management from Cardiff University and took a hospital role on the clinic for Temporomandibular Disorders at the University Dental Hospital of Manchester. It was challenging to engage in a very different kind of work compared to my experience in primary care dentistry. I now lead that department and have transitioned the majority of my clinical work away from the dental drill!

What areas of pain research, treatment or policy are you most passionate about?

I think the world of pain medicine demonstrates better than any other branch of healthcare the need for multi-disciplinary working and just how valuable that is. Looking out beyond your own bubble is both fascinating and rewarding. So what I love most is learning from such a variety of people.

When I'm talking with patients I always say that the foundation of good pain management is the things that they can do for themselves. Therefore, if I had to pick one aspect, it would be health psychology, particularly how to engage and enable patients to help themselves.

What are you most excited about for the future of *Pain News*?

I think *Pain News* is a great platform to tell the story behind the science. The world of pain management is full of interesting people with many different experiences (and the new editorial committee full of examples of that!) So together I hope we can assemble a publication that members of the BPS look forward to receiving.

I want *Pain News* to be the kind of periodical that people pass on to other colleagues so that they too can read that 'really interesting article'. On that note I would like to pay tribute to my predecessor, Rajesh Munglani, who certainly achieved this through his tenure.

What's one thing you wish more people understood about pain management?

The thing that would make the biggest difference would be if everyone understood that it is rare for there to be one magic treatment that makes everything better. This is why we call it pain management and not pain treatment. Unfortunately some of the myths around modern medicine, and the advertising industry's desire to sell their products, mean that we often have to start by reframing expectations before we can begin to make progress.

Is there a book, article or piece of research that has had a significant impact on your work in this field?

The paper by Christophe Tanguay-Sabourin and colleagues in *Nature* a couple of years ago was an excellent attempt to

draw together prognostic factors in chronic pain.[1] There is plenty of food for thought in that. And for a book, I enjoyed Joanna Bourke's 'The Story of Pain', which demonstrates just how much has changed in our approach and understanding.

And a little off the topic of pain, but still very relevant, is Iain McGilchrist's 'The Master and his Emissary'. It is not an easy read (I did it in chunks!) but it is an incredible piece of work that will change the way you see the world. For pain professionals it highlights the need for a rounded approach to our work, trying to maintain the whole picture and not just our own representation of it!

Outside of your professional role, what are some of your hobbies or interests?

Well to be honest I am a failed novelist, but I tell myself that it is just a matter of time. And more importantly, I enjoy reading and writing across most genres. I have two Lakeland Terriers who I love walking. They are mother and daughter (we decided to have a litter of puppies in lockdown). They are very naughty but are always pleased to see me when I come home.

Reference

1. Tanguay-Sabourin C, Fillingim M, Guglietti GV, et al. A prognostic risk score for development and spread of chronic pain. *Nature Medicine* 2023; 29(7): 1821–31.

ASM announcement

Pain News
2025, Vol 23(3-4) 79

We are pleased to announce that the 59th Annual Scientific Meeting of the British Pain Society will be held from 21 to 23 April 2026 at the Harrogate Convention Centre.

The programme will highlight the multidisciplinary nature of pain management with keynote lectures, topical debates, workshops and interactive sessions designed to stimulate both scientific and clinical discussion. Delegates will also have opportunities to engage with leading researchers, experienced clinicians and industry partners through dedicated networking events.

We are delighted to announce that parallel session submissions for the ASM is now open. Prospective authors are asked to consider submitting a session under one of the conference themes and according to the guidelines.

Submissions must be received by 11:59 pm GMT on 5 November 2025.

For more details and how to register for the event please go to the website https://bpsasm.org/

Dr Hadi Bedran

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Dr Hadi Bedran

Clinical excellence with deep compassion

Dr Bedran was born on the 22nd of January 1979 in Lebanon. He studied medicine in Lebanon before graduating from the University of Istanbul, School of Medicine, in 2003. He completed his specialty training in Anaesthesia and Pain Medicine in the United Kingdom in 2016 and was appointed as a consultant at St George's Hospital, London, where he pursued his interests in anaesthesia, neuromodulation and pain management.

He dedicated his life to alleviating the suffering of others, combining clinical excellence with deep compassion in every patient interaction. A gifted teacher and mentor, he generously shared his knowledge with colleagues and trainees, inspiring future generations of doctors.

Beyond his medical career, Hadi was deeply committed to humanitarian causes, offering his skills to those in need both in the United Kingdom and abroad, including work in Gaza to treat injured children and families affected by war. An intellectual thinker and lifelong learner, he was curious, reflective and engaged with the world around him. Outside of medicine, he found joy in sports, especially martial arts, where his discipline and perseverance shone as brightly as in his professional life. He will be remembered for his kindness, wit and unwavering commitment to others.

He cherished his family above all – his beloved wife, Sema, and their two children, Fadila and Kerem. After a brave battle with lung cancer, he passed away peacefully surrounded by his family on the 23rd of May 2025, leaving behind a legacy of kindness, service and selflessness.

BPS ASM 2025 Pain News Collage

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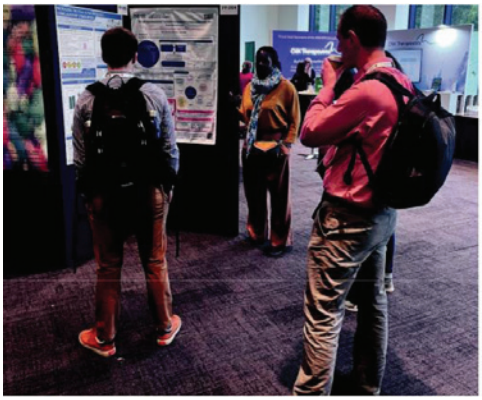
Newport, Wales 2025 Annual Scientific Meeting

Over 450 delegates gathered for the British Pain Society's Annual Scientific Meeting, creating a vibrant atmosphere for networking, knowledge exchange, and advancing the field of pain management.

Roger Knaggs presenting Sam Ahmedzai (L) and Patrick Hill (R) with BPS Honorary Membership.

BPS ASM 2025 Pain News Collage



Ancor Serrano Afonso

Anton Emmanuel

Sohier Elniel

Roger Knaggs presenting Sam Ahmedzai (L) and Patrick Hill (R) with BPS Honorary Membership

BPS ASM 2025 Pain News Collage

Emma Fisher

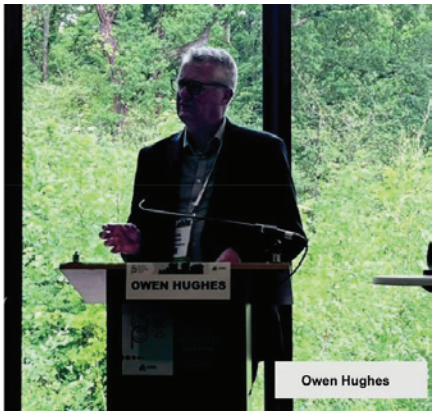
Lauren Wilkinson

Sheila Black


Nordic walking session with Karen Ingram from British Nordic Walking

Martin Galligan

Jamie Glen Burgess

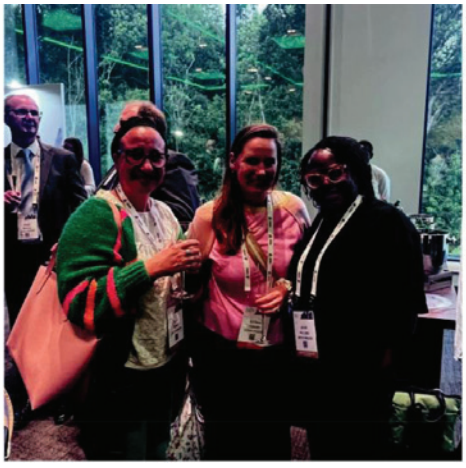


Owen Hughes

Ancor Serrano Afonso, Neil Collighan, Adrian Williams, Arun Bhaskar

BPS ASM 2025 Pain News Collage

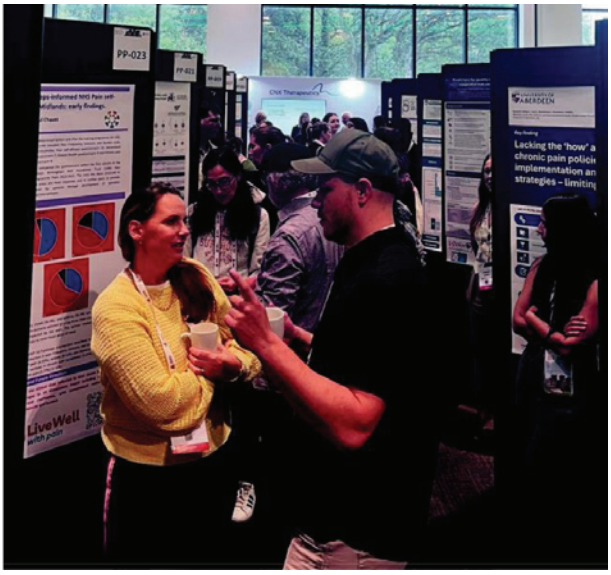

Tim Hales




Paralympian Funmi Oduwaiye


John Finch from the Pain Concern team recording Airing Pain podcast


Krishna with the harpist at the Welsh Pain Society session

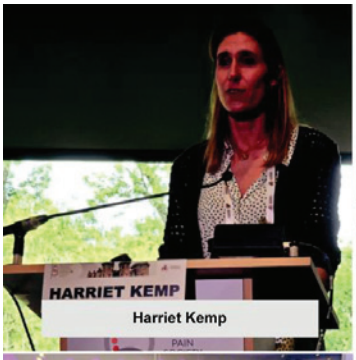


Education day: Opioids in Clinical Practice with the Pain Nurse Network


Sunil Dasari

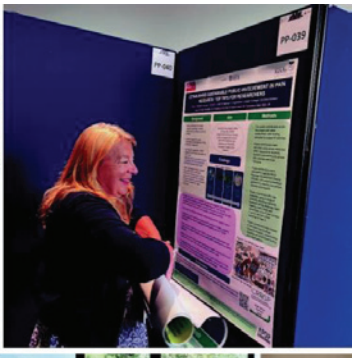

Ed Keogh

BPS ASM 2025 Pain News Collage



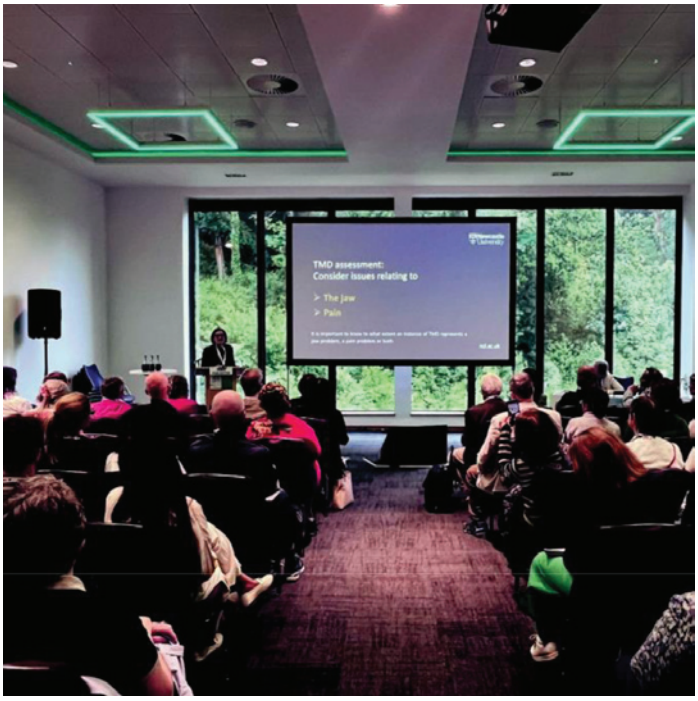
Harriet Kemp

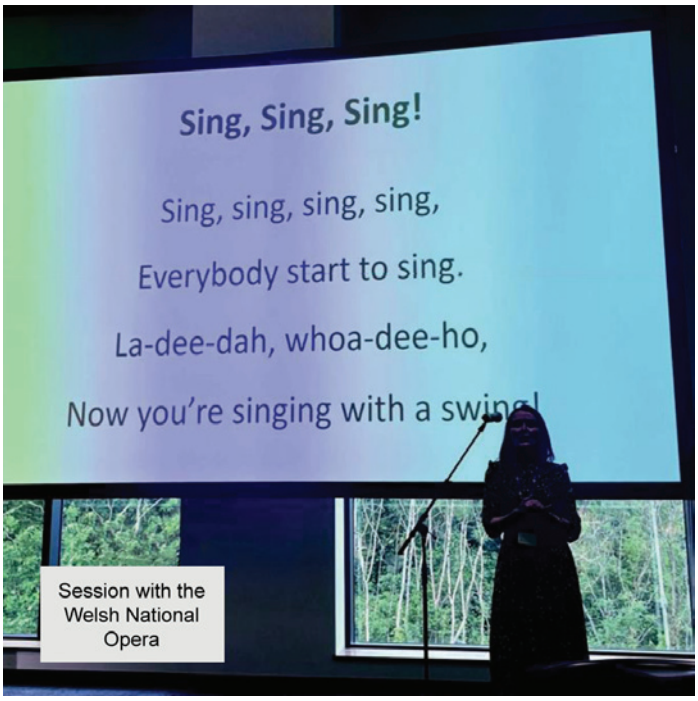
Craft corner



Members of EPCC: Nick Richardson, Sarah Harrisson, Fiona Symington, Mark Agathangelou, Sam Ahmedzai and Victoria Abbott-Fleming

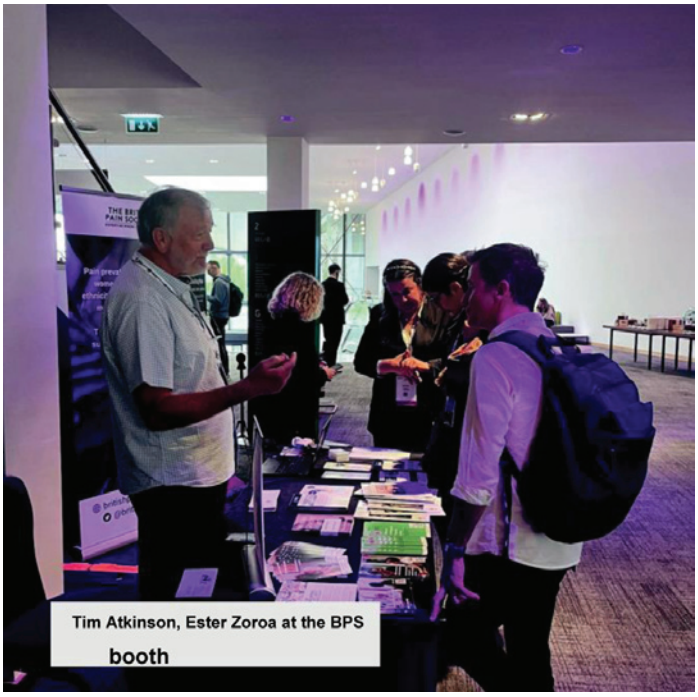
Jane Quinlan with her BPS Lecture Medal





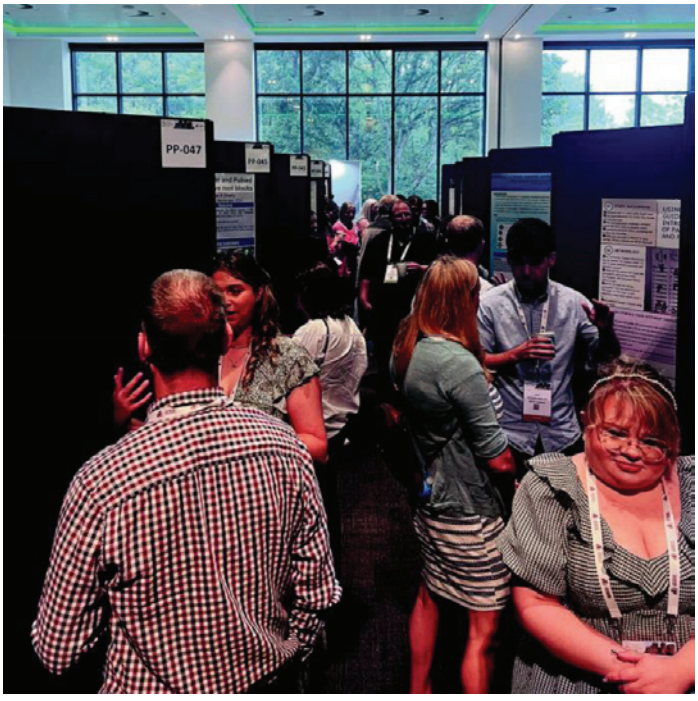
Session with the Welsh National Opera

BPS ASM 2025 Pain News Collage



Tim Atkinson, Ester Zoroa at the BPS booth

Tim Atkinson, Louise Trewern, Deepak Ravindran, Mark Agathangelou, and Sam Ahmedzai



Article

Global pain management SPECIAL INTEREST GROUP

Pain News
2025, Vol 23(3-4) 87–91

This year the theme for the IASP's global year is 'Pain Management, Research and Education in Low and Middle Income Settings' (see link at the end of this article) and so with this in mind we took the opportunity to relaunch what was previously the 'Pain in Developing Countries' SIG with the new name of 'Global Pain Management' SIG, a title which perhaps better reflects the aspirations of the SIG in 2025 and beyond.

For this edition of Pain News we wanted to highlight an example of the impact that pain management training can have in an article documenting the experiences of three people who have seen the impact of the Essential Pain Management Course in Benin, West Africa.

It is exactly this sort of promotion of good clinical practice in managing pain that the Global Pain Management SIG aims to support.

If you find this article inspiring, please join us as we plan our programme for the future and work with clinicians in a variety of settings to help make a difference to those suffering with pain.

For further information please do contact me through the BPS email address (info@britishpainsociety.org) or join us as we meet next year at the BPS Annual Scientific Meeting at Harrogate

Roy Miller
Global Pain Management SIG chair

Experiences of pain work abroad

Dr Helen Makins, Pain Consultant, Gloucestershire Hospitals NHS Foundation Trust, UK

My experiences of working abroad are some of the things I treasure most from my career to date. In order to raise awareness of the new specialist interest group and to encourage membership, I was asked to put down on paper some of the reasons why I have enjoyed this aspect of my work so much and to include a perspective from international colleagues who have joined me on this journey.

Anyone starting out in this area may be wondering how to get involved. So, the first point I'd like to make is that there isn't a path that I've followed, or necessarily a particular way of getting into this area. Getting involved for me, has been mostly about being open minded, putting myself in situations where I have met people who've opened the door to opportunities, answering unusual adverts, or pro-actively approaching people or organisations involved in the area. One thing often leads to another in unpredictable and unexpected ways. Having said all that, I do appreciate that I am very lucky with friends, family and colleagues who have always supported me enormously and I would like to take this opportunity to thank them unreservedly.

My second point is unashamedly stolen from Terry Waite, the British missionary who was captured and held hostage for over 1000 days in Lebanon in the late 1980s. I heard Terry speak about his experiences, explaining that he is often commended by people who meet him, for being a selfless person and for all the fantastic work he has done over many years for the good of others. Whilst he accepts fully that the output of his work has benefitted many less fortunate than himself, he reminded us that the nature of human decisions is that they are largely made for the good of the individual. This is certainly my experience and in this section of the article, I hope to tell you a bit about what I've done and how it has helped me professionally and personally before handing over to my inspirational colleagues, Dr Odry Agbessi and Walid Agro for their perspectives. Odry is a reconstructive plastic surgeon, whilst Walid is a journalist and leader of a voluntary civic engagement organisation for young people. They live in Cotonou, Benin, West Africa.

My first experience of administering anaesthesia was in Papua New Guinea, on my elective at medical school. The single-handed Voluntary Service Overseas doctor at the mission station had completed only a few years of medicine in the UK before arrival and we were in a tiny remote village, with no telecommunications or vehicular access aside from a tiny plane that flew by and dropped off supplies every few days. There was no alternative but to do our best. And so, with me as anaesthetist administering ketamine and him as surgeon, we undertook a skin graft to a burn and I am pleased to say that all went well. A second memorable event from that trip was when the same doctor was stung by a stone fish. This scenario had

not been covered at medical school but with impending death from the toxin as a possibility, we needed to immerse his foot in hot water as soon as possible. The fire was at the top of the hill and he was in agony at the bottom. Thankfully the "fight or flight response" got us all up that hill faster than we would ever have imagined possible, painful swollen foot only slightly impeding progress, and it all ended well.

Aside from learning about tropical medicine and management of unexpected circumstances, I had learnt that the comradery of facing challenges and teamwork with colleagues was an extremely rewarding experience. The personal connections become strong quickly and this is a consistent feature of all the work I've done abroad since.

A few years later, when my sons were around 5 and 7, I was just finishing my anaesthetic training, about to apply for consultant jobs and life was hectic. A colleague at work was going to Mozambique and looking for someone to join him to deliver an anaesthesia refresher course. He and I had discussed working abroad before so he asked me if I would help. Initially I was worried about leaving family behind but nothing disastrous happened at home in my absence which, much to my husband's delight, made me realise that I wasn't as indispensable to the household as I imagined! We imparted our clinical updates but what the Mozambique anaesthetists wanted was some support and plans for speaking up if they weren't clinically happy to proceed. We discussed and debated a lot about creating respectful teams and communication skills. These were areas just starting to be highlighted with the WHO surgical briefings and things weren't ideal in the UK either. I felt more empowered to speak up following that trip.

A couple more years passed by, and I answered an advert asking for help at short notice to deliver Essential Pain Management (EPM) training in conjunction with the charity Mercy Ships in Benin. I had to move all my clinical work into the preceding month to avoid cancellations but was eager to go. Interestingly, my children have always been hugely encouraging of this work and fascinated by the stories. Neither have any enthusiasm for medicine but they both have interests and career aspirations in humanitarian work, politics and travel, and I am sure this is no coincidence.

That first Mercy Ships course really set the scene for the last 8 years. The EPM course includes a section on barriers to implementation of the course content and then a group discussion around how to overcome them. At that first Benin course, there was one participant, Dr Odry, who was more positive than the others. Although my French language skills were limited, I understood that where many of the group were frustrated and expressed being powerless to elicit change, Odry felt it was their joint responsibility to find ways to overcome the challenges they face. After the course, Odry and I exchanged WhatsApp details, communicating through my poor French. I had an instinct that she would be a helpful contact in the future.

A year later, I was asked to lead the next course with the NGO Mercy Ships[1] and we agreed that it would be motivating to include a previous participant, so the What's App details came in handy! To my amazement, in the interim year, Odry had learnt to speak fluent English and written pain management protocols for her hospital. She was able to share her valuable and inspirational experience, actions and outcomes with participants in the next few countries - Cameroon, Guinea and Senegal. We have shared these trips with fantastic colleagues from Mercy Ships and from the UK pain community, including Jane Mills, Sam Jayaweera, Alan Fayaz and Fozia Hayat. This has expanded by network of friends and colleagues in the UK and around the world, which has been a cherished and valuable by-product of the trips.

Travel paused over the COVID era and I was worried I'd lost my work abroad but Odry invited me to join an EPM course online instead. Subsequently, she wanted to run courses in person, to spread the EPM training around the country and I joined her for a week in 2023. That week coincided with a volunteer camp that Walid was leading in the same city, highlighting the benefits of civic engagement. We visited an orphanage together and spoke to the young people living there about the development opportunities gained by volunteering, attempting to encourage them to try new things and take every opportunity that comes along, for the benefit of themselves and their community. It made me reflect on the things I'd learnt along the way.

This year, the annual volunteers camp joined with the healthcare project. With support from a French medical charity, Odry and Walid organised a week of outpatient clinics for the local population in a remote town in West Benin. This included EPM and several other training courses, and I was involved in the clinical work too. Interestingly, widespread pain was one of the most common reasons for attendance. Formal pain management interventions are limited due to training and financial means, so pain education and lifestyle-advice were the only options for management. However, lifestyles are of course very different in rural Benin, where access to electricity and fresh water is a luxury and so I often found myself learning from locals about the challenges they face and thinking through meaningful ways to manage these. It reinforced my appreciation of the power of shared decision making and coaching, rather than

giving well-intentioned advice. There are plans to make this healthcare camp an annual event and I think a group patient educational component may well be included next time.

The camps end with a campfire and a celebration of voluntary work in Benin. There is always lots of singing, dancing and games. Initially, my English reservations held me back. However, the atmosphere is always so positive and welcoming that I now find myself attempting to join in with the locals and being clapped and cheered on enthusiastically. I have actively tried harder to build the inclusivity and lack of judgement from Beninese culture into my life and I worry less about what others think. I am truly grateful to Odry and Walid who have become great friends and who have shared their family, friends, country and culture with me. I have no doubt that even in my middle age, I am continuing to grow and develop in ways I would never have imagined and I can feel the benefits every day, both professionally and personally.

I would like to take this opportunity to recognise the incredible hard work and the support provided by Mercy Ships, The Faculty of Pain Medicine - especially the EPM working group[2], the Association of Anaesthetists[3] and the Australian and New Zealand Faculty of Pain Medicine[4]/World Federation of Societies of Anaesthesiologists[5] EPM Global working group The expertise, financial support and coordination provided by these organisations and the tireless efforts of colleagues within them has been crucial to the success of so much pain education around the world.

Dr Odry Agbessi, Reconstructive Plastic Surgeon, Centre National Hospitalier Universitaire Hubert Koutoukou Maga (CNHU-HKM), Cotonou, Benin

Navigating the world of pain management is navigating the path of my destiny. Participating in the essential pain management workshop is a significant step in fulfilling the mission I have set for myself. I am Fifonsi Odry AGBESSI AGRO, and this name of mine is full of meaning. It means in my language "when you wake up, when your breath is renewed, it is a golden opportunity to live, to rebuild." It is a renewed chance to rewrite your story.

I am convinced that we should not see life, our life, as just a simple passage, an appearance, a coincidence. It is important to have a vision and to fulfil it; not to remain just in the crowd; not to limit ourself to the vision of the masses; to dream of making a difference; to dream of contributing something to our community and why not to humanity; not to think only of our own and only interests because there is always benefit for oneself in doing good for others, and in general one feels good having done good.

The medical career has inspired me since a young age, having lived with a couple of doctors. From then on, I only had eyes for games where I pretended to have a stethoscope around my neck, examining and treating so-called patients. My love for doing things well, coupled with diligence, also developed during this time as my parents constantly told me, 'If you want to be a doctor, you must work hard.' The dream became a reality, the decision was made, I wanted to give my best to have the opportunity to one day become a doctor in service of the community. A series of events led me to choose my current specialty, plastic and reconstructive surgery. The most important is that I realised that access to safe surgical care is not a reality in my country and that I needed to contribute to improving things. So, it is full of this dream that I returned to Benin, my country, after my 5 years of specialization in Morocco. As a young graduate just back home and still full of my dreams, I had the opportunity to participate in the Workshop on Essential Pain Management organized by Mercy Ships. Our trainers from the UK were very passionate about the subject. What amazed me is that although Helen could not speak French, she was able to directly convey her passion for the topic and make us realize that not treating pain is inhumane. From that moment on, nothing could convince me that there could be insurmountable obstacles to showing all caregivers that managing pain is just as important as addressing a patient's fever.

An objective was born in my mind, which was to ensure that as many healthcare professionals as possible could access this training, in order to standardize pain management in our facilities, a step towards improving the quality of care. When I approached Helen, she happily agreed to share with me the necessary tools for organizing the training workshop. At that moment, I could not imagine that a long story of collaboration, then friendship and brotherhood, was about to begin.

Two weeks after the end of this workshop, I organized the first workshop as a trainer at the CNHU-HKM in Cotonou with the support of Mercy Ships. During these sessions, we all identified the lack of a standard protocol as an obstacle to the implementation of the Recognise, Assess, Treat (RAT) pain management system. This led us to extend the training to other healthcare professionals at CNHU-HKM and establish a unified pain management protocol. This was an innovation that created a significant change in the pain management of patients, as revealed by the evaluation of the protocol's use, which was carried out in the form of a thesis.

Thanks to Mercy Ships and Helen's trust, we were able to raise the dream higher by participating as trainers in these workshops at the West African level. Even though COVID-19 slowed us down, we remained focused on the same objective and organized workshops not only online but also in person. Indeed, determination and hard work are crucial for succeeding in this journey of fulfilling one's destiny. This year again, we were honoured by Helen's participation at the Volunteer Camp that we organize every year as part of this vision to contribute to access to safe healthcare. The innovation this year was to organize capacity-building courses for healthcare professionals in this region of Benin to make the impact more sustainable. This is an opportunity to thank Helen for her simplicity, her contribution to the success of this camp, which has impacted over 1,000 Beninese and will continue to do so thanks to the new skills that have been developed. This is the place to say a big thank you to her entire family, and especially her husband, who supports her in this adventure. Yes, treating pain can be a crossroads and a witness to the fulfilment of a destiny, that of serving for the well-being of all.

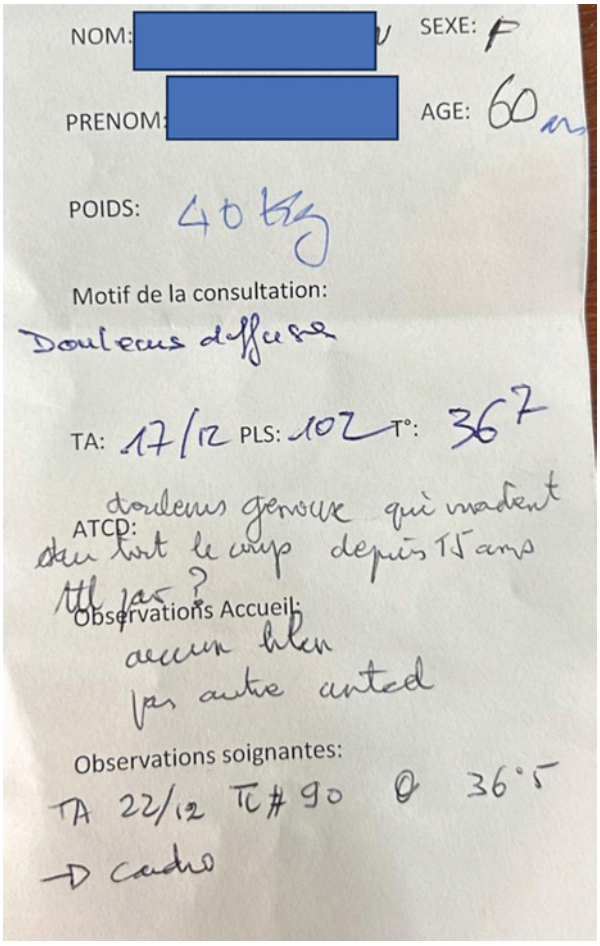
I will conclude my remarks with this thought that inspires me: "Every man is a sacred story. Before birth, the path is already traced; I follow the path that is simply mine; all success comes from within; I bless God for his works." Indeed, whether it is my story with medicine or more specifically with plastic surgery, my encounter with Dr. Helen and pain management, everything is connected and constitutes a testimony that I have the opportunity to give through this document.

Mr Walid Agro, Program Director, Volontaires itinérants Actifs pour le Mieux Etre des populations (Via-Me), Benin

If there is one thing that has always frightened me since I was young whenever I go to the hospital, it is the pain I imagine I will suffer at the hands of doctors and their staff. This is a direct result of the bad experiences I had in the hospital in Benin, after injuries, injections, and especially when I had a double fracture of the fibula and tibia in an accident. Frankly, I was very negatively affected, even traumatized. And this is also the case for many patients.

So you can imagine how happy I was to learn recently that there is pain management training for healthcare professionals. I was even happier when, as Program Director of the VIA-ME Association, I learned that Dr. Helen Makins will be training doctors and other healthcare professionals in pain management during the Volunteer Camp we recently organized in Pobè, one of the most disadvantaged areas of our country, Benin.

During the Volunteer Camp last April in Pobè, I had the opportunity to attend some of Dr. Helen's training sessions. Even though I am not a doctor, I saw the relevance and richness of its content, partly because I firmly believe that this course will contribute significantly to reducing the suffering caused by inappropriate pain management in hospitals in my country. On the other hand, the video testimonials I recorded from the participants prove that, thanks to Dr. Helen, they will now be able to manage pain more effectively in their work. Sodjinou Gérad, a nurse and health centre manager in the municipality of Kétou, said: "Thanks to this training, I can relieve a patient's pain, even if they have no financial resources, with psychological preparation. We were also trained in wound management and healing. In our communities, there is a lot of financial hardship, and with this training, I will be able to wash the wound with soap and water every day until it heals. Frankly, I commend this initiative, which was offered to us free of



Triage form for a typical outpatient, Voluntary Healthcare Camp, Pobè, Benin, April 2025

charge". Dr Hostus Gegbe Yao, a general practitioner, testified: "We were also trained on how to recognize, analyse, and effectively treat pain according to the RAT system. We learned a lot, and I would like to thank the trainers."

The pain management course, is one of the most innovative and impactful activities at Volunteer Camp since it began five years ago, based on what I have seen myself and, above all, on the testimonials of the doctors and other healthcare professionals who have taken it. I therefore hope that we will have the opportunity to have UK support with us every year at the Volunteer Camp for the pain management course to help train our healthcare professionals.

A local doctor, delivering the EPM course, Pobè, Benin, April 2025

The outpatient waiting area, Pobè, Benin, April 2025

Walid Agro, Helen Makins and Odry Agbessi celebrating the end of the Volunteers Healthcare Camp

IASP Global Year website:
https://www.iasp-pain.org/advocacy/global-year/pain-management-research-and-education-in-low-and-middle-income-settings/

Notes

1. Your Donation Doubled for Free | Mercy Ships
2. EPM UK | Faculty of Pain Medicine
3. International | Association of Anaesthetists
4. Essential Pain Management program | ANZCA
5. Essential Pain Management - WFSA

Article

Shaping the future of pain education: call for contributions

Pain News
2025, Vol 23(3-4) 92

The British Pain Society (BPS) is a beacon for advancing the understanding, management and relief of pain. Education is at the core of this mission, and as a multidisciplinary society, we recognise that pain impacts everyone – and that understanding pain is everyone's business – healthcare professionals, academics, patients, the public and students alike. To build a robust, inclusive and accessible education programme, we need your ideas, expertise and passion.

Why pain education matters

Pain is a universal experience, yet it remains misunderstood and often poorly managed. Education can bridge the gap between research, clinical practice, patient and public understanding. By fostering awareness and providing diverse learning opportunities, we can empower all stakeholders to contribute to better pain-management strategies. The BPS aims to develop a pain education programme that reflects the diversity of our multidisciplinary community and the needs of our diverse UK population.

What we've achieved so far

The Society has hosted a range of successful education activities, including workshops, webinars and conferences. These events have featured expert-led discussions on topics such as pain mechanisms, clinical interventions and the psychosocial aspects of living with pain. Special interest groups (SIGs) have also played a vital role in delivering tailored content to professionals and the public.

However, we know there is more to do. Expanding our educational reach requires fresh perspectives, innovative formats and contributions from the entire BPS membership.

Your role in building the future

We are calling on all members, including those in our SIGs, to help shape the next phase of our education programme. Whether you are a clinician, researcher, patient advocate or student, your input is invaluable. For example, you may work with minority populations, underrepresented or disadvantaged groups in society. Here is how you can contribute:

1. Propose new ideas: What topics do you feel are underrepresented in pain education? How can we make education more engaging and accessible? Share your thoughts with us to help identify gaps and opportunities.
2. Offer your expertise: If you have experience or knowledge to share, we encourage you to lead a workshop, webinar or panel discussion. From evidence-based interventions to lived experiences, every perspective enriches the learning experience.
3. Collaborate with SIGs: SIGs are the backbone of the Society's specialised educational content. Join forces with your SIG or explore cross-SIG collaborations to develop unique offerings for a broader audience.
4. Think beyond pain professionals: Pain education is for everyone. How can we better engage patients, caregivers, students and the public? Ideas such as interactive sessions, storytelling or community outreach events are all welcome. Do you work with people with learning disabilities, older minorities, for example, BAME, in unusual clinical settings? We can learn from these.

Our vision for the education programme

The education programme we envision is multidisciplinary, accessible and relevant to diverse audiences. It will include traditional formats, such as conferences and seminars, alongside innovative approaches like e-learning, podcasts and public outreach events. Importantly, it will be designed to foster understanding and collaboration among healthcare professionals, patients and the wider community. We don't know what you need, so this is your opportunity to get involved and promote to needs of the populations you see.

How to get involved

We invite you to share your ideas and offers of support by contacting the BPS Education Committee at info@britishpainsociety.org. Submissions are open to all members and SIGs, and we welcome suggestions from those outside the pain profession who are passionate about pain education.

Together, we can create a programme that not only informs but inspires, ensuring that pain education remains at the forefront of improving lives. Let's work together to make pain education a shared journey of discovery and impact.

Article

Pain Medicine in New Zealand

Pain News
2025, Vol 23(3-4) 93–95

A personal reflection on leaving the NHS and relocating to New Zealand in 2022

In April 2020, just 1 month into the first national lockdown of the COVID-19 pandemic, my wife and I found ourselves reflecting on our future in the United Kingdom. We felt increasingly disillusioned, not only by the political direction the country had taken following the 2016 Brexit referendum and the leadership of then Prime Minister Boris Johnson, but also by the broader handling of the pandemic.

As a German national, I had already felt a growing sense of uncertainty about my place in the United Kingdom after its decision to leave the European Union. Therefore, I obtained dual citizenship as a British citizen in 2019. Early in 2020, as COVID-19 began to unfold, a colleague and I attempted to engage with the management at my base hospital, East Surrey Hospital of the Surrey and Sussex Healthcare NHS Trust. At the time, the hospital was led by a CEO who had notably transformed it from one of the country's lowest-rated hospitals to one with an excellent CQC rating between 2010 and 2020. Unfortunately, our requests to meet and discuss preparedness for the pandemic went unanswered. There was a marked lack of engagement, leading to delays in suspending elective services and inadequate preparation for the surge of COVID-19 patients. This resulted in shortages of personal protective equipment (PPE), intensive care capacity, ventilators and testing facilities.

These challenges compounded the existing pressures of increasing workload demands, limited family time and financial strain. Amid this environment, a colleague in my anaesthetics department shared a job listing from Global Medics, an agency recruiting doctors for positions in New Zealand. The idea of practising medicine in a country known for its natural beauty, temperate climate and emphasis on work–life balance was immediately appealing. My wife and I exchanged a knowing look: we were ready for a change. The following day, I contacted the agency to express my interest.

What followed was a protracted process lasting over 2 years, from initial inquiry to eventual relocation. A significant obstacle came when my hospital initially refused my application for a 1-year sabbatical, despite my 8 years of service as an anaesthetist and pain specialist. The reasoning was to secure a replacement pain specialist to 'ensure continuity of care', with an approach focused largely on meeting national referral targets mainly based on the old-fashioned biomedical service model. As clinical lead of the pain department, I accepted this decision and supported the recruitment of a suitable successor. I then submitted a revised application for a 2-year sabbatical, which was finally approved in February 2022.

This experience has highlighted the profound personal and professional impact that national policies, institutional constraints and the management of global health emergencies can have on individual clinicians. It has also reinforced the importance of remaining open to change, irrespective of age, professional standing or circumstance – and how, at times, embracing uncertainty can lead to a more sustainable and fulfilling path forward.

Since April 2020, I had remained in contact with the job agency Global Medics as we gathered information about the immigration process and employment opportunities in New Zealand. In 2021, we also began arranging insurance, mortgage adjustments to rent out our house in England and drafting our wills to provide for our 4-year-old son and my two adult sons from a previous marriage. Having never travelled beyond Europe and Turkey in my life, the prospect of relocating to the other side of the world was daunting but exciting.

I remain deeply grateful for the opportunity to live and work in the United Kingdom for 18 years, having grown up in East Germany behind the iron curtain and served in the army under Russian control when the Berlin Wall fell. Encouragingly, even my 79-year-old mother in Germany supported our decision to relocate to New Zealand, and we arranged flights for her and my eldest son to visit us over Christmas 2022.

Job and visa application, finances and relocation logistics

The job application process in 2022 was, overall, relatively straightforward. On the advice of Global Medics, the agency facilitating my job application, I initially focused my search on smaller district hospitals in New Zealand rather than larger tertiary centres. My first application was submitted through the agency, and in May 2022, I attended my first interview via video link with Lakes District Health Board (DHB) in Rotorua, located on the North Island. My interview was successful, and I was offered a consultant position in anaesthesia, obstetric anaesthesia, critical care and acute pain medicine.

While financial considerations were not the primary motivation behind our move, I was pleasantly surprised by the remuneration package. The offered base salary was approximately 1.5 times my NHS salary in the United Kingdom. My full-time role at Rotorua Hospital involves six clinical sessions (28 hours per week) and 12 hours of non-clinical (administrative) time. On-call duties, including nights, weekends and public holidays, are remunerated separately at excellent fee-for-service rates, comparable to UK waiting list initiative tariffs.

Despite the job offer being secured in May 2022, it took a further 6 months before I was able to commence work at Lakes DHB in November 2022. The validation of qualifications and visa processing proved both time-consuming and costly. Fortunately, the relocation expenses, amounting to approximately GBP 10,000, were reimbursed by Lakes DHB as part of my 2-year contract. In addition, the hospital provided a courtesy car and 4 weeks' accommodation upon arrival.

From 2020 to 2022, my wife and I saved around GBP 20,000 to cover anticipated relocation expenses, including registration fees, interviews, shipping essential household items and bicycles, visa applications, initial accommodation and a 5-week holiday upon arrival. This holiday included 3 weeks travelling in a motorhome to explore the country and familiarise ourselves with New Zealand's rich natural landscapes, culture and the traditions of the indigenous Māori population (New Zealand's two largest ethnic groups being approximately 68% European and 19.5% Māori).

Lakes DHB itself is a medium-sized district hospital with approximately 230 beds, situated in the centre of Rotorua – a city of 60,000 people in the heart of the North Island, renowned for its outdoor recreation opportunities, world-class mountain biking trails, towering sequoia forests, geothermal spas and pools, lakeside and volcanic landscapes.

The registration of my medical qualifications, including my primary medical degree and approbation in Germany, my research MD in Germany and The Netherlands, and anaesthesia and pain medicine fellowships in the United Kingdom, through the American-based EPIC platform took about 2 months. Delays occurred primarily due to response times from my former university in Jena, Germany. This was followed by my provisional vocational registration with the MCNZ, including supervision and induction arrangements in anaesthesia. In May 2023, I successfully completed the requirements to obtain a full vocational scope of practice in anaesthesia, allowing me to practise independently in any hospital or healthcare institution in New Zealand.

The visa application process presented its own challenges. New Zealand's visa regulations were undergoing changes in 2022, and the application appeared complicated. On advice from Global Medics, we engaged an immigration advisor based in Wellington. To enable me to start work in November 2022, we initially applied for a Critical Purpose Visitor Visa, which was approved within 4–6 weeks for a duration of 12 months. In hindsight, applying directly for a 2-year work visa might have been a more practical option, as the visitor visa classification created complications when renting accommodation and during routine border checks. However, my wife's national security check took approximately 9 months for the 2-year work

and residence visa as a Turkish citizen, significantly longer than the expected 6–12 weeks. Fortunately, we applied for the 2-year residence visa immediately upon arrival in New Zealand, which enabled a seamless extension of our initial visa to a 2-year residency visa by 2023.

Financial overview of relocation costs

The total expenses incurred prior to commencing employment in New Zealand included:

Expense	NZD	GBP
EPIC verification of qualifications	1,200	640
Visa applications (Critical Purpose, medical, resident)	7,500	4,100
Relocation shipping costs	7,000	3,600
Flights for three people	7,700	4,000
Medical Council application (anaesthesia)	4,260	2,270
Final MCNZ registration and annual fee	930	480
ANZCA preliminary advice	2,060	1,110

Approximately 90% of these costs were reimbursed through an allocated relocation budget of NZD 20,000, with additional medical registration expenses covered separately by my employer.

Post-arrival, further professional expenses incurred

Expense	NZD	GBP
ANZCA anaesthesia fellowship interview fee	4,850	2,500
Anaesthesia Assessment Day	10,500	5,000
Medical Council application (pain medicine)	4,460	2,300
ANZCA Pain Medicine interview fee	4,800	2,500
Pain Medicine Assessment Day	11,500	5,100

These fees – totalling approximately NZD 36,110 (GBP 17,400) – were also reimbursed by my base hospital in Rotorua and QE Health.

Article

Resources for anaesthetists acting as expert witnesses

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Pain News
2025, Vol 23(3-4) 96–103

Sage

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The administration of justice and official inquiries into healthcare often rely on assistance from doctors performing what a 19th century medical ethicist described as 'the offices, required from them as citizens qualified with professional knowledge'.[1] Providing assistance as medical experts to courts, tribunals and inquiries requires doctors to achieve and maintain high standards of ethical and professional practice. Anaesthetists fulfilling this role have an important resource in the Association of Anaesthetists' *Medico-legal practice in anaesthesia: a guide on how to get started as an expert witness* (https://anaesthetists.org/Home/Resources-publications/Guidelines/Medico-legal-practice-in-anaesthesia-a-guide-on-how-to-get-started-as-an-expert-witness). The purpose of this article is to bring to the attention of anaesthetists three further resources that can assist them in the expert witness role and to draw from them some guidance as to expert medical witness practice.

Multisource feedback on expert practice

In his 2011 Macfadyen Lecture, The Honourable Thomas A. Cromwell, former Puisne Justice on the Supreme Court of Canada, said:[2]

> *Clear professional standards, appropriate training, credentialing and quality control for expert witnesses have the potential to address more directly the sorts of problems that arise from the evidence of unqualified, careless, overworked or even unscrupulous experts.*

The General Medical Council in *Good Medical Practice*, para. 13, states:[3]

> *You must take steps to monitor, maintain, develop, and improve your performance and the quality of your work.*

One quality control tool is feedback. Although judges sometimes include criticism of experts in judgements, positive feedback is less common, and in many cases, experts receive no feedback at all, including in the Family Court where a practice direction requires it. 'Multisource Assessment of Expert Practice' (MAEP), modelled on the multisource feedback tool used by the GMC, and now the Medical Practitioners Tribunal Service, for chairs and members of the fitness to practise panels, and then developed for psychiatrists and psychologists, is a system that can be used by any medical or other healthcare expert, whatever their specialty, for anonymously obtaining and collating feedback (and comparing their performance with that of other experts who have registered for MAEP). Multisource Assessment of Expert Practice is an interactive guide to MAEP. The latest GMC expert witness guidance *Providing witness statements or expert evidence as part of legal proceedings* (PWSEE)[4] lists MAEP as a resource:

> *Royal College of Psychiatrists: Multi-source Assessment of Expert Practice. RC Psych online tool. For experts in all specialisms to collect feedback for appraisal and revalidation.*

If reporting in a Family Court case, '*Standards for Expert Witnesses in Children Proceedings in the Family Court* (Annex to FPR Practice Direction 25B – The Duties of an Expert, the Expert's Report and Arrangements for an Expert to Attend Court)[5]' includes as Standard 9: 'The expert has undertaken [. . .] quality assurance activity – including *actively* seeking feedback from cases in which they have provided evidence' (emphasis added). What is a requirement in one jurisdiction is often regarded as good practice in other jurisdictions.

The feedback can be used to guide professional development and learning, such as a personal development plan or a programme of continuous professional development, and shared with a peer group so as to support professional and personal development. It can be submitted as evidence at the annual appraisal which informs the responsible officer's recommendation to the GMC as to the doctor's revalidation and relicensing and having regard to the GMC's requirement that 'where you hold a licence to practise, your full scope of practice must be covered in your appraisals and the revalidation process' (PWSEE, para. 34).

An expert may choose to disclose the results to potential instructing lawyers if they ask for evidence as to the expert's competence. The mere fact of being registered for, and using, MAEP, included in a CV and included with details of the expert's qualifications, training and experience in a report, can indicate to potential instructing lawyers, their clients and readers of their reports how seriously the expert takes their responsibility to monitor their expert witness practice. So, experts can make explicit their commitment to quality assurance, and in family cases achievement of Standard 7, by including in their CV a sentence to the effect:

> *For quality assurance, I use 'Multi-source Assessment of Expert Practice' actively to seek feedback from cases for which I have provided evidence.*

Medical experts registered for MAEP, when a case is concluded, using or adapting an email template, can contact those from whom feedback is sought and indicate that they will be invited to provide anonymous feedback by completing a short, online questionnaire. It takes only a few minutes to complete. Feedback can be sought from the instructing lawyer, the instructing party's counsel, the adverse party or parties' lawyers and counsel, other experts, including the expert or experts instructed by the adverse party or parties and, if the case proceeds to a hearing or trial, the judge or tribunal chair. In order to receive feedback on a specific case, responses have to be received from at least two, preferably four respondents. Where only one response is received, this contributes only to the cumulative feedback. Thus, experts can accumulate reports on individual cases and also periodical cumulative reports.

Feedback is provided on up to eight domains of expert witness practice:

- Professionalism
- Ethics
- Skills
- Reliability of opinion
- Presentation of opinion/report
- Understanding of law, procedure and rules of evidence
- Oral testimony
- Business manners and affairs

For each domain, there are examples of 'negative' and 'positive' features to guide respondents. On each domain, the expert is rated between 1 (extremely unsatisfactory) and 6 (excels at standards). Results are summarised in a 'radar chart' and also presented in tabular form where they are compared with the expert's self-rating (and the mean scores for the other experts who are registered with MAEP). Respondents can also provide 'free text' comments as to 'What you like about this expert's practice', 'What you do not like about this expert's practice' and 'What you would like this expert to do in order to improve their practice'.

My own experience illustrates the importance of anonymous feedback. Not until I started using MAEP did I receive critical but constructive feedback from which I would have benefitted over the previous 30 years.

Case-based discussion of expert evidence

Medical experts often tread a lonely furrow, and this is partly because peer review or case-based discussion of live cases, valuable as it can be, is fraught with difficulties. An expert must disclose the fact and nature of any discussion of 'the content of a proposed report in detail with another expert under a peer review arrangement' (*Pinkus v Direct Line Group* (2018) 1 WLUK 3). This only applies where the peer provides 'constructive input', and it does not apply to proofreading, but such disclosure risks questions as to whose opinion it is and how competent the expert is if they have relied on a colleague's assistance. It is permissible for an expert to research a topic to enhance their existing expertise by obtaining 'the views of others, including work colleagues, so long as he records where he went for that advice' (*R v Pabon* (2018) EWCA Crim 420). In *OXR v Mid and South Essex Hospital NHS Foundation Trust* [2023] EWHC 2006 (KB) an ear, nose and throat surgeon was

judged to be 'vulnerable to challenge on the grounds that he had sought the views of unidentified colleagues and allowed them to inform his opinion on breach of duty'.

Many fewer difficulties arise in a case-based discussion of an expert witness case that takes place after the case has concluded. This is the system that was developed at The Grange Consulting Rooms, Cleckheaton, West Yorkshire.[6] An even number of experts are randomly paired twice, but without the same two experts being paired together twice. The first-named expert in each pair provides the second-named expert with a copy of a report along with usually nothing more than the letter of instruction. Choice of the report can be delegated to the expert's personal assistant who is asked to select a case randomly. At the peer review meeting, scheduled for 2 hours, each expert spends an hour providing a critique of the other expert's report and an hour being provided with a critique of their own report.

The results of the discussion are set out on an evaluation form that allows the expert and their report to be rated on the following items:

- Within the doctor's expertise;
- Evidence of consent where appropriate;
- Acceptable structure and properly presented;
- 'User-friendly';
- Compliance with relevant rules;
- Methodology explained and includes such information as the court may need;
- Whether the opinion is sufficiently reliable to be admissible;
- Knowledge, understanding and correct application of legal tests;
- Facts and opinions clearly separated;
- Issues addressed;
- Evaluation of quality of evidence/clinical veracity;
- Opinions supported by reasons and withstand logical analysis;
- Includes range of reasonable opinion;
- Summary of opinion/conclusions;
- Glossary (if applicable)/terms explained;
- Evidence of independence and impartiality;
- Expedition at all stages, particularly achieving all deadlines;
- Probity (terms and conditions, record of time spent, detailed, itemised billing).

Some items are rated on a three-point scale: 'Requires attention/improvement' – 'Adequate' – 'An example to others'. For others, it is a two-point scale. For example, it is or it is not within their expertise.

This is a formative experience with emphasis on improvement and the pursuit of excellence. It is not a pass/fail test. The free text section of the form begins with 'Good practice'; it starts with the most positive and affirming outcome. It then moves on to: 'Suggestions for improved practice'. When these sessions are incorporated into a conference with a plenary session, or followed by an experts' meeting, examples of good practice can be collated and difficulties discussed. However, the content of the discussions is confidential between the evaluator and the evaluee. The forms are signed by both the evaluator and the evaluee.

A copy of the form can be obtained from the author (ProfessorKeith.Rix@2drj.com). A modified version of the form has been adopted for use in appraisals carried out by the Independent Doctors Federation.

The expert healthcare witness matters newsletter

The Royal College of Psychiatrists now sends out a free monthly newsletter for all healthcare experts. It began as a monthly newsletter for psychiatrists and psychologists and as a quarterly newsletter for members of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians (https://www.rcpsych.ac.uk/improving-care/ccqi/multi-source-feedback/maep/maep-newsletter-resources). It now aims to meet the needs of all healthcare experts.

Its regular features include the following:

- Experts of the month
- Book or quote of the month
- Charity of the month
- Conferences and training events
- Summaries of judgements
- General interest (all experts)
- Specialty matters

Items specific to one or more specialties are listed alphabetically (and alphabetically by specialty if relevant to more than one specialty) and hyperlinked from the contents page. For example, in December 2024, there was an item 'A case for trainees' about *Re CC (Fact Finding: Head Injury)* [2024] EWFC 317 (B) on subdural haematoma dating which was listed under 'Neurosurgery, Paediatrics and Radiology', thus enabling a radiologist to click and go directly to this item.

The same approach is taken to organising items that relate to a specific legal jurisdiction, such as 'Criminal', 'Immigration and asylum', 'Personal injury', etc.

Table 1. Expert anaesthetist and pain experts of the months.

"I find the analysis of Dr Simpson, based on her very considerable experience, persuasive, focussing as it does on the symptoms and signs which led the claimant to decide to undergo amputation. Dr Simpson was able, in my judgment, to disentangle the symptoms and their causes."
HHJ Dight CBE in *Tuffin v University Hospitals Coventry and Warwickshire NHS Trust* [2024] EWHC 3318 (KB)
"Dr Valentine [. . .] was a thoughtful, careful witness who was unshaken in cross-examination."
HHJ Melissa Clarke, sitting as a Judge of the High Court, in *Wilson v Ministry of Justice* [2024] EWHC 2389 (KB)
"I found Dr Munglani to be an impressive expert who was willing to be flexible of mind and whose evidence did evolve over the course of his journey from report to witness box."
HHJ Glen in *De Francisci v Hampshire Hospitals NHS Foundation Trust* (County Court, Basingstoke sitting at Southampton, 9 May 2024) Case No: F16YM828

Occasionally, items refer to a document that subscribers might want to adopt or adapt for their own purposes, such as a consent form for medicolegal assessment, or to which they might want to refer in the future. Links are provided to these.

Occasionally, the newsletter has had a leading article written by a guest contributor. Professor John Gall, who is the Expert Witness Lead of the FFLM and has experience as an expert witness in Australia and New Zealand, contributed an article in which he reflected on some of the lessons learned in those jurisdictions.

Experts of the month

Particularly because some of the judgements considered in the newsletter, or summarised in the annual compendia of summaries of judgements, accessible by a link in the newsletter, include criticisms of experts (who are anonymised), the newsletter starts on a positive note with a list of healthcare experts about whom judges have made positive comments. In Table 1 are examples of anaesthetic and pain management experts whose practice has been commended.

Book or quote of the month

Some months, there is a review of a book of interest to healthcare experts. Most have been recently published books, such as *A Brief Clinician's Guide to the Coroner's Court and Inquests*, edited by Gabrielle Pendlebury and Derek Tracy (Cambridge University Press). In the absence of a book review, we have recently been using quotations from the fictional *A Trial in Three Acts* by Guy Morpuss KC (Viper, 2025). They have included:

If I want a judge to know that they're being pig-headed and stupid, my submissions start 'with respect'. If I want them to know that they've come out with a legal proposition that would make even the dumbest first-year student blush then I say, 'with great respect'.

Charity of the month

The rationale for having a nominated charity of the month is that the newsletter, and its related resources, are provided free of charge. That is a condition on which it is written. If subscribers appreciate it, they are asked to consider making a donation to the nominated charity at least occasionally. Nominated charities have included INQUEST, CRISIS, Action *against* Medical Accidents, the Legal Afghan Working Group, Hundred Families, Inside Justice, the Access to Justice Foundation and the Clink charity.

Summaries of judgements

The summaries of judgements in the annual compendia have three primary purposes: (a) to enable healthcare experts to keep up to date with the constantly changing legal context in which they offer their assistance; (b) where appropriate, to learn from case law how best to communicate their knowledge and understanding so as to assist courts and tribunals on particular matters within their expertise and (c) to illustrate how cases are decided when particular medicolegal issues arise.

Table 2 shows the format for the listing of recent judgements.

In the compendia of summaries of judgements, each summary begins with 'Headline', 'Relevance' and 'Key terms', as in Table 2, followed by a 'Commentary' and then 'Learning points' before setting out the summary of the case. The learning points are set out separately as 'General' and 'Specific' (to the specialty/ies) so that non-specialists can have regard to the learning points of general application without reading the summary of the judgement. They represent a best effort at distilling key practice points from the judgement.

Table 2. The format for the listing of recent judgements.

Case	Relevance	Key terms	Headline
Tuffin v University Hospitals Coventry and Warwickshire NHS Trust [2024] EWHC 3318 (KB)	Orthopaedics Pain medicine Spinal surgery Vascular surgery	allodynia, Budapest criteria, causation, complex regional pain syndrome, deep vein thrombosis, post-thrombotic syndrome, spinal surgery	Complex regional pain syndrome or post-thrombotic syndrome?

Many of the learning points arise from judicial criticism of experts. Table 3 shows aspects of medical expert witness practice which have been repeatedly criticised by judges since 2021 based on judgements reported by the British and Irish Legal Information Institute. They are listed in descending order from the most frequent to the least frequent instances, and although the absolute numbers are too small for any formal statistical analysis, it is significant that so many instances of 'malpractice' are in the double figures and what might be regarded as one of the most fundamental aspects of the expert's role tops the list. The evidence of an expert may assist little or not at all if the court cannot understand, critically analyse and test the process of the expert's reasoning. With the exception of criticisms about the use of medical literature, the criticisms otherwise appear to be much the same as those made of experts in general.

Most of the criticised aspects of expert practice are self-explanatory. Some benefit from further comment. The expert's language is an issue both in relation to the report and also oral testimony. As sometimes reports are prepared within a tight timescale, with an unavoidable degree of haste, it is a good idea to sleep on a report and then check it in the cold light of day. As to language in the witness box, once it is said, it is on record. The most common criticisms are of experts being defensive and argumentative, which may be read as partiality. Impartiality may also be called into question by the use of language such as 'we' and 'us', by referring to previous cases 'won', by expressing hope that the instructing party will 'win' its case and by referring to 'representing' the subject or their instructing party. Given the general expectation and, in many jurisdictions, the requirement that experts should set out any range of opinion, it is disappointing that so often failure to do so should result in judicial criticism. Before the disclosure of the report of the adverse party's expert and the experts' meeting, it ought to be possible to anticipate their opinion. Only to acknowledge their reasonable opinion at the experts' meeting, or worse still, in cross-examination, calls into question the knowledge and impartiality of the expert. If the case were to be presented at a team meeting, what would be the alternative opinion of your reasonable colleagues be? And if one of your unreasonable colleagues might have an opinion, are you able to explain why it is not in the range of reasonable opinion?

What is not clear from this table is that a common factor connects a number of these aspects of expert practice. There is much more to being a medical expert witness than providing an expert report and, in a minority of cases, turning up to court to give oral testimony. Acting as a medical expert witness is best regarded as a *process*, and 'justice will be best served if there is a close collaboration between healthcare specialist and lawyer from as soon as the need for expert evidence is appreciated and thereafter through the litigation process'.[7] Such collaboration includes, but is not limited to, negotiation of instructions; clarification of instructions, issues and the expert's field of expertise; making sure that the expert understands and applies appropriately any legal test; keeping the expert informed of developments with witness evidence, including other expert evidence and ensuring that, if necessary, the expert's own evidence is updated; ensuring the report complies with procedural rules and that the opinions are satisfactorily explained; identification by the expert of any missing evidence, particularly medical records; ensuring that the expert's sources are cited and cross-referenced sufficiently for the court readily to identify and locate the facts on which the expert is relying and ensuring that the expert is aware during the trial of procedural or evidential developments, which may include a requirement for the expert to hear evidence or consider transcripts thereof.

Table 4 shows the anaesthetic and pain management cases that have been included in the annual compendia of judgements and news items since 2021.

Subscribers also have access by a link from the newsletter to a list of judgements in which medical literature is cited or analysed along with the full bibliographic citations for the

Table 3. Aspects of medical expert witness practice which have been repeatedly criticised by judges (in descending order from the most frequent to the least frequent instances).

Criticised practice	Principle/rule/precept	Frequency
Reasons absent; reasoning unclear, lacking in logic or lacking in cogency	Deductive reasoning	27
Misuse of literature: selective citation; misrepresentation; inappropriate; misapplication; questionable methodology; disregard or misunderstanding of limitations; misunderstanding or disregard of statistics; unreliable or questionable source (industry publications; not peer-reviewed).	Thoroughness Impartiality	25
Carelessness and haste: mistakes.	Accuracy	22
No triangulation with medical records and/or other evidence; taking subject's account at face value	Corroboration	20
Not keeping up with evidence: as case unfolds before trial and as evidence evolves in trial, a failure to reconsider opinions.	Evidence-based reasoning	18
Language: emotive; unprofessional; trenchant; defensive; disrespectful	Forensic language	17
Introduction of evidence too late to be considered by other experts and sufficiently tested by the court	Fairness	16
Instructions/issues: failure to set out substance of all material instructions; failure to comply with instructions; failure to address all issues; addressing what are not issues.	Compliance (with instructions) Transparency	16
Procedural rules and guidance: failure to set out required declaration of compliance and statement of truth; failure to comply in letter; failure to comply in spirit.	Compliance (with procedural rules) Duty to the court	14
Identification with, and advocacy for, instructing party	Impartiality Duty to the court	14
Inadequate referencing	Citation	13
Range of opinion: none, only emerging at experts' meeting or cross-examination	Range of opinion	11
Ignorance or misunderstanding of legal test	Compliance (to the law)	11
Disregard of, or challenge to, previous factual findings	Respect for prior findings	11
Outside expertise	Circle of competence	9
Failure to refer to evidence that undermines opinion	Impartiality	9
Unwillingness to make reasonable concessions	Open-mindedness	9
Guidelines: misuse	Guideline appraisal	8
Criticising other experts	Respect	6
Dishonesty	Honesty	4

literature analysed. These judgements include *Suresh v General Medical Council* [2025] EWHC 804 (KB) in which the court considered:

> *Plunkett E, Costello A, Yentis SM, Hawton K. Suicide in anaesthetists: A systematic review. Anaesthesia. 2021 Oct;76(10):1392–1403.*

Another link is to a list of judgements that can be used in the education and training of practitioners or expert witnesses.

General interest (all experts)

General interest items frequently include cases of general interest of which there is no summary in the compendia as well as other items of interest to all experts. The July 2025 issue included: an item about, and a link to, the 2024 Macfadyen 2024 lecture 'Evaluating the Expert Witness in the Modern Legal Landscape' delivered by The Right Honourable Dame Siobhan Keegan, the Lady Chief Justice of Northern Ireland; *The Guardian* article on Monday 16 June in which Mr David Sellu referred to expert witnesses as the weakest link in the

Table 4. Anaesthesia and pain management cases that have been included in the annual compendia of summaries of judgements and news items since 2021.

Citation	Nature of case
Palmer v Mantas [2022] EWHC 90 (QB)	Chronic pain
Scarcliffe v Brampton Valley Gp Ltd [2023] EWHC 1565 (KB)	Dangers of a hastily prepared addendum
O'Donovan v Cork County Council (Rev2) [2024] IEHC 33	Chronic regional pain syndrome
O' Sullivan v Ryan [2024] IEHC 326	Pain management
Norney v Watt [2024] NIKB 78	Consent for blood patch procedure
Tynan v Bon Secours Health System Company Ltd by Guarantee [2025] IEHC 81	Pacemaker insertion
Suresh v General Medical Council [2025] EWHC 804 (KB)	Regulatory investigation and suicide risk
De Francisci v Hampshire Hospitals NHS Foundation Trust (County Court, Basingstoke sitting at Southampton, 9 May 2024) Case No: F16YM828	Chronic pain syndrome
Rezmuves v Birney [2024] IEHC 592	Spinal cord stimulator
Wilson v Ministry of Justice [2024] EWHC 2389 (KB)	Pain management programme
Winterbotham v Shahrak (Rev1) [2024] EWHC 2633 (KB)	Treatment for chronic post-surgical pain
Tuffin v University Hospitals Coventry and Warwickshire NHS Trust [2024] EWHC 3318 (KB)	Complex regional pain syndrome or post-thrombotic syndrome?
Keane v Johnson & Johnson Vision Care [Ireland] [2025] IEHC 216	SLAP lesion – traumatic or degenerative

English justice system; unregulated experts; re-traumatising claimants in medicolegal litigation; capacity, consent and GDPR; cost of treatment in personal injury litigation; challenging the conclusions of single joint experts/court-appointed experts and giving evidence from abroad. There are often items on fees, and in July 2025, it was 'Guidance on the Remuneration of Expert Witnesses in Family Cases'.

Items specific to a particular geographical jurisdiction are grouped accordingly. The newsletter has subscribers from all the largest geographical jurisdictions in the British Isles. Some jurisdictions rely on medical experts from outside the jurisdiction, so, for example, items in the Ireland section may be relevant not only to medical experts in Ireland but also to medical experts from outside Ireland who have to provide evidence to a jurisdiction with different statutes, laws and procedures to that for which they usually provide expert evidence. The July 2025 issue included an item 'The standard of approach' about the law of negligence in the Republic of Ireland arising out of *AMS v Birthistle* [2025] IEHC 331.

And it's not all serious

Occasional news items and quotations from judgements are light-hearted and not least items in the April newsletters. Last year, the April fools were the ones taken in by an article about the announcement of an award by the Judicial College for the longest expert report to have been presented by the Lady Chief Justice. The prize was a scale model of *The Ikarian Reefer* (*National Justice Compania Naviera SA v Prudential Assurance Co. Ltd (The Ikarian Reefer) (No. 1)* [1993] 2 Lloyd's Rep 6), 1 of only 250 models manufactured for the owners by model makers Britains, and of which the last one had been offered for sale by Vectis Auctions (Collectibles Specialists) on 5 December 2017. The winner, announced in the May issue, was Dr T.O.O. Long. A diligent reader could have discovered that no such model was offered for sale by Vectis Auctions. Britains never manufactured a model of the vessel that ran aground and caught fire, leading to its abandonment off the coast of Sierra Leone, and resulting in the marine insurance claim and case in which what are known as the Ikarian Reefer rules or the Ikarian Reefer principles for expert witness practice were established.

Conclusions

Expert witnesses and their practices are often subject to public scrutiny and comment; some of it adverse, and some inappropriately so. Challenges in the near future, possibly resulting from an assessment of the conduct of experts in the prosecution by the Post Office of sub-postmasters and sub-postmistresses, may include proposals for the accreditation and better regulation of expert witnesses and mandatory training. If this happens, the Royal Institute of Chartered Surveyors will already be ahead of the game, as will be experts who have achieved accredited status with The Academy of Experts or certified status with the Expert Witness Institute.

Healthcare experts have much to learn from each other and can do much to support each other in what is often a demanding form of public service. Participation in multisource feedback, peer review of cases, peer support and utilisation of publications such as the Expert Healthcare Witness Matters Newsletter can assist in raising the profile of the ethical and responsible expert healthcare witness and preparing healthcare experts for the challenges ahead.

Conflict of Interest

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

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Article

The Ferret Walker

Pain News
2025, Vol 23(3-4) 104–106

As a doctor I have found that you can't help having feelings for your patients. It may be a professional relationship but it's still a relationship. Some patients you hate, some irritate you, some engender lustful feelings and inevitably, some you develop great affection for. The best doctors can park the unhelpful feelings and channel the others to work for the patient's good. But it's a tightrope walk. Me? Well, anger has got me into trouble countless times. Lust has been easy to bat away because the consequences of acting on that are so career-threatening. Affection is the difficult one. I tell myself I can channel it and make it work for the patient's good. But can I really?

Alison referred to Tony as the love of her life. But it wasn't until some years after his death, possibly not until after she remarried, that I first heard her describe him in that way. It surprised me as I had considered them an odd match. Alison was warm, bubbly and tactile; every consultation with her seemed to involve tears – tears of joy, of sadness or sometimes . . . just random tears. Tony, on the other hand, was aloof and unemotional, and I couldn't gel with him. He died of stomach cancer in his early forties. He presented late and died a few weeks after coming to see me with a 6-month history of weight loss and abdominal pain.

I think, looking back, I definitely had a soft spot for Alison. I wasn't physically attracted to her, but if I saw her name on my list for that morning, I could sense my mood lift, and the day take on a brighter note. I told myself that my feelings wouldn't influence my care for her because they would never be acted upon.

Alison's emotions were expressed unfiltered and in such a way that I, and I suspect any listener with a beating emotional heart, would be immediately transported into her world and live her life vicariously with her. Although Alison was willing to share her generous heart with anyone, she reserved her amorous love for just one person. When she told me, a few years after Tony died, that she was remarrying, I considered Pete to be a very lucky guy. He was much older than she was, 60, to her 45. I had known him for 20 years as a patient, and I liked him. Pete was friendly, self-deprecatingly funny and finished most sentences with an infectious chuckle, quite different from Tony who I'd never seen smile, let alone laugh.

Pete took semi-retirement after marrying and got a 2-day per week job driving cars on and off the auction floor at a local auctioneers. Alison carried on working full-time as a carer in one of the many Canterford residential homes. They lived in the north of Canterford, at the foot of the Downs where Pete walked his ferrets most days through paths and woods he had known since boyhood. Other than that, he spent his time doing odd jobs for neighbours and friends. He was a practical man who could turn his hand to pretty much any plumbing, electrical or mechanical problem and was in great demand from his elderly neighbours. He never charged but would accept a fiver, if offered, for a pint. If Alison was doing a late shift at the residential home, he would spend the evening in the pub and then meet her at her finishing time and walk her home.

At a routine blood pressure check a few months after marrying Alison, I asked Pete how things were going. He told me he was happier than he felt he had any right to be. His only concern was their age difference – he didn't want Alison to end up as his carer, that would be a busman's holiday for her he said, chuckling.

'*Oh, and Dr J*', he added, unprompted by me, '*Our sex life is great. I really thought that part of my life was over, but, you know, it's better than it's ever been*'.

'*Well*'. I said, '*I'm very happy for you. I've known Alison a long time and I think she's a very special lady. I'm jealous*'.

Pete pointed at me. '*I'll tell her you said that; it'll make her day*'. He chuckled, and I couldn't help but join in.

So, I was frankly very surprised when Alison revealed to me, a year or so later, that all was not well with their marriage.

'*He's not a soulmate, not like Tony*'. She explained, in a consultation about her ailing interest in sex. I was trying to establish whether this was attributable to the menopause or relationship issues.

Alison had told me previously that Pete had taken care of her in the dark days after Tony's death. He lived a few doors away, and he performed errands for her, left foil-wrapped meals on her door-step and turned up in his car to take her home from the residential home when it was raining.

'*I'd imagined you were very much in love?*' I replied. '*You seem so well suited?*'

Alison shook her head. '*Pete's been very kind to me, don't get me wrong, but I think I mistook my feelings of gratitude for feelings of love*'.

To have been a recipient of Alison's unconditional love and then feel it slowly slip through your fingers must be one of life' s worst experiences. I thought. Did Pete realise? Poor man, if he did.

Pete described himself as a 'what-you-see-is-what-you-get' guy: he didn't do subtlety; he didn't think through the consequences of his actions in a calculated way, and he considered the female species to be altogether different from the male species – in a mysteriously lovely way but also in an incomprehensible way. Trying to understand females, in Petes' eyes, was like trying to understand particle physics or string theory. Pete was gallant, thoughtful, protective and chivalrous, but I began to see, he could not be a soulmate in the way that Alison wanted. You can't have a deep emotional connection with another person if that person can't begin to comprehend your thought processes.

So, having initially thought she was in love with Pete, Alison slowly realised she wasn't, and then his previously charming eccentricities became more and more irritating, and his kind actions became more and more suffocating.

Pete appeared blissfully unaware of all of this, or to be more accurate, he was vaguely aware of a change in Alison but unaware of the underlying cause. His mates in the pub, when he revealed to them that Alison was not as affectionate as she had been, suggested it must be the menopause. Alison was happy to let Pete believe that and didn't want to reveal the truth to him.

I suggested relationship counselling, but that was batted away.

'*What? Pete talk about his feelings? You're kidding me!*'

I don't know if Alison was planning some kind of decisive action to remedy her marital unhappiness, but if she was, it was sidelined by a sequence of events that were out of her control. She received a complaint at work. It was totally unjustified but, for someone like Alison, whose sense of self-worth was irrevocably entwined with her caring role, it was devastating. Even more so because her cowardly manager did not take her side. This had Pete storming into the manager's office and telling him that he could stick Alison's underpaid, underappreciated job where the sun doesn't shine. A week later, Pete was mowing his front lawn, and he watched a group of teenage boys deliberately key the door of a neighbour's parked car. He got in the face of the boy who seemed to be the leader and demanded his name and address. The boy, who was a head taller and surrounded by his mates, laughed and gently pushed Pete away. Pete grabbed the boys arm and twisted it up behind his back. One of the others punched Pete in the side of the neck causing him to release his grip and the boys ran off.

Alison brought Pete to see me the next day. He had a stiff neck and sat down very gingerly.

'*He's sixty-one years old, Dr Johnson. Please tell him he cannot be squaring up to a gang of teenage boys'.*

'Well someone needs to, love, or they'll just carry on running riot'. Pete chuckled.

'Well it doesn't have to be you, Pete'. Alison snapped back. *'Especially as now you're the only breadwinner in our house after you quit my job for me'.*

Pete looked sheepish, and I then remembered Alison telling me that, before they married, Pete was walking her home late

one summer night and they passed a parked open car containing two men eating McDonalds. The passenger wolf-whistled at Alison and the driver laughed. Pete and Alison kept walking. Then the driver made a derogatory comment about Alison's weight. Pete was at the side of the car in a flash, he reached over and clicked the central locking button then snatched one of the large soda drinks and upended it into the laps of the driver and passenger. He plucked the keys out of the ignition, dropped them on the ground and kicked them under the car. While the men swore and busied themselves shining a phone light under the car for the keys, Pete and Alison walked on. When Alison had told me this story, Pete was portrayed as an imaginatively chivalrous white knight. Today, in her eyes, he was a boorish and foolish old man.

At his next blood pressure check, Pete told me that things had changed with Alison. She was irritable with him, she didn't want to spend time with him and when he wasn't working, she made it clear she wanted him out of the house.

'*I don't know what's happened Dr Johnson, Alison used to be so lovely to me, now I feel like she can't stand the sight of me. If it's the menopause, how long does that last?*'

'*Well*', I blundered, '*For some women it can go on for years*'.

Pete pondered that for a moment and then he asked the question I had seen coming and was dreading.

'*Dr J? Do you think it could be that she doesn't love me any more?*'

'*I guess that's a possibility, yes. Have you asked her?*'

'*She says "Of course I do, you've been so kind to me", and she gets all tearful . . . well, you know Alison?*' Pete chuckled, but quickly became serious again, '*but it sounds like she's trying to convince herself as well as me*'.

'*I'm sorry, Pete*'.

Pete looked at me curiously. '*What? She's told you?*' He wagged his finger. '*You know?*'

I didn't say anything, and Pete stood up, pocketed the large bunch of keys and the paperback he'd placed on my desk, smiled, shook my hand and left.

Pete's body was eventually found after a 2-day search. He'd not returned home after walking his ferrets. He was often out for 3 or 4 hours, so Alison didn't become really concerned until an hour after it got dark. The search party began looking the next morning. His body was found in a cavern at the bottom of a Dene hole*. There were no injuries other than some scratches, presumably from the brambles covering the entrance to the shaft. His blood contained a large amount of alcohol, and an empty whiskey bottle was found in some bushes near to the entrance to the shaft.

The coroner returned a verdict of accidental death, concluding he had fallen down the hole and, drunk, was unable to get out; he died from hypothermia. My belief was that the verdict was a kindness, to spare Alison from the truth that he had taken his own life.

*Dene holes. There are hidden holes with deep shafts on the top of the North Downs above Canterford. They are the result of mining in days gone by, the chalk extracted from them was spread over the fields and used in building. Many of the holes are known about and have been covered over, but there are still some undiscovered and therefore unmarked holes, big enough for an animal or person to fall down into the gloomy cavern below.

Article

All drug addicts lie

Pain News
2025, Vol 23(3-4) 107–108

My wife tells me I am a cynic. She tells me that I assume any information contained in an advert is a distortion of the facts; I assume any 'good deal' has a catch; I assume all patients have an agenda, however straightforward their problem might seem. I haven't always been that way . . .

The events in the following story took place about 20 years ago.

I met Brian for the first time when he attended with his new partner, Beverley. She had been my patient forever. She had five children from three previous partners and announced that she and Brian were expecting number 6. At least two of Beverley's previous relationships had been abusive. Beverley was a resilient lady with low expectations of life in general and men in particular. Brian seemed similar to her previous partners in that he exuded a tough, don't-mess-with-me, testosterone-driven maleness, but there were also some striking differences. He was tender and attentive and – a first for a partner of Beverley – accompanied her to antenatal appointments. And another first – he was gainfully employed. He was a social worker and was keen to tell me about what he saw as his God-given mission – to stand alongside his socially disadvantaged caseload and fight their cause. He was charismatic, funny and self-deprecating enough to balance his tub-thumping zeal. He didn't earn much, and Beverley existed on child and housing benefit, but they had managed to find a rental which enabled them to move off the crime-ridden council estate they currently lived on. The rental was cheap because it needed extensive redecoration. A deal had been reached with the landlord that Brian would be tackling the redecoration in his spare time.

At that time I was a churchgoer and helped run the church youth group. Once or twice a year there were combined events for local church youth groups, and at one such event I ran into Brian. He ambled over and enthusiastically told me about the church he was involved with, located in the middle of one of the most run-down areas of Canterford; how it was providing a place for the young people of that deprived area to hang out – somewhere away from the temptations to graffiti, do drugs and boost cars – I came away inspired but with a feeling that our cosy, middle-class church group located in a well-to-do suburb of Canterford wasn't quite at the cutting edge of social evangelism.

Sometime later, Brian made an emergency appointment to see me. He came on his own. He told me that in the past he had had a drug habit; he had relapsed and was once again using stimulants such as amphetamine and cocaine. If his employer found out, he would be sacked. If Beverley found out he was sure, she would throw him out. He had re-enrolled in NA and wanted me to prescribe tranquillisers and sleeping tablets to help him come down off the drug highs so that he could sleep and function normally. He told me the doses he had used before when he was withdrawing, and I took him at his word and prescribed them. He became tearful and told me that, as well as going to NA, he had told a few key people at his church. They had been sympathetic and understanding and come up with a plan to meet him twice weekly for prayer and support. He asked if he could come back and see me when the tablets were running low and update me on progress. He said he really appreciated my non-judgemental attitude and willingness to help.

Beverley gave birth to Chloe, his first child, and Brian was the very picture of a doting dad. I remembered us previously having

to chase Beverley to get some of her other children vaccinated, but Brian brought Chloe to every vaccination and every development check. Over the next 2 years, I saw Brian once a month or thereabouts. I signed him off work when it became clear he had too much on his plate, juggling new fatherhood with renovating their house and trying to stay clean. He continued to request tranquillisers and sleeping tablets and gave convincing reasons why he still needed them. He assured me, and I believed him, that he was off the stimulants and going to meetings; and he told me, full of his customary enthusiasm, he was setting up a group at his church for alcohol and drug users. He had enrolled on a counselling course. He showed me the details and suggested that, as a sympathetic GP, I might consider enrolling, to enhance my skills in helping addicts. I got as far as filling out the application form and asking my partners for study leave to attend the induction week.

It took one of my partners to rumble him:

I saw Brian Enstone while you were away on holiday, Steve. He wanted more Nitrazepam and Diazepam. He said you were weaning him off them very slowly. Cock and bull. I did some maths and he's having the same quantities now as he was when he first requested them. He's an engaging guy, I'll give him that, but it's all me, me, me. I think he's a narcissist. I sure as hell don't trust him.

The scales fell from eyes.

I decided that when I next saw Brian, I would confront him and tell him that I would prescribe him enough Nitrazepam and diazepam to do a quick withdrawal and then no more. But he managed to confound me again:

Dr J, I'm afraid this is goodbye. We are moving up to London. I'm starting new a job as a drug counsellor in Tower Hamlets. I'm off all drugs, I don't need any more tranquillisers. I just need a certificate to say I'm now fit for work.

I was dumbfounded:

I want to thank you for all of your support. I don't think I could have done it without you.

I typed the certificate, pressed print and handed it to him:

Well! I said, fumbling to say something of consequence. All the best to you and Beverley. I hope it all goes well for you.

'You too Doc'. He got up to leave:

Just one thing. I really think you should do that course. I am clean now but only for the last few weeks. Pretty much all the Benzo's you prescribed me were traded for Amphetamines. I kept back a few to help me come down. You're a great guy but you don't want to believe anything you're told by an addict.

Article

2020 what GPs got up to during COVID

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Pain News
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Sage

In the spring and summer of 2020 – the early months of COVID – the small world of General Practice felt a bit like a parallel universe. We went into work every day, same as usual. We consulted with ill patients, prescribed, organised tests and acted on the results, same as usual. But everything was different. If we saw anyone in person, we went through an elaborate ritual of disinfecting the room and donning a protective suit with gloves and mask before seeing them. Then afterwards, carefully peeling off our protective gear, in a prescribed sequence, into a bag for incineration which we then took around the back of the building, and then finally, we carefully disinfected all of the equipment and surfaces, including door handles and walls the patient may have touched, ready for the next patient. That took at least half an hour per patient. We were used to having 10 minutes per patient.

We played our part in a hastily-cobbled-together Primary Care Network (PCN)-organised COVID assessment clinic. Marquees were set up in the car park of a local leisure centre and volunteer cars brought in patients who had contacted their surgery with symptoms suggestive of COVID, or patients with COVID who had other medical conditions that needed assessment. Each of the four PCN surgeries sent a delegation of clinicians to man it. As the oldest Doctor, with grown-up children, I felt I should be the one from our surgery. We stood around, in protective suits, alternately madly busy or finger-drummingly quiet. Local restaurants provided food in abundance. The volunteer cars were taxis with partitions between the driver and back-seat passenger. And a local funeral director provided a similarly specified hearse. I particularly remember a teenager being brought to the centre in the back of the hearse, his eyes wide with fear and confusion as the car drew up and the team of white-suited and masked clinicians emerged from the marquees to see to him.

Back at the surgery, we were dealing with patients with complicated medical issues who could no longer access hospital services because the hospital was struggling with wards full of patients seriously unwell with COVID and staff getting sick with COVID.

Karen was one of these patients who fell between the cracks in the early days of COVID. Repeated episodes of collapse following chemotherapy for ovarian cancer had led to a diagnosis of severe magnesium deficiency. It had been determined that oral replacement did not suffice so a PIC line had been inserted to enable twice weekly intravenous (i/v) infusions. When the COVID pandemic hit, Karen turned up at the hospital at her appointed time only to find everything in chaos and nobody expecting her. After waiting for hours, she learned that her oncology consultant was off sick with COVID and the Chemo nurse in charge of her infusions had been seconded to an acute COVID ward at short notice. She was told to return the next day only for the same thing to happen. On the third day, Karen texted her chemo nurse before leaving for the hospital. The nurse slipped out of the ward and came and found Karen in the waiting room and gave her a large carrier bag containing all of the infusion kit. The vial of Magnesium had to be prescribed and she had organised this with a doctor colleague. The nurse suggested she talk to me, her general practitioner (GP), to see if I could make alternative arrangements for the infusions. A series of phone calls to the hospital got us nowhere other than the suggestion to sit in A&E and take her chances. Understandably not wanting to do this,

Karen asked if I would do the infusions at the surgery? A number of reasons to say no immediately sprang to mind – lack of clinical expertise, lack of equipment, ensuring the sterility of the PIC line – but these were exceptional times and the alternative – Karen sitting in A&E twice a week waiting, not knowing when, or even if, the infusion would happen – seemed like a worse option. I phoned the medical registrar who told me performing the infusions at the surgery was a bad idea due to the infection risk, but she acknowledged she could offer no better alternative than the waiting-in-A&E option. Karen gently pushed me to agree to her suggestion. She had a degree of anxiety around hospital attendances – a sort of mild post-traumatic stress disorder (PTSD) from past unpleasant experiences – so she was keen for her care to happen outside hospital whenever possible. What the hell, I thought; exceptional times and all that. I texted the chemo nurse who, in a coffee break, recorded and sent me a short video explaining how to take blood from the PIC line and set up the infusion, and she assured me she could get the i/v magnesium prescribed. And so began a bizarre arrangement where Karen would turn up twice a week and be directed round to the bicycle shed at the back of the surgery (the infusions took a couple of hours and we couldn't tie up a room inside for that long). I would don my protective kit and go and take some blood from her PIC line which Karen's husband, Keith, would drive to the hospital lab. The lab would phone with the magnesium level about an hour later and then I would set up the i/v line. Karen would sit on a plastic chair under the corrugated plastic roof of the bicycle shed for a couple of hours while the infusion ran through. With no electronic machines, I had to set the rate of infusion the old way, by counting the drops per minute, and I hung the infusion bag from a nail in the wooden frame. Karen would take a book or some knitting to while away the time and I would check on her periodically. Honestly? It felt like an adventure. Something to take our minds off the horrors surrounding us, friends, relatives and colleagues dying or losing loved ones to COVID.

When the PIC-line infection came, it was swift and dramatic. Karen spiked a temperature and started shivering uncontrollably. Keith called and I cycled round to her house. I stood outside the front door asking questions to exclude COVID. By the law of probabilities, it had been a bacteraemia.

Karen refused point blank to go to hospital. So I rang the medical registrar.

Part of the kit Karen had been given by the chemo nurse was a set of blood culture bottles. The registrar talked me through the correct procedure for collecting the sample, and Keith drove the bloods to the hospital and collected the i/v antibiotics the registrar had prescribed. Karen got worse the first night, started talking mumbo-jumbo, and having muscle spasms that sent the TV remote flying across the room and an ice-cold glass of water into her lap. Once she was a little better, Karen insisted on coming to the surgery for the twice daily i/v antibiotics rather than me visiting, so I administered them in the car park with her sat in the front seat of the car. I have no idea what curious passers-by on their way to central Canterford to get their essentials thought was happening.

I exchanged mobile numbers with the medical registrar and sent progress reports until the blood culture result came back confirming a bacterial growth sensitive to the antibiotics we had administered. Mercifully, the PIC-line stayed patent and we were able to restart the magnesium infusions. The registrar texted me out of the blue a few weeks later to say she had been in discussion with her colleagues about Karen's magnesium deficiency and suggested we try adding a potassium-sparing diuretic to Karen's treatment. We did this and the pre-infusion magnesium blood levels started to rise. We tried going 4, and then 5, and then 6 days between infusions. Eventually, we managed to wean Karen off the infusions altogether. She baked a cake to celebrate the day we removed the PIC line, and to this day she manages on oral magnesium supplements and a hefty dose of Amiloride.

I hope the chemo nurse and the medical registrar got the same buzz that I did from being prepared to think and act outside the box, and from making the effort to work closely and collaboratively with colleagues across primary and secondary care. In fact, I believe it was essential that we all did so in order to keep Karen safe and well during COVID. Much has changed for the better since COVID, but I do not see that these practices are currently being encouraged in any way by our employers or indeed, by our profession. That's sad.

Endpiece

Paradise, lost

Dr Ruth Whiteman

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

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Sage

It's 'follow-up' hour, the portion of a Pain Clinic during which any tender shoots of hope emerging from the new patient consultations fall prey to the heavy-hooved ungulate of despair. There are undoubtedly some people whose condition improves under our care, most often as a result of masterly inactivity on our part. But if someone has made it into one of my follow-up slots, by definition, they're not better.

Worse than that, our regular healthcare assistant, about whom the world of a pain clinic revolves, is on holiday. She can read minds, and will steal out at an opportune moment to put the kettle on in response to my wordless appeals for coffee. Without her, I am more than usually depleted by a morning of pain in Backend Hospital, the place with no security, no receptionist, a broken fridge and the fairly plausible suggestion that the white powder coating our desks every morning might be asbestos.

I recognise the name of my first follow-up patient, which is not unusual in these circumstances, but on this occasion, it's the name itself rather than the story attached which has lodged with me. Her name means Paradise.

She darts through the door and perches on the edge of the chair opposite. She can't return my tentative smile.

'So, how are things?'

My opening gambit is usually delivered with the facial expression of a person trying to climb through an electric fence, but this morning the question feels more than usually charged.

'Terrible. Really, fucking terrible'.

Paradise struggles with eye contact, and she's now rocking back and forth on the chair looking at the floor a few feet to the right of my shoes. I remember that she has previously been treated for an eating disorder. She's certainly slim, but doesn't look to be in imminent danger on that front.

She takes a deep breath, then launches into a long monologue about exactly how things are. She paints a vivid portrait of a life largely confined to the four walls of her flat. I don't need to ask much, everything tumbles out unbidden. There's a partner whose patience is wearing thin because she's always crying with the pain. A family she's avoiding because they can't handle her distress. There are neighbours who complain about her music and her screaming.

As she talks, I get an image of her, curled up on the floor, hugging her knees. She is wrapped in barbed wire. I wish to untangle it, to unwrap her from it, but I can't.

She acknowledges as much. She is bright, insightful and has done a lot of her own research. She knows the drugs don't work, she's tried most of them and she's no better, so why bother? She has been to physio; it hurt too much. She's been under the Community Mental Health Team for years, attracting various diagnoses, so our team psychologist can't help her.

I've deliberately never delved into the depths of her early life trauma, but I know there is enough trouble in there to cause her to dissociate on a regular basis. She will sometimes do things during these episodes that her pain would ordinarily prevent, like cleaning the whole flat in one go. So there are some upsides, she acknowledges ruefully, but not without cost.

She is 3 years into a 4-year waiting list for an assessment for both autism and ADHD. I think we both know what the outcome will be, but she would like the validation. Four years is probably better than some waiting times for this, but it's still a long time, especially when you're 19.

I can see that she's becoming increasingly agitated. My room is stuffy and has the type of wipe clean chairs that people tend to stick to when hot. She tears off her jacket and recoils from the back of the chair as though it's on fire. The rocking increases in tempo, and her exposed arms are a lattice of tattoos and self-harm scars of various ages.

'I hate being hot!'

I've been wondering, while listening, what we are going to do now. 'What's the plan, doc?'. The medical paradigm is a poor fit here. I find myself wondering not only how to bring this to a close but also how it came to pass that someone whose primary skill

set relates to keeping people alive during an operation can be considered the right person for this conversation.

Yet here I am. Her reaction to the heat has thrown us both a lifeline.

'Do you have any other sensory issues?'

'Oh God, yes!'

'Can you tell me about them?'

I don't think it's a coincidence that many of our patients with widespread pain are also neurodivergent or have family members who have autistic spectrum conditions. Many have sensory processing differences. I wonder whether the experience of pain in these people is on the same spectrum; pain is after all far more than, but certainly not less than, a sensory experience. I have also seen at uncomfortably close range the impact of developmental trauma on the sensory system of a child who shared our home for 6 chaotic months. It's given me some ideas, which are just beginning to crystallise and will require an awful lot more data to back them up.

On this occasion, though, I don't seem to have anything else. So we talk about which sensory experiences she seeks out, whether any of them soothe her, how it can be worse to be under-stimulated rather than over-stimulated. She becomes animated in a different way, and she can manage to look at my face from time to time. There's even a smile.

We end with no concrete plan. We agree that I'm going to ask some people about some things, which may or may not help. But she seems a little lighter as she leaves. I feel weighed down and will keep thinking about her all weekend. There is no map for consultations like these, and the disorientation lingers.

I've always been conscious of the choice to be made, on entering a career in Pain Medicine. Am I interested purely in nociception, and the nerves or receptors that I can block, or am I prepared to engage with suffering? Ours is an unusual discipline, where we operate almost as reverse sales representatives for the biomedical framework people tend to turn to first to fix their problem. I feel I am doing a good job if someone becomes convinced that I really have nothing very useful to offer them, at least not in terms of drugs and injections. I am comfortable with that, at least in the field of chronic non-malignant pain.

Increasingly, however, I am encountering a growing group, where I am not sure that even the best efforts of the interdisciplinary team can help. These are people for whom the demand to be psychologically flexible hits them in a particular weak spot. People whose capacity for hyper-focus can sometimes lead them down a path of seeking more and more surgical intervention, despite mounting evidence of harm. People who have multi-system dysfunction and are poorly served by silo models of care.

While the lurking presence of trauma has always been evident in Pain Clinic, where there has been single-event trauma in adolescence or adulthood, the psychological interventions available to us have been transformational. But what to do for those where trauma is embedded in their DNA, or has been so pervasive from *in utero* onwards that their brainstem has been molded by it? These are often people considered too complex for primary care mental health services, but with needs too protracted, crossing too many disciplines for secondary care to be able to manage in the long term. A diagnosis can be enormously helpful in facilitating understanding and acceptance of the self, but it rarely comes with a roadmap of how to live.

So we find ourselves standing in the gap and acknowledging the inadequacies of what is available. I am mindful of the need to remain within my zone of competence, but sometimes, as with Paradise, a different approach is needed to convince her, and me, that all is not lost.

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