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PAIN NEWS

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THE BRITISH PAIN SOCIETY

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SPECIAL ISSUE ON PAIN PATIENT PATHWAYS



British Pain Society Calendar of Events



2013

Pain in Older People (27th Study Day)
Monday 28th January
Churchill House, London

Harnessing interactive technologies in Pain Management (28th Study Day)
Monday 25th February
Churchill House, London

Annual Scientific Meeting
16th – 19th April
Bournemouth International Centre, Bournemouth

Commissioning Pain Services (29th Study Day)
Monday 10th June
Churchill House, London

Philosophy & Ethics SIG Conference
Tuesday 10th June to Friday 13th June
Launde Abbey, Leicestershire

Visceral pain (30th Study Day)
Tuesday 3rd September
Churchill House, London

Interventional Pain Medicine SIG Annual Scientific Meeting
Friday 18th October
Churchill House, London

Topic TBC (31st Study Day)
Tuesday 19th November
Churchill House, London

More information can be found on our website
http://www.britishpainsociety.org/meet_home.htm
Or email meetings@britishpainsociety.org

Please, Sir, I want some more?



'Please, Sir, I want some more'

Oliver Twist (Charles Dickens)

Oliver Twist (*The Parish Boy's Progress*), the second novel from Charles Dickens published in 1838, mocks the hypocrisies of that time including poverty, child labour and recruiting children as criminals. Orphaned from early infancy, Oliver is brought to a Parish workhouse; desperate, hungry inmates decide to draw lots and the loser must ask for another portion of gruel. Oliver, getting this unfortunate task, comes trembling forward and gives his famous request: 'Please, Sir, I want some more.' The following uproar and the story that follows is the interesting novel that many would have read.

As my son was reciting this song loudly with these words for his school Christmas play, I sadly felt some resonance. In the pain clinics, we are always struggling to maintain our services for the benefit of our

patients. Not only do we need to make business cases for new services, but, in the present financial and economic climate with the double-dip recession, we are supposed to analyse and give reasons for why we should continue our existing services. We are facing the biggest changes in the NHS in its 63-year history. Managers and health policy makers may sometimes consider chronic pain patients as excessive consumers of health services.¹ However, enough studies have shown the benefit and the need for the chronic pain services; they have also shown that health status and health outcomes deteriorate as patients wait longer to be seen in the pain clinic.² Studies have shown the need for more multidisciplinary clinics to meet demands; a Canadian survey in 2007 proved that the present multidisciplinary pain treatment facilities are unable to meet the clinical demands of chronic pain patients, both in terms of regional accessibility and reasonable waiting time for the first appointment.³ As reported by the Institute of Medicine of the National Academies, chronic illnesses are not only a burden to those living with them, but also to their societies and cultures, taking a tremendous toll on welfare, economic productivity, social structures and achievements.⁴



For the last four decades, our pioneers in the specialty fought for newer pain management interventions; we all realised that although none can be a 100% cure, they all have a role in the multidisciplinary management strategy. However, now we see a situation where evidence-based medicine is used for all the wrong reasons to make savings and financial gains. None can deny the stress that our specialty has gone through in the last few years; we were partly to blame as we did not produce enough evidence for all the treatments that we practised. We were happy with satisfying patients, improving their quality of life and maximising the use of resources at all times. Did we spend enough time and resources to measure and document the outcome? Why did we fail to produce enough research for even the simple procedures that we do in the Pain Service?

How did our Society respond?

We can give all sorts of excuses to these important questions. At the critical juncture, the question was how to proceed and progress? The BPS has responded ideally and appropriately at all these difficult times. Under the stalwart leaderships of Sir Michael Bond at the most crucial time, followed by the excellent teamwork of Prof Richard Langford, many members of the Society have worked hard in the last four years in various ways. Space limits my ability to quote and thank each and every individual, but the most important successes have been to make NICE realise the need for more appropriate chronic low-back pain guidelines and the publication of Pain Patient Pathways in the Map of Medicine format.

Pain pathways are vital to prove the value of the consensus-based pain



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Please, Sir, I want some more?

management guidance. The Chief Medical Officer's report of 2008 highlighted chronic pain as a clinical priority and the need for a consensus on best practice care pathways.⁵ Our Society set up a working group to produce Pain Patient Pathway mapping guidelines in 2011. The aim of this was to establish normal patterns of management for chronic pain sufferers and influence commissioning by producing Pain Commissioning Packs. This was supported by the Department of Health, Chronic Pain Policy Coalition (CPPC), Royal College of General Practitioners (RCGP) Pain as a Priority Group, RCGP Centre for Commissioning and sponsors.

Reviews from other countries have proven that the current facilities cannot meet clinical demand and effective prevention or treatment strategies are needed earlier in primary and secondary care settings to minimise suffering and chronicity.⁶ The pathways help to educate the clinicians involved in managing these patients at an earlier stage as well as the commissioners to direct the services appropriately. These should be the backup and support that we should use to defend our services in these difficult times. Hopefully, we need not beg for our services in future, but give the consensus evidence in the form of these pathways.

Pain Patient Pathways

This issue of our newsletter is dedicated to the Pain Patient Pathways. Despite their busy schedules and last-minute pressures before the pathways were to be published, the leads and the executive members of the Pathway development group have contributed excellent articles to this issue. They realise the need to inform the members about the enormous work that has gone into developing these pathways and to explain the processes that brought these decisions. We thank them for all their hard work and dedication.

Thanks to Prof Pat Schofield

Our special thanks also go to Prof Pat Schofield, who is finishing a bit earlier than scheduled due to personal reasons.

Her tireless effort as the Honorary Secretary in most difficult times has steered the Society in the right direction. Her role in the Pain in the Elderly SIG does not need any explanation. Her relentless hard work and support will be missed but she will keep supporting the Society in the best possible ways. *Pain News* thanks her for all her efforts and wishes the best for her future. On the same note, we welcome Dr Martin Johnson, Honorary Secretary Elect, who has agreed to step in and help us by taking up the responsibility earlier.

Is opioid a solution or a problem?

Opioid prescription always brings dilemmas in pain medicine. My personal feeling is that many opioid prescriptions are not reviewed in the primary care and even so, do not have the resources to measure outcomes in terms of quality of life in the long run. Research rarely investigates, and guidelines rarely support, complex and difficult decisions about when to stop or not give treatments.⁷ In this issue of our newsletter, the West Suffolk Hospital Pain Management Team has described their experience of introduction of the opioid pathway. This will help many of our members to think again about their opioid treatment strategies. I thank Joan Hester, who has vast experience in this intervention, for writing a foreword in this issue, despite her busy schedule and at a very short notice.

Overhaul of benefits system

Recently, we have realised that the 'social' part of our *biopsychosocial* model of management was taking up more of our time; lots of our patients have been unhappy and distressed with the Work Capability Assessments and the following changes that ensue. This was discussed in short by the BPS Council last time, when a few Council members brought to notice the significant distress that was being raised by a few patients. We thank clinical psychologists Andy Jenkins and Rhona

McGurk for raising these issues in their article 'What's the benefit? The impact of the overhaul to the benefits system on chronic pain patients – Should we be doing anything about it?' The aim of the article is not to propose a solution, but to start dialogues among ourselves regarding what our role is in these situations. If you have any views, please do not hesitate to write to us. *This is your newsletter and is made of your views; please contribute to the future issues.*

I once again sincerely thank all of you for your contributions and support to our newsletter. When this issue reaches your hands, hopefully you will have finished your Christmas shopping and will be ready for the festive period. **I wish you all a very happy Christmas and a prosperous New Year 2013.** Now, enjoy this issue of *Pain News*!



Thanthullu Vasu
Editor

References

- 1 Hintringer F. Chronic pain – a chronic headache for health services? *Tidsskr Nor Laegeforen* 1990; 110: 3653–4
- 2 Lynch ME, Campbell F, and Clark AJ et al. A systematic review of the effect of waiting for treatment for chronic pain. *Pain* 2008; 136: 97–116
- 3 Peng P, Choiniere M, and Dion D et al. Challenges in accessing multidisciplinary pain treatment facilities in Canada. *Canadian Journal of Anesthesia* 2007; 54: 977–84
- 4 Institute of Medicine. *Living Well with Chronic Illness*. Washington, DC: The National Academies Press. Available online at http://books.nap.edu/openbook.php?record_id=13272 (accessed November 2012)
- 5 Donaldson L. *150 Years of the Annual Report of the Chief Medical Officer: On the State of Public Health 2008*. Available online at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206 (accessed November 2012)
- 6 Choiniere M, Dion D, Peng P, et al. The Canadian STOP-PAIN project – part 1: Who are the patients on the waitlists of multidisciplinary pain treatment facilities? *Canadian Journal of Anesthesia* 2010; 57: 539–48
- 7 Mangin D, Heath I, and Jamoulle M. Beyond diagnosis: Rising to the multimorbidity challenge. *British Medical Journal* 2012; 345: 11–12

PAIN?

NOT ON MY WATCH.*

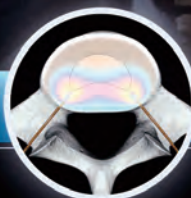
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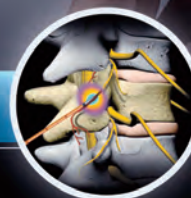
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Pain pathways in changing times



Nothing endures except change

Heraclitus (523–475 BC)

This winter edition of *Pain News* has the Pain Patient Pathways Maps (PPPM) as its major theme to coincide with their imminent publication in the Maps of Medicine format. At the time of writing, the first two pathways – ‘Initial Assessment and Management of Pain’ and ‘Spinal Pain’ – are expected to be published at the end of October, and the final three pathways – ‘Musculoskeletal Pain (non-inflammatory)’, ‘Neuropathic Pain’ and ‘Pelvic Pain’ – are due the following month.

This project, the largest undertaken by the BPS, has been an onerous process. Much of the work was completed some time ago; therefore the actual publication of the pathways is very welcome. The further hurdles that had to be overcome to get this far were unavoidable; however, they have led to more robust pathways. They can be viewed as the finest available consensus on evidence-based practice. We would like to take this opportunity to thank the executive committee of the PPPMs and the individual pathway working groups for

all their hard work, which is ongoing, around this project.

The pathways will be published not a moment too soon. There is huge pressure on resources with the nation enduring a double-dip recession worse than in the 1930s. The NHS is in the midst of major changes. The Coalition reforms are not going to go away; in fact they are now starting to bite and this is being increasingly felt at the frontline.

It is planned that the needs of the local (as opposed to national) population will be assessed by the local authority Health and Wellbeing Boards (HWP). They will look not only at the health requirements of the local population but also their social requirements. This will be done through the HWP's Joint Strategic Needs Assessments (JSNA). The commissioning of local health services is to change with the phasing out of primary care trusts (PCTs) to the new clinical commissioning groups (CCGs) going live in April 2013. It will be the responsibility of the CCGs to meet the needs of the local population as identified by the JSNAs. There is to be more of an emphasis on clinical engagement, which should involve you, and a focus on quality. Our services will need to work with GP practices, the CCGs and local authorities to develop ideas and ensure that patients receive the pain care they need. The PPPMs are designed to support you in that process. The vast majority of pain services will fall under CCG commissioning and will be in the community and secondary care as appropriate. However, highly specialised regional/tertiary services will be under the remit of the newly formed NHS Commissioning Board (NHSCB). The BPS is heavily involved in



supporting the NHSCB in its work to define what characterises the specialised services.

We have seen a number of different models before – many will remember GP fundholding and what followed – and the changing balance of influence – purchasers, providers and non-NHS concerns. Change does feel relentless and with change comes uncertainty. Clinicians are increasingly seeing the need to be involved more and more with wider processes at work in their local health economy and will need the support to do this. Engagement with the commissioners will be key – with trust and open dialogue both ways. The recent BPS education day on commissioning was heavily oversubscribed and more are to follow early next year and at the Bournemouth Annual Scientific Meeting; also a series of regional workshops are being planned. With this will be a range of commissioning support materials of differing levels and I am pleased that we have in this edition a contribution on commissioning to start us off. The BPS website, which itself is under imminent change and reconfiguration, will have

actual pain commissioning examples as these become available and are volunteered in to be posted.

Interdisciplinary/multispecialty pain services offering a full range of treatments and with access to comprehensive therapies have been hard fought for and if disengaged would be very difficult to rebuild. There are concerns that in these changing times resources may be diverted elsewhere away from pain services or to just generalist care of less complex patients and stop only at that level, perhaps even to independent providers looking to service the most lucrative aspects of care such as interventions that are high-tariff items. What is certain though is the huge burden of pain in terms of prevalence and its socio-economic impact. While many patients with chronic pain do manage, we know that there are very many that require our

care and support – so the need is there. Efficient, patient-centred, high-quality services using evidence-based best practice and able to deal with the right patient at the right location by the right person will be more valued than ever. Ensuring that services are not fragmented but instead work in an integrated fashion should be the key aim. The Pain Patient Pathways will help support community, secondary and tertiary flow of care.

The pathways will help to embed pain services and also help lead to their improvement. They have been well received to date, perhaps largely due to the consensus process based on best evidence care that was used. Independent peer review through the Map of Medicine process will also have ensured credibility. In the next phase, which is their implementation and dissemination, uptake and usage, will

demonstrate their relevance. Another area of major focus will be to 'morph' the pathways into NHS Evidence/NICE endorsement. This will help to inform the commissioners. Meetings with senior NHS figures involved with these processes are already in place. There is much more still to be done and we are grateful for the help and collaboration of our partner organisations – Faculty of Pain Medicine (FPM), Royal College of General Practitioners (RCGP), Chronic Pain Policy Coalition (CPPC) and patient groups – with these continuing efforts in changing times.

Dr Andrew Nicolaou
Chair BPS PPPM Implementation
and Dissemination

Dr Andrew Baranowski
Chair BPS PPPM Executive
and CRG Specialised Services

Pain News and SAGE wish
the readers a very Happy Christmas
and prosperous new year 2013.



THE BRITISH PAIN SOCIETY



Reducing the risk of opioids



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Reducing the risk of opioids for persistent pain is a matter of great concern. In this issue of our newsletter, the West Suffolk Hospital Pain Management Team elaborate how they introduced a very comprehensive pathway for their patients, something that we all might like to consider. It is interesting that the patients were given a copy of the BPS patient information booklet on opioids to read; homework before consent seems a good way of achieving concordance. It would be

interesting to have more feedback from patients on the usefulness or otherwise of the information. The consent form used asks detailed and specific questions; it is well worth considering the use of this, or something similar, although the team found that a lot of time was necessary to explain the questions and to achieve understanding. We shy away from such investments of time, but the benefits, as expressed in this article, reach beyond the immediate issues of consent and must lead to a greater understanding of the use and risks of all opioid medications.

Use of the Screener and Opioid Assessment for Patients with Pain (SOAPP) 14 questionnaire as a routine screening measure is arguably not necessary in a UK population, and could be construed as being offensive, but perhaps we are kidding ourselves. It has been used here without apparent dissension, though I would like to hear a more detailed assessment of its use from the study group and would like to know how many patients were considered to be 'high risk'. Were there any false positives? If so, how were these handled?

Stratification into low, medium and high risk as an indication of the level of monitoring needed is a worthy aim, and the differentiation between low-risk

patients managed in primary care and medium/high-risk patients managed in secondary care seems very sensible. I do feel that there are too many questionnaires mentioned here; just remembering what each acronym stands for is a major exercise in itself and the system requires a dedicated person to administer it correctly.

The authors do not recommend a specific timescale for a trial of opioids, whether functional goals were achieved and how many patients withdrew, or indeed in how many a trial was never started. There are also the cost implications of the monitoring of hormones and bone density. Are these really necessary before initiation of the trial of opioids or should they be reserved for patients going on to long-term use?

There are many unanswered questions. I feel that the process needs to be simplified and made more accessible for a UK population; but having said that, it is a most interesting and comprehensive start on tackling a difficult problem, it will provoke interest and, I am sure, will lead to more studies. It is a subject *we will all have to address in the future*.

Joan Hester
Kings College Hospital, London

Gran Thelma



If there's a
CHEESY
Photo happening
I want to be in it

Being able to cuddle up and grin for the camera seems like a small victory. But there are times when small victories count.

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moderate to severe hepatic impairment, severe renal impairment, chronic constipation, concurrent administration of monoamine oxidase inhibitors or within two weeks of discontinuation of their use, galactose intolerance, lactose deficiency, glucose-galactose malabsorption, any situation where opioids are contraindicated, pre-operative use or use during the first 24 hours post-operatively, pregnancy. **Precautions and warnings:** Hypothyroidism, opioid dependent patients, raised intracranial pressure, hypotension, hypovolaemia, toxic psychosis, diseases of the biliary tract, pancreatitis, inflammatory bowel disorders, prostatic hypertrophy, adrenocortical insufficiency, alcoholism, delirium tremens, chronic renal and hepatic disease, severe pulmonary disease, debilitated patients, elderly and infirm patients, history of alcohol and/or drug abuse. Do not use where there is a possibility of paralytic ileus occurring and if this is suspected or occurs during use discontinue immediately. Patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive **OxyContin** tablets for 12 hours prior to the intervention. **OxyContin** 60 mg, 80 mg and 120 mg tablets should not be used in opioid naive patients. **OxyContin** tablets should be used with caution following abdominal surgery, and not used until normal bowel function returns. **OxyContin** tablets have a similar abuse profile to other strong opioids. **OxyContin** tablets must be swallowed whole and not broken, chewed or crushed which leads to a rapid release and absorption of a potentially fatal dose of oxycodone. Concomitant use of alcohol and **OxyContin** tablets may increase the undesirable effects of **OxyContin**

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respiratory depression, pin-point pupils, hypotension and hallucinations. Circulatory failure and somnolence progressing to stupor or deepening coma, skeletal muscle flaccidity, bradycardia and death may occur in more severe cases. The effects of overdose will be potentiated by the simultaneous ingestion of alcohol or other psychotropic drugs. Please refer to the SmPC for a full list of side-effects. Tolerance and dependence may occur. It may be advisable to taper the dose when stopping treatment to prevent withdrawal symptoms. **Legal category:** CD (Sch2) POM. **Package quantities and price:** 5 mg – £12.50 (28 tablets), 10 mg – £24.99 (56 tablets), 15 mg – £37.41 (56 tablets), 20 mg – £49.98 (56 tablets), 30 mg – £74.81 (56 tablets), 40 mg – £99.98 (56 tablets), 60 mg – £149.66 (56 tablets), 80 mg – £199.97 (56 tablets), 120 mg – £299.31 (56 tablets). **Marketing Authorisation numbers:** PL 16950/0097-0100, 0123, 0139-0141, 0150. **Marketing Authorisation holder:** Napp Pharmaceuticals Limited, Cambridge Science Park, Milton Road, Cambridge CB4 0GW, UK. Tel: 01223 424444. Member of the Napp Pharmaceutical Group. For medical information enquiries, please contact medicalinformationuk@napp.co.uk. **Date effective April 2012 (UK/OXYC-12006)** © **OxyContin** and the NAPP device are Registered Trade Marks. © 2011–2012 Napp Pharmaceuticals Limited. European Patent (UK) 0 253 104, European Patent (UK) 0 576 643, European Patent Application No. 96102992.3



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Code: UK/OXYC-12014.

Professor Richard Langford



This is a particularly opportune moment to be writing to you, as only this week a number of projects and strategies, pursued with dogged determination, have come to fruition, or reached significant milestones. In particular, I can bring you important news on developments regarding NICE and our BPS-endorsed Pain Patient Pathways.

NICE

Low back pain clinical guideline 88

Ever since the publication in May 2009 of 'NICE clinical guideline 88' (CG88), developed by the National Collaborating Centre for Primary Care: 'Low back pain – Early management of persistent non-specific low back pain', and the ensuing disquiet, the BPS has maintained a dialogue with a number of senior officers at NICE. Aside from robust expressions of our disagreement with some of the contents of the guidelines and omissions, various elements have been examined and discussed in detail. As previously reported, we succeeded in identifying

serious flaws in the costings and in persuading NICE to withdraw these.

This week witnessed a pivotal meeting with Prof Mark Baker, Director of the Centre for Clinical Practice at NICE. He informed us that he has decided to cancel the planned update of CG88, which would have been of limited scope and under the auspices of the same panel. Instead, he will initiate the commissioning of an entirely new guideline development process, with a newly constituted committee. Their remit will be to start afresh with a focus on chronic (and not acute) low back pain. It is to be anticipated that there will be appropriate multidisciplinary representation of pain medicine, and we hope to be able to build on the consensus achieved in developing the BPS Spinal Pathways. Of course, this will take time and we will need to see tangible outcomes, but I am sure that you will agree that we do appear to have achieved real progress in our dealings with NICE.

NICE accreditation

Another meeting with NICE took place earlier this week when Nick Allcock, Chair of our Communications Committee, Andy Nicolaou, Chair of the Pathways Implementation and Dissemination Workstreams, Ollie Hart as lead of the Commissioning Workstream and I, met with Paul Chrisp, Associate Director, NICE Accreditation, and Stephanie Birtles, Technical Analyst. At first sight, achieving 'NICE accreditation' may be thought to be of lesser relevance or potential significance. However, in our meeting with Prof Baker, he also told us that our BPS-endorsed pathways hosted on the Map of Medicine would at least inform the development of both NICE guidelines on pain and subsequently the

Pain Quality Standard. If these guidelines were to achieve NICE accreditation, by adhering to and gaining approval of our guidelines development process manual, then the pathways could be directly incorporated into the NICE guidelines. However, although we have been addressing this, we should not underestimate the very considerable challenge of achieving this very demanding level of approval.

BPS-endorsed Pain Patient Pathways Publication

At the time of writing in October, two of the five evidence- and consensus-based pathways have been published, with the remaining three due to be uploaded onto the Map of Medicine website in November. Also by the time this edition reaches you, we should have established a 'microsite' on our website, via which the Maps can be viewed without a Map of Medicine licence.

As this first phase of our strategy to establish BPS-endorsed best practice comes to fruition, I would again like to thank all involved, and particularly Andrew Baranowski for his leadership and dedication, without which this enormous project would not have been realised.

Implementation and dissemination

The second phase of implementation and dissemination led by Andy Nicolaou is now underway. Supported by Andy and Martin Johnson, I have obtained pledges of funding by the Association of the British Pharmaceutical Industry (ABPI) group of pharma companies to support a series of regional meetings, which will take place in the first quarter of 2013. We will use these events to roll out the pathways and our commissioning strategy.



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That these topics are key issues for our members was confirmed by the oversubscribed and very well received Commissioning Pain Services Study Day held on 10 September, which included presentations and workshops on submitting evidence-based practice and proposals to commissioners.

National Pain Audit

The National Pain Audit, as you will be aware, was originally a two-year BPS and Dr Foster Intelligence collaboration, funded by the Healthcare Quality Improvement Partnership (HQIP). The second of the data collection phases was completed this year, in which patients were recruited and consented to provide baseline information when first attending their pain service, and follow-up data six months later. For this second phase, 91 clinics returned data, giving a response rate of 56%. A total of 9,430 patients were entered onto the case-mix tool. The 67-page National Pain Audit Final Report has been written and submitted to HQIP for its comments, and will be launched on 18 December 2012. The details are embargoed until then, but I think that we will gain useful insights into the impact of pain on our patients' quality of life and on the utilisation of health service resources. Such evidence will be of potential influence on policy makers and commissioners.

The Society owes a great debt of gratitude to all of our members and their patients who were responsible for the return of the data, and to the following, who made major contributions to this exercise - see table on the side.

In addition, I would like to particularly thank two individuals for steering this ambitious project through its many challenges: Dr Stephen Ward for chairing the Project Board; and Dr Cathy Price, Chair of the Scientific Advisory Committee, for her outstanding contribution and colossal amount of work.

Authors of the report

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Project board

Dr Stephen Ward (Chair), Consultant in Pain Medicine, British Pain Society; Representative, Faculty of Pain Medicine
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Replaced by Mr Colin Preece 2012

Governance committee

Julian Brooks, South West Strategic Health Authority
Prof Richard Langford, President, British Pain Society
Douglas Smallwood, Chair, Patient Liaison Group, British Pain Society

Drug-driving legislation

The BPS is currently active in several opioid-related areas of interest, including legislation being drafted by the Department for Transport intended to curb the perceived rising problem of driving under the influence of illicit drugs. An unintended consequence however is that patients on legitimately prescribed opioids will give positive tests, and potentially be liable to prosecution. Cathy Stannard, Martin Johnson, Beverly Collett and I have petitioned for a mechanism to be identified by which our genuine patients are not caught in this trap, and have enlightened the authorities regarding the considerable evidence

showing no significantly deleterious effect of stable doses of opioids.

Pain Less Exhibition

I have mentioned previously that the BPS has joined other organisations in co-sponsoring an exhibition at the Science Museum in London covering pain medicine and anaesthesia called 'Pain Less'. It will run for a year until 7 November 2013, and in this edition of *Pain News*, is the subject of an article, kindly contributed by Dr Andrew Morley (consultant anaesthetist at St Thomas' Hospital), who won the grant to stage this event.

From the President

Professor Richard Langford

Honorary Secretary

Prof Pat Schofield requested, with regret, that she demit office early for personal reasons, and Dr Martin Johnson has kindly agreed to act as interim honorary secretary until the next AGM, when he commences his three-year term, as planned, in this role. I would like to thank

Pat personally and on behalf of the Society, for her major contributions on Council and as an executive, and am pleased to say that she will continue as chair of the Pain in Older People SIG and in her work towards convening the joint Working Group with the British Geriatric Society.

With kindest regards,



From the Honorary Secretary

Professor Pat Schofield



As the exciting events of the summer become a distant memory and we settle down into the run-up to winter and the festive season, we still have so much to look forward to. We have just facilitated a very successful study day around the commissioning of pain services. Due to its success, we may offer another opportunity to attend next year. In the meantime, we have a study day on psychological therapies in November and pain in older adults in January. This is just more activity being facilitated by the education committee, led by Professor Paul Watson. We also have a Pain Education SIG seminar in November, so lots of activities are taking place. The preliminary announcement for the Annual

Scientific Meeting is on the website; we are due to go to Bournemouth next year for what promises to be another exciting programme developed by Professor Gary Macfarlane and his scientific committee. Keep an eye on the BPS website for details of registration and submission of poster details.

We have recently lost our chair of the patient liaison committee; Douglas Smallwood has sadly moved on and we all wish him well. We have advertised for a replacement and should have someone in post very soon – so, watch this space. The patient liaison committee is a very important group that contributes to many of the activities of the Society and so this is a key role to work with the group and our professional members.

Membership

At the time of writing this report, the membership stands at 1487 and is represented by 707 anaesthetists, 252 nurses, 98 psychologists and 85 physiotherapists with other disciplines accounting for 345 members. Other disciplines include occupational therapists, rheumatologists, neurologists, pharmacists, general practitioners and basic scientists. As usual we encourage members to promote our Society to their colleagues. Information on joining can be found at

http://www.britishpainsociety.org/join_home.htm and the benefits of joining are many.

Special Interest Groups

We have a number of special interest groups (SIGs), which reflect the diversity of our member's interests. As chair of the Pain in Older Adults SIG, I am really excited to report that the *Management of Pain Guidelines* will be published very soon. They are the result of over three years of extensive literature reviewing and provide clear recommendations based upon the current state of the literature, along with recommendations for key areas for research. The guidelines will be available on the website very soon. We will be updating the pain assessment guidelines over the next 12 months.

If you are interested in writing a publication, take a look on the website; there is an application form that needs to be completed and submitted to the Communications Committee.

Finally, thanks as always to Felicia Cox and Thanthullu Vasu, who work tirelessly on our two publications: *British Journal of Pain* and *Pain News*. They are going from strength to strength. If you would like to submit any of your work, I am sure they would both be keen to hear from you.



"Sometimes it seems to take over your life"

"Don't feel normal" "Cannot sleep"

"Part of your mind is on your **pain**, and another part of your brain is taken up with **constipation**"

"I know I have to take my pain meds but it's *awful* to always feel constipated"

"Makes one feel isolated"

"It is a constant discomfort and makes me unhappy"

"It dominates **everything** I can do"

"Constantly worrying or upset"

Real patient quotes taken from a survey commissioned by Napp Pharmaceuticals of 2,000 UK opioid treated patients.

When was the last time you asked them about it?

59% of patients taking opioids suffer from constipation.¹
They might not tell you unless you ask.

1. Napp Pharmaceuticals Limited. Constipation survey of 2,000 UK adults taking opioids. July 2012. Data on file.



From the Honorary Treasurer

John Goddard



THE BRITISH PAIN SOCIETY

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SAGE



Time flies: I'm nearing the end of my tenure as Honorary Treasurer of the Society – only a few months to go when this edition of *Pain News* lands on your doorstep. During my tenure I honestly believe that the Society has moved ahead significantly in many areas, for the benefit of patients and the services on which they depend for their clinical care.

The Society has put tremendous effort into the development of its five Pain Patient Pathways: 'Initial Assessment and Early Management of Pain', 'Spinal Pain', 'Neuropathic Pain', 'Pelvic Pain' and 'Chronic Widespread Pain'. Their publication will, we sincerely believe, provide a firm basis for the commissioning of pain services by clinical commissioning groups (CCGs). The Pain Summit has produced a strategy for developing services and the Society is leading ongoing work on a data strategy. The Society has developed a close working relationship with NICE; a pain Quality Standard is in

development and our representations for an update of the low-back pain guidelines have been heeded. Discussions with BUPA have resulted in its recognition of pain medicine specialists and further work on funded interventions. Our educational initiatives continue and develop. The *British Journal of Pain* is a significant step forward. We are involved in a joint e-learning project with the Faculty of Pain Medicine (FPM). We continue to produce high-quality publications; our grants and bursaries are consistently awarded. The National Pain Audit continues with a further year's extension for new work and, although slowly, work is ongoing to develop our website to provide an improved platform for member communications and support.

All of this activity takes a considerable amount of time, by the Council and other members of the BPS. This time is largely unfunded. However, we do reimburse travel expenses and there are costs associated with many of the activities. Our major projects are fully funded by external grants: patient pathways by pharma, importantly through the Association of the British Pharmaceutical Industry (ABPI) as we move forward rather than individual companies; e-learning and the national audit by the Department of Health.

My primary role as treasurer and member of Council is to maintain the financial viability of the Society. I believe that I have achieved this: the Society's reserves remain in a healthy state. However, the recession is beginning to bite seriously.

Our office costs (heating, lighting, postage, professional services, insurance, etc.) are increasing at about 7% per annum, and in recent years your membership subscriptions have only been increasing at about 2% per annum.

Traditionally, membership fees covered office costs; this is no longer the case – there is now a deficit. Interest rates also remain low.

In the past, financially successful ASM's have enabled the Society to correctly charge the office overheads of the meeting against its income. Reduced ASM income jeopardises this arrangement and more costs need to be met from the general budget (being mainly subscription fees).

The ASM, was not so financially successful last year – a combination of reduced trade support (although as noted above, support for specific projects is generous) and fewer attendees. The recession is hitting the NHS too: restricted trust leave and funding; vacant posts not being reappointed and alterations in job plans.

The executive officers have planned a major review of our finances over the coming months, where we will consider our position and any action that needs to be taken. Obviously we will try to cut our costs, but we will also have to consider maximising our income and, equally obviously, this will include discussions over realistic increases in membership fees for future years. Although well intentioned, increasing membership fees below the level of inflation is not sustainable in the long term unless other streams of income can be identified. As you will now be aware, the increase in membership fees this year reflects our commitment to support lower-earning members, but at the same time reflects a prudent increase for the upper band particularly.

We, Council, firmly believe that now, more so than ever, the Society represents good value for money. I refer to my second paragraph and the major initiatives that have been delivered successfully in recent times.

University of Birmingham Interventional Pain Management Pain Forum and Cadaver Workshop

PART 1

10 – 12 April 2012

Lumbar and pelvic procedures
Neuromodulation and programming
Musculoskeletal US - upper limb and trunk

PART 2

25 – 27 September 2012

Cranio-cervical procedures
Advanced neuromodulation
Musculoskeletal US - lower limb and abdomen

**4 DELEGATES PER DEMONSTRATION TABLE, ONE TO ONE TUITION
MAXIMUM 28 DELEGATES. INTERNATIONAL FACULTY**

PAIN FORUM DAY – MAXIMUM 75 DELEGATES

Lumbar facet joint denervation
Dorsal root ganglion blocks
Disc procedures
Sacroiliac joint procedures
Lumbar sympathectomy
Hypogastric plexus block

Cervical facet joint denervation
Cervical nerve root blocks
Thoracic splanchnicectomy
Trigeminal ganglion procedures
Sphenopalatine ganglion procedures
Stellate ganglion block

Spinal and peripheral nerve percutaneous lead insertion and specific programming session

SPECIALIST WORKSHOPS Epiduroscopy US guided procedures

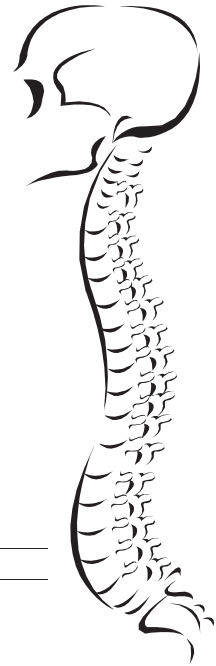
Further info: Dr Dalvina Hanu-Cernat
Dalvina.hanu-cernat@uhb.nhs.uk
Tel: 07976 697761

Consultants £850 / £1600
Trainees £700 / £1300
Pain Forum £125 / £200

Registration: Mrs Lynne Murphy
Pain Unit
Nuffield House, 3rd floor
Queen Elizabeth Hospital
Birmingham
B15 2TH
Tel: 0121 371 5100 Fax 0121 371 5101
lynne.murphy@uhb.nhs.uk

DISCOUNTS FOR COMBINED BOOKINGS

FURTHER INFORMATION AT www.painmanagementcourse.co.uk



Annual Scientific Meeting 2013



The British Pain Society invites all healthcare professionals with an interest in pain to attend their 2013 Annual Scientific Meeting, which will be held 16th – 19th April at the Bournemouth International Centre.

Student Rate

This year a special rate has been introduced for students to attend. The early bird rate is £90 up until the 18th February 2013; thereafter the rate is £110 and applies to both member and non-member students. Do encourage any students you know to attend.

Deadlines for delegates

Poster Abstract Deadline

Friday 7th December 2013

Bursary Application Deadline

Friday 8th February 2013

Early Bird Deadline

Monday 18th February 2013



Pain pathways: initial assessment and early management

Ms Ann Taylor (Anaesthesia), Dr Martin Johnson (GP), Dr Chris Barker (GP), Ms Val Conway (Nurse), Neal Edwards (Anaesthetist), Sonja Bigg (Physio), Mr Douglas Smallwood and Jo Cummings – jointly supporting (Patients), Dr Roger Knaggs (Pharmacy), Owen Hughes (Psychology)

The decision to have an 'Initial Assessment and Early Management of Pain' pathway was based on the need to get patients appropriately screened, assessed and managed with the emphasis on being timely. At this stage, patients are managed from a 'generalist' perspective with more specialist care being offered in the other pathways. While it is a pathway that can be used by anyone initially seeing a person with pain, the majority of professionals using this pathway will be working within the primary care, of which the largest proportion will be GPs. We recognise that GPs and the primary care teams manage day-to-day pain effectively, as a large proportion of people visiting them have pain as an issue. However, it has been identified that what is needed is support and help to screen for, identify, assess and manage those who are likely to develop pain-related disability, distress and chronic pain.

Core to this pathway is the issue of early screening for 'problematic pain' by whoever is in initial or early contact with the person presenting with pain. The term 'problematic' may need to be changed as clearly we would not want patients to be seen as problematic. The BPS pathway builds on and expands an earlier Welsh pathway for primary pain management, which advocated the importance of early screening for problematic pain.

There are two major concerns when considering how to capture those who actually need added support. One is that we appear to be 'missing the boat' in that we are failing to capture those with early indications that they are on the path to developing chronicity; although sterling work is ongoing in the low-back pain arena. Second, we have a large number of patients with chronic pain who are managing their pain and coping; they are maintaining a reasonable quality of life, working and engaging with family and friends and the last thing we should consider is medicalising their condition. However, others have problems in managing and coping with their chronic condition and how these patients are identified without medicalising those that are managing their condition can be difficult. In the pathway, we have used a four 'D' – disability, distress, diagnosis uncertain, drug use – problematic. In order to screen for the first two, we propose using Chris Barker's screening questions:

In the past month has your pain been bad enough to often make you feel worried or low in mood?

In the past month has your pain been bad enough that you are unable to carry out your day to day activities?

A 'yes' to either of these should alert the practitioner to further screening and



or assessment and we have included Keele University's back and musculoskeletal tools to commence this process. Resources are being considered to support the pathway in terms of which assessment tools would be appropriate. The issue of problematic pain also sits within Recommendation A of the Pain Summit, work that the Faculty of Pain Medicine (FPM) is taking responsibility for and may become important for commissioning.

Implementation – working with patients

As already discussed, the dissemination and implementation of the pathways has four work streams: commissioning, primary care, BPS and patients. Two members of the BPS Patient Liaison Committee (PLC) have volunteered to sit on each of the work streams to ensure that there is a

Pain pathways: initial assessment and early management

cohesive approach to dissemination and implementation reflecting patients and health professionals. Within the patient work stream, we have two PLC members who have happily agreed to facilitate communication between the dissemination and implementation committee and the PLC. We have

discussed some ideas including interviewing patients about their views on the pathways using a semi-structured questionnaire, jointly designed, and about obtaining some patient stories using a supportive template. Both are seen as very important in contributing to an

evidence base for commissioning of services. Other ideas have been around using the press to publicise the patient stories and pathways and producing business cards so that people with pain have links to the maps at hand, which they can give to health professionals.



The Sharp End of Pain Control

21-22 March 2013 £180

St Christopher's Hospice, London

This two-day course will offer participants an up-to-date insight into the role of specialist pain management in the palliative care population, including those cared for in a hospital, hospice or home environment. It will define the place of interventional procedures and new drugs appropriate to this group of patients. Teaching will include practical advice about neural blockade techniques including epidural and intrathecal catheters and cordotomy. There will be opportunity for participants to discuss patients they are currently caring for. The course lasts two days and is run jointly by St Christopher's Hospice and the Pain Relief Unit at King's College Hospital, London.

The programme will also include sessions on:

- Opioid Toxicity
- Pharmacokinetics of Neuraxial Drugs
- Neuropathic Pain
- Other interventional pain techniques

There will be a strong focus on case material throughout the two days and we would invite participants to send us in advance short case studies that they would like to discuss with the panel.

Accreditation: CPD applied for through RCP

www.stchristophers.org.uk/education 020 8768 4656 education@stchristophers.org.uk @stcheducation



Pain Pathways: Spinal pain

Dr S Gupta, Dr A Williams, Dr J Hill, Dr O Hart, Dr S Ward,
Mr J Timothy, Mrs C Hughes and Mrs E Killick

Following a meeting on 19 January 2011, a multi-professional group was formed to include psychologists, nurse specialists, physiotherapists, pain medicine specialists, neurosurgeons, spinal surgeons, GPswSI (general practitioners with a special interest) in pain medicine and patient representatives. The group comprised of the following members:

Dr S Gupta, consultant in pain medicine and anaesthesia (Lead); Dr Ollie Hart, GPswSI in Pain Medicine; Dr Tim William, GPswSI in Pain Medicine; Ms Keren Smallwood, spinal nurse specialist, Liverpool; Dr Karen Eastman, GPswSI in pain medicine and clinical commissioning lead for planned care West Sussex PCT; Dr Amanda Williams, Reader in Clinical Health Psychology; Dr Patrick Hill, consultant psychologist; Dr Jonathan Hill, research physiotherapist; Ms Ruth Sephton, consultant physiotherapist; Mrs Elizabeth Killick, BackCare Helpline volunteer, patient representative for BPS; Ms Christine Hughes, Pain UK trustee, Pain Concern trustee and BackCare Helpline former manager; Dr Tony Hammond, consultant physician and rheumatologist; Dr Manohar Sharma, consultant in anaesthesia and pain medicine; Dr Stephen Ward, consultant in anaesthesia and pain medicine; Dr G Baranidharan, consultant in anaesthesia and pain medicine; Dr Simon Dolin, consultant in anaesthesia and pain medicine; Dr Joan Hester, consultant in pain medicine; Mr Jake Timothy, consultant neurosurgeon; Mr John Carvell, consultant spinal surgeon. The executive members of the group were Dr Sanjeeva Gupta (Lead), Dr Ollie Hart, Dr Jonathan Hill, Dr Stephen Ward,

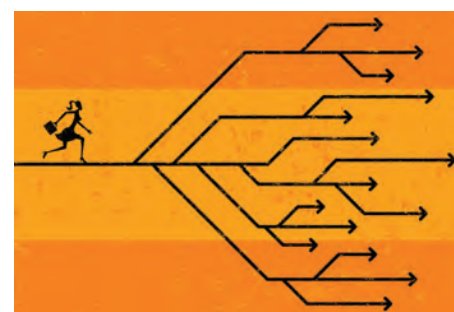
Dr Amanda Williams, Mr Jake Timothy, Mrs Elizabeth Killick and Mrs Christine Hughes. We had several telephone conferences in the evening, running up to 10 p.m. on occasion. It was indeed a big commitment for the members of the group.

We decided that the pathway should represent a consensus opinion based on the best available evidence and practical common sense where evidence is not available. We also felt that the pathway should be pragmatic and should follow the patient's journey as seen by the clinicians. Once the evidence was gathered, we had a face-to-face meeting and agreed on the available evidence. We were aware of other pathways within the UK and our aim was to ensure that these are reflected where possible. We accepted that the STarT Back Screening Tool was more appropriate in streamlining patients in the pathway. We also agreed that we should include neuropathic/radicular pain management in the low-back pain (LBP) management.

The information below should be read in conjunction with Map of Medicine Spinal Pathways. Please see the maps for references to the evidence base.

Initial assessment of spinal pain in primary care by Dr Ollie Hart, GPswI in Pain Medicine

The initial assessment generally occurs in primary care. It would most commonly be done by a GP, although it could be a nurse practitioner, or a direct access physiotherapist. The GP consultation offers a number of challenges. The consultation time is



usually limited to 10 minutes (including time for note writing and referral generation), and spinal pain may be one of a number of problems – with either the patient or GP having other agendas needing to be covered in the consultation. The time from onset to first presentation is often variable, ranging from a day or two, to a number of weeks. This may be dependent on patient factors (such as previous experience, or level of anxiety), accessibility of appointments, or availability of other treatment options.

The main aims of initial assessment are to exclude emergencies, serious pathology or an inflammatory spinal condition, and then consider the biopsychosocial context of the patient's condition. Emergency conditions such as cauda equina or rapidly progressing neurological signs would necessitate an emergency specialist referral. If serious pathology is suspected, it would normally be expected that a GP would carry out initial investigations such as blood tests or spinal imaging, to inform the likelihood of a serious pathology being present. It is worth remembering that the most common serious condition of the spine is metastatic cancer, with history of previous cancer being the biggest risk factor.

It is also worth establishing the likelihood of nerve root pain from the patient's history as this alters the advice and explanation given to the patient, with importance attached to the symptoms that might be associated with progression to emergency conditions.

However, despite the importance of these medical screens, the majority of patients will not have any of these symptoms or signs, and will fall into the category of uncomplicated nerve root pain or mechanical spinal pain. Research is very clear that it is the psychosocial assessment of these patients that is crucial in predicting the risk of poor recovery and progression to chronic pain problems.

We hope that these pathways will encourage a biopsychosocial assessment at every stage of consultation for spinal pain. Given the time constraints in primary care and the need for quick standardised tools, we feel that the STarT Back tool is an excellent method of conducting evidence-based biopsychosocial assessment.

The reassessment at two weeks after onset of pain has been highlighted for a number of reasons. Some people present very early and the expected natural history of spinal pain suggests that many will settle spontaneously in this time frame; however, for those with persisting pain it is important to reassess and establish their ongoing risk of developing chronic pain. As has been highlighted earlier, other patients will already be two weeks or more from onset of pain by first consultation. We suggest that this is where clinical judgement comes into interpreting clinical pathways. It may be that if the patient has had no analgesia, or proper medical advice that it is most appropriate to establish these and review again in two weeks. For others it may be felt clinically more appropriate to follow the pathway according to the STarT Back tool assessment as suggested in the pathway.

Throughout the primary care management, it is crucial to highlight

the importance of maintaining normal everyday activities and movement. The pathway and attached resources highlights a number of self-help resources to facilitate this. The pathway also highlights the importance of good-quality analgesic strategies to enable patients to remain mobile.

Physiotherapy by Mr Jonathan Hill, Research Physiotherapist

Most health-care systems are facing the challenge of delivering effective primary care for LBP within tight financial restraints, despite increasing patient demands for more to be done.^{1,2} Results of clinical trials have demonstrated the effectiveness of treatments such as manual therapy, exercise and cognitive behavioural approaches compared to minimal care, but have not helped to inform us about the optimal approaches to target limited resources and improve efficiency of the overall model of care provided.³ It is clearly not feasible to refer all patients with LBP, due to the high numbers and associated costs. However, with over 60% of back pain consultants reporting pain and disability a year later,^{4,5} and high rates of re-consultation, work loss and sickness certification,⁶ something new has urgently been needed to reduce disability, work incapacity and spiralling costs due to common LBP.

One important answer to these problems has been research investigating stratified care approaches for back pain, which have demonstrated its enormous potential for improving LBP primary care management.^{7,8} Stratified care is well known to many other areas of medicine but is new to musculoskeletal medicine. The concept involves using a brief clinical tool to identify patient prognosis, categorising individuals into low, medium or high-risk groups for developing persistent disabling problems and then matching these risk strata to

appropriately targeted treatment pathways. The research used a randomised controlled trial (RCT) design to compare stratified care (prognostic risk stratification into low, medium and high-risk subgroups plus matched treatment pathways) with current best practice. The results demonstrated that stratifying patients led to altered clinical decision-making regarding treatment referral in a more appropriate manner, with low-risk patients supported to self-manage while medium and high-risk patients were provided the additional resources of physiotherapy treatment. While this proof of principle study was conducted in physiotherapy-led clinics for operational reasons and to ensure high levels of protocol compliance and internal validity for a trial, further research has gone on to test the implementation of this approach into general practice, with promising findings.⁹ The additional study (the IMPACT Back study) paper is not yet published but it has demonstrated that stratified care can be implemented into an everyday UK general practice setting and leads to patient benefits, particularly reduced time off work, without increasing health service costs.

The Map of Medicine pathway has therefore applied this relevant evidence to complement the NICE guidelines on individual treatment modalities. We have suggested that GPs should use the STarT Back Screening Tool to help inform their referral decision-making for patients with non-specific LBP. The pathway also recommends that physiotherapists should re-score patients with the tool to help determine the extent to which psychosocial risk factors might be involved and to better target their service to ensure that an individual receives treatment from an appropriately skilled practitioner. While stratified care does not alter existing knowledge of the effectiveness of individual treatment modalities, its use has been shown to reduce the number of treatments given

Pain Pathways: Spinal pain

to low-risk patients and conversely to ensure that physiotherapy resources are better targeted at higher-risk patients. Local commissioners and service leads therefore need to carefully review their pathways to consider whether stratified care might be usefully adopted into their spinal pathways for the benefit of patients and to reduce health-care and societal costs.

Psychology in the pathway by Dr Amanda Williams, Reader in Clinical Health Psychology

The principles informing the guidelines concern evidence and access. As with other specialised pain treatment, provision of specialised psychological help for people with chronic pain falls far short of the number of people with chronic disabling pain who could benefit. Instead the patient is offered whatever is available, however poor the evidence of effectiveness, or is dismissed entirely without help. Current generalist assessment of patients is very variable, and fraught with risks of the patient being dismissed as having 'medically unexplained symptoms', or inappropriately directed towards multiple investigations and treatments.^{10,11}

So our guidance uses evidence as far as possible, and is aspirational rather than describing the current status. It remains to be seen whether the aspirational approach raises expectations and standards as we hope. Guidelines are phrased in terms of skills and specific tasks, rather than in terms of contact with a particular health-care professional. We recommend specific issues to raise with the patient which are of known importance, and identification of risk factors. We also recommend various sources of information to help the person with LBP better understand the pain and its implications. These information sources are provided variously by national and local health services and charitable organisations, and include the

only book demonstrated to be an effective intervention.

Use of the STarT Back Screening Tool as the best available to us combines established risk factors in physical and in psychological state. For those at high risk who do not respond to information and reactivation or whose condition worsens, a more psychologically informed approach is recommended: identification and rectification of unhelpful beliefs; goal setting and problem solving; enquiring about relevant social factors. It is unclear to what extent the GP will be able to do this without liaison with psychological services, lacking in many areas.

After this, the patient who continues to struggle is referred to specialist pain management, where recommendations are based on rather more secure evidence of the efficacy of psychologically based pain management,¹² summarised and elaborated in the BPS guidelines for pain management programmes. The content of these programmes, of course, can be delivered to individuals by a collaborating pain team, such as when the patient requires an interpreter to work in English.

Spinal interventions by Dr Stephen Ward, Consultant in Pain Medicine, and Dr Sanjeeva Gupta, Consultant in Pain Medicine and Anaesthesia

One of the primary aims of the pathways project was to encourage the early treatment of neuropathic pain. There is provision in the LBP and radicular pain pathway to refer patients with radicular pain early to a specialist centre. Patients with mechanical LBP and radicular pain should be referred to a pain centre no later than three and six months, respectively, from the onset of symptoms if conservative therapy has failed.

The LBP specialist management pathway includes red flag identification, the optimisation of self-care and

pharmacotherapy. There is an emphasis on biopsychosocial multidisciplinary assessment and individualised stepped management approaches; informed choice is the key here.

With regard to interventional pain therapies, the BPS pathway group agreed that therapeutic facet joint intra-articular injections should be performed only in the context of clinical audit or research and with special arrangements for clinical governance. We acknowledge, though, that medial branch block is a safe and simple diagnostic procedure to test whether pain originates from the facet joints. They may have some therapeutic effect and are useful in predicting response to radiofrequency denervation/neurotomy.

We agreed that fluoroscopically guided injection of local anaesthetic and corticosteroid into the sacroiliac joint (SIJ) could facilitate diagnosis of SIJ pain and provide short-to-intermediate-term pain relief in carefully selected patients. This in turn may provide an opportunity for more effective physical rehabilitation.

We agreed that in carefully selected patients, facet joint or SIJ radiofrequency denervation should be considered. While NICE does not currently recommend radiofrequency facet joint denervation, recent outcomes of radiofrequency denervation have improved with better understanding of the neuroanatomy of the spine, improved patient selection criteria and improved radiofrequency ablation techniques. Older studies that have not used appropriate selection criteria and/or radiofrequency technique do not stand up to scrutiny with current standards.¹³⁻¹⁵ We recommend that the radiofrequency denervation should be performed in the context of a multidisciplinary team. There should be ongoing assessment following a trial of treatment to show evidence of response.

At least one diagnostic medial branch block should be performed prior to denervation techniques. Proceeding

directly to denervation may be more cost-effective, however this will be associated with a lower success rate and two branch blocks are likely to be better, but less cost-effective.¹⁶ We agreed that SIJ radiofrequency denervation (SIJ RF) may be offered to a carefully selected group of patients, who respond with at least 80% pain relief after fluoroscopy-guided diagnostic SIJ injections. We agreed that all spinal interventions should be performed under appropriate imaging. Where available, the BPS/Faculty of Pain Medicine (FPM) of the Royal College of Anaesthetists (RCOA) Good Practice Guidelines regarding interventions should be followed.

For severe radicular pain, we agreed that an urgent MRI and image-guided corticosteroid injection may be necessary for patients with unresolving, debilitating, acute radicular pain to provide pain relief and prevent disability. We recommend therapeutic epidural steroid injections for nerve root pain within eight to 12 weeks of onset of symptoms, or earlier if the individual situation demands. Transforaminal injections appear to be superior to interlaminar injections in terms of accuracy of placement. Image-guided transforaminal epidural corticosteroid injection may have a surgery-sparing effect. All spinal interventions should be performed under fluoroscopic imaging. The recommendations for good practice in the use of epidural injection for the management of pain of spinal origin in adults should be followed.¹⁷

We mention that some specialists would consider image-guided epidural corticosteroid injections for spinal stenosis, particularly for those patients for whom surgery is contraindicated. Some specialists would consider minimally invasive disc interventions for persistent radicular pain in selected cases (ensure special arrangements are in place for consent, audit or research).

Spinal surgery by Mr Jake Timothy, Consultant Neurosurgeon

Surgery for back and radicular pain for degenerative pathologies (excluding cauda equina) should only be considered once the non-surgical treatments have been performed. Although modern techniques are relatively straightforward and have low risks, they are invasive procedures and potential serious harm can occur to the patient. In an ideal setting, there should be a multidisciplinary team approach where the patient can be fast-tracked to surgery once it is clear that non-surgical treatments are not working and the patient is still disabled by pain. Unfortunately, the main cause of angst for patients is due to waiting to see a spinal surgical specialist. The Map of Medicine algorithm provides an evidence-based basis on which patients can be followed providing there is adequate access to all the specialists in a timely way.

Therefore, if the patient presents with radicular pain and an MRI scan has demonstrated a disc herniation, foraminal stenosis (due to facet or ligamentary hypertrophy) and has persistent symptoms for over eight weeks, they would be amenable for surgical intervention. This generally consists of a microdiscectomy approach under general anaesthetic, with a minimal muscle strip unilaterally, and the compression due to disc or facet hypertrophy is released. The risks are small, including infection and cerebrospinal fluid leak, with the most common small risk being recurrent disc herniation, generally in the region of 5%. The success of permanently curing the radicular symptoms has been reported in the region of 95%. There is good evidence, however, that early surgery does relieve pain faster and there is a perceived faster recovery.¹⁸

With regards to surgery for back pain, most surgeons would agree that

this is a more contentious issue. Unless there is a direct focus for back pain, such as tumour, osteoporotic collapse or infection, surgery for back pain is not as successful as compared to surgery for radicular pain. Often, however, few surgeons would operate on patients who do not have a surgical target and doing so could cause more problems in the long term. Sometimes, however, patients may not be satisfied unless they come face to face with a surgeon to explain why surgery may not be an answer to their back problems and this is why multidisciplinary working groups are important to assess and manage patients with back or radicular symptoms in a timely manner.

Representing patients by Mrs Christine Hughes, Mrs Elizabeth Killick

We have worked together for a number of years in BackCare, Chris as manager of the helpline and Liz as a volunteer. We both have extensive experience of talking to patients who are at various stages of their journey with back pain, from those experiencing first episodes to those with intractable difficulties. Liz also has personal experience of living with chronic back pain.

We participated in the spinal and radicular pain group, which was energetically and inclusively led by Sanjeeva Gupta, along with professionals working in the field of spinal pain. The work was done in a series of telephone meetings over a period of many months, with many tweaks and changes along the way. A huge amount of careful work went into refining the pathway as it is now presented. We were able to witness that the aim of achieving best outcomes for patients was always the focus of discussion. We all came to understand that although there is a wide range of good work being done, from the point of view of patients it is not always a process that is well joined up. The information

Pain Pathways: Spinal pain

that has now been presented in a coherent way simply did not exist in printed form until now.

On behalf of patients, we wanted the work to achieve an outcome that would allow them and their families to make informed decisions about treatment options, alongside their medical advisors, within appropriate timescales, so that they can avoid falling into the chronic states that we know blight so many lives. It should allow them to work out where in the sequence of treatments they should be seeking advice.

Alongside established medical treatments there are a wide variety of treatments and techniques that are not supported by statistical evidence, but that play a vital role in helping people to get back to a healthy and/or well-managed state. As patient representatives we were always anxious that the critical importance of self-management would be recognised, and be as prominent in the pathway as possible. This is a tricky area – what works for some does not work for others, and patients have to take

responsibility for finding their own way through managing their pain.

Clear information plays a vital role in allowing patients to manage their conditions, and we hope that the pathway as now presented, when read alongside the supporting references, will help individuals to have clearer, more informed understanding of the options that are available to them in managing spinal pain.

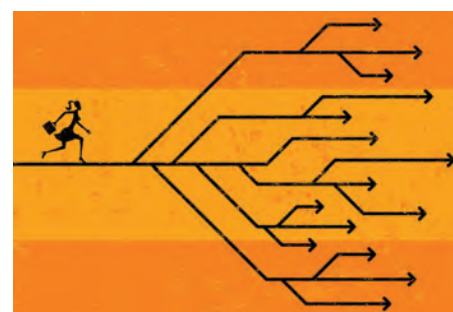
References are not included but can be obtained from the authors by email.

Pain Pathways: Chronic Widespread Pain

Dr Frances Cole

The pathway is designed to facilitate a multidisciplinary primary care approach for the majority of people with chronic widespread pain, while ensuring that those with underlying diseases requiring treatment and those with complex pain management needs are referred early to the appropriate services. The intention of the pathway development group is to ensure that people with chronic widespread pain receive complete care addressing their physical, psychological, social and personal needs; supporting them to become knowledgeable about their own health and confident in self-management, thus reducing reliance on health services; and enabling them to recover and maintain maximum quality of life.

The production of the chronic widespread pain pathway is very timely and provides a clear process and understanding of this challenging pain condition for a very wide range of clinicians. It will help primary care practitioners and those from therapy services, especially physiotherapists who can struggle with awareness of this pain condition. It is a condition that has crept up in prevalence and severity in the last 10 years and leaves many clinicians puzzled or struggling to make a coherent early diagnosis. The pathway and practical guidance embedded in it has endeavoured to provide clarity about the diagnosis itself and the role of self-management, medication and non-drug treatments. It drew on expertise at a



national level as well as from the grass roots of primary care; the BPS working party engaged with patient input from the fibromyalgia and pain-related groups. Communication is an essential skill when working with people with chronic widespread pain syndrome and the pathway highlights the importance of

reducing clinical and patient fears about the diagnostic label, pain itself causing harm or indicating serious disorders. Numerous resources and tools are highlighted at the steps both for patient use, clinician education and care monitoring.

It is an accessible care map and the extensive patient input included in the pathway team emphasises the role of self-management, self-report diaries and tools, and the value of the different websites and other self-care options. The team realised the current difficulty with the patchwork range of self-care services such as expert patients, accessing cognitive behavioural approaches or therapy in different areas in England. Guidance about referral to these types of services is provided. It was seen

as important to ensure that evidence-based practice where available and quality clinical care were included, given the lack of understanding of the condition and emerging differing views on causation and management. Early approaches to self-management are a repeated theme of all the pathways and the recognition of the role of patients in their own care is valued. Managing symptoms related to fibromyalgia is amply covered in different steps of the pathway.

Making the diagnosis should be much easier and guidance about referral should ensure that those patients who need specialist help can access it better and earlier. The indicators on poor outcomes are enlightening and should guide clinicians in their reviews and

decision-making about management and referral. Avoiding polypharmacy is essential and if encountered the pathway advises its reduction to reduce harm and over-reliance. The only opioid use advised in the pathway is tramadol as this drug has some limited evidence base of usefulness in pain symptom reduction. The use of other strong opioids is not seen as helpful by the pathway team and is not advised. The aspect of agreed regular reviews is covered well in section 14 and is seen as fundamental in the management of those with fibromyalgia. This pathway will be a useful step to managing this puzzling and challenging pain condition and may improve the quality of more people's lives.

Pain Pathways: Neuropathic pain

Dr John Lee

The neuropathic pain care pathway is one of the simpler pathways that the BPS is producing. However, it is recognised that there is controversy in a number of quarters. With this in mind, the membership of the pathway development group represents a cross-section of the stakeholder community: Dr David Bennett (Neurologist), Dr Sam Chong (Neurologist), Dr Clare Daniel (Consultant Clinical Psychologist in Pain Management), Prof Andrew Rice (Clinical Academic Pain Doctor, with a special interest in Neuropathic pain), Dr Mick Serpell (Pain Doctor with a special interest in Neuropathic Pain),

Prof Blair H Smith (Academic Primary Care Doctor), Ms Heather Wallace (Patient Representative) and Dr John Lee (Pain Doctor).

The bulk of the pathway represents the work done by NICE in its clinical guideline on 'The pharmacological management of neuropathic pain in adults in non-specialist settings' (CG96) but widens its range to develop recommendations on assessment and then suggests the pathways of care that will be taken in the specialist setting. At all points, the pathway is patient focused; there is a strong emphasis on agreeing individualised care plans that recognise



patients' choices with self-help advice and topical treatments. Other issues that caused a lot of discussion were: the inclusion of gabapentin (which is not in the current NICE guideline) and the

Pain Pathways: Chronic Widespread Pain

advice that stronger opioids should only be used by those who are competent to do so. A variety of specialist therapies have been outlined, for example spinal cord stimulation and intravenous drug trials with ketamine or lidocaine. The guideline is likely to need change fairly soon as research is very active to help us understand neuropathic pain and how best to treat it.

On a more reflective note, I think that the experience of drawing together any guideline is often overlooked; as chairperson, I have been lucky in having consummate professionals working on the neuropathic pain

pathway. The first step for any guideline is to set out the facts that are available, or to draw them from scratch; we were lucky in having a well-trodden path. Yet each piece of work that discusses oral medications, or spinal implants, or self-help tools, never really brings everything to the table. This has been the job of the BPS pathway groups. Drawing consensus from a mixed group of professionals takes time and patience. The purist academic may have an opinion diametrically opposite to the patient representative or GP working at the coal face, but as a group, we have to collaborate and

serve the patients' interests best. After this process, we have been subject to review from the BPS steering committee and then again from the Map of Medicine, who have scrutinised our work. Each step has issues to be discussed and agreed with deadlines to hit. The BPS has also endeavoured to include its wider membership and stakeholders, with sessions at the Annual Scientific Meetings and multiple methods available for feedback. The neuropathic pain pathway group has certainly been very grateful for the steady hands that have guided the processes to fruition.

Pathways – Commissioning

Dr Ollie Hart

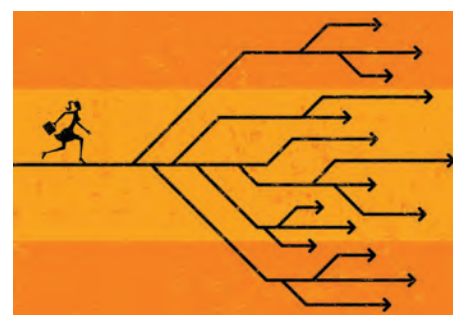
Your help is needed to help new commissioners understand solutions to the pain management challenge!

Judging by the level of attendance at the most recent BPS study day there is a keen interest in commissioning within the Society. It appears to be driven by mixed feelings. Some are understandably nervous about what the future holds, especially with stories of sweeping cuts to services in some areas. Others are interested, or dare I say excited, at the potential for new clinically led commissioning groups to lend a 'new ear' to cases for health provision.

Commissioning is not new; it has long been a part of health care. It describes the process of planning, procuring

(contracting with providers) and monitoring services. What is new is that the pressure on service funding has got a lot tighter, and the teams responsible for commissioning have changed.

In terms of funding, we are moving from a period of 10 years of unprecedented investment in health care with around 10% per year expansion of funding, to a period when real-life spend on health care will shrink (estimates range from zero growth to 5% reduction in real-term funding). This means that there has to be a much closer scrutiny applied to the value for money of services. It is unlikely that the NHS will be able to continue to fund all the services it has previously funded, especially in the context of pressure to



cover expensive new technologies and drug treatments. So judgements will need to be applied across the board to consider what sort of outcomes are being delivered for the money being spent on these services. The services most vulnerable to this sort of scrutiny will be those where clear evidence of

cost-effective patient benefit is not easily demonstrated.

Since the Health and Social Care Bill became law in March 2011, the NHS is committed to an ambitious reorganisation of its statutory bodies. The responsibilities held previously by primary care trusts (PCT) are passing to clinical commissioning groups (CCGs). Practically this means that the decision-making around how NHS money is spent will move from predominantly management-led, to predominantly clinician-led boards. Where this works well, new CCGs should combine the operational know-how of managers with the clinical experience of day-to-day management of patients that clinicians bring. However CCGs will, just like their predecessors, hold statutory accountability for financial balance. And in the current fiscal environment that will be a significant challenge. They will have to pursue value-based commissioning, perhaps even more aggressively than PCTs, as the true impact of the 'austerity cuts' reach full impact.

Chronic pain services have in the past been victim of these sorts of value-based judgements, at times without clear justification, and resulting in complete cessation of treatments. These sorts of 'blanket bans' have subsequently attracted criticism from senior NHS leaders, who demand a more measured patient-centred approach to decision-making. The BPS is working hard to ensure that these dramatic and poorly reasoned changes do not happen in the future.

The Map of Medicine pathways form part of this process of ensuring that commissioners understand the value of pain management services. They lay out pathways for best practice in key areas of pain management. They provide evidence-based consensus opinion from key opinion leaders in the field. They have been externally reviewed and have been tested against opinion from leaders in parallel specialties. They are well needed as commissioners need to know what the best care pathways for pain management look like. We will need BPS members and all those who believe in pain management, to be highlighting these pathways to commissioners in their region. We need providers to align their services to fit in with these recommendations and we need patients to be made aware of what is considered best practice.

However to complete the package for commissioners, we will need to apply 'value' illustrations to the pathways. We will need to establish what level of outcome can be achieved, for whom, for how much spend. Within this there is a need to establish what outcomes matter to patients. Traditionally, quality-adjusted life years (QALYS) are used by health economists to model these outcomes, providing a 'currency' for comparing services. We will need to establish the characteristics of patients who will most benefit, and at what thresholds. Given the high prevalence of people living with pain, we need to identify those most in need of help, and

those who are likely to respond to the services we can offer. We will also need to illustrate the most innovative and cost-effective ways of delivering these services. I hope, however, with clinicians leading new CCGs that the emphasis in health-care planning will move away from short-term financial balance towards long-term consideration of population health needs.

Work is well underway to look at these areas. It is not easy as the evidence base is limited, outcome measures are patchy and inconsistent (and not easy to compare across services) and true costs of services are bundled within combined tariffs. It may trigger research, audit and service evaluations to help plug the knowledge gaps. We may need to pilot new, innovative ways of working. We will need to involve patients in helping us understand what really matters to them. But if we are to provide evidence that can help commissioners perform their difficult tasks, we must work together to develop this understanding.

A series of workshops is planned around the country to help gather opinion and evidence of best practice from pain management practitioners. The BPS has established a team of people who will work with Faculty of Pain Medicine (FPM), Royal College of GPs (RCGP), patient groups (Pain UK), Chronic Pain Policy Coalition (CPPC) and NICE to establish consensus on value judgements for pain management.

Your ideas and feedback are very welcome.



Commissioning – Top 10 tips for BPS members

Dr Ollie Hart

1. *Be familiar with latest evidence base.* New map of medicine pathways across five domains – national, clinician-led, BPS consensus on common pain management pathways.
2. *Be aware of landscape changes.* With the new Health Bill, responsibility for commissioning has shifted from NHS managers to clinical commissioning groups (CCGs). These CCGs are boards constructed mostly of GPs.

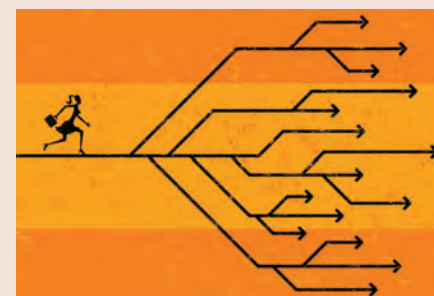
Pros – clinically led, opportunity for new perspective

Cons – inexperienced, clinician's time limited, vulnerable

Changeover scheduled for April 2013 – depends on satisfying an authorisation process. With GPs leading the commissioning process, it is important to understand their priorities of population management and long-term care planning for patients.
3. *Be aware of pressure on costs, and need to demonstrate value of services.* Large changes in budgets – moving from 10% growth per year to 5% shrink per year (real terms). These financial restrictions are forcing a re-examination of 'value' of services (cost: benefit). Remember GP practices will be accountable for the budget of their patients' care – this may become directly or indirectly linked to their personal income.
4. *Understand patient priorities and needs.* There is a strong focus in new policy on empowering

patients to be capable of managing their own condition – especially for long-term conditions. *Liberating NHS May 2012 – No decision about me without me* – 'patient voice' remains a very powerful influence in local and national decision-making. *NICE clinical outcomes framework August 2012* – one of the eight top priorities is 'proportion of patients feeling supported to self-manage'.

5. *Understand the wider context of pain management in a population context.* Pain management consumes large volumes of resources in primary and intermediate care (physiotherapy services especially).
6. *Consider chronic pain as a long-term condition.* Move towards viewing chronic pain (persistent pain) as a long-term condition in its own right – requiring ongoing support/management strategy.
7. *Understand how long-term pain management can be integrated with other care pathways and frameworks.* There is a move towards care planning for multi-morbidity, where long-term conditions are not treated in isolation. Most people with long-term conditions (including chronic pain) have at least three (e.g. hypertension, chronic obstructive pulmonary disease, asthma, diabetes, congestive heart failure, ischaemic heart disease, mental health, chronic kidney disease, obesity, hypercholesterolaemia, chronic pain).
8. *Continue to push for assessment of chronic pain in local needs*



assessments. Recognition of the prevalence and impact of chronic pain within population needs assessments has been poor. However where it has been assessed it regularly comes out as having the most significant impact. Population needs assessments will shape the strategy of health commissioning.

9. *Establish and measure meaningful outcome data to show the value of your services.* Commissioners will focus on patient outcomes to decide value of services. They will want to compare outcomes for different services and specialties. To compare outcomes it is useful to be able to measure quality-adjusted life years (QALYs) for a service.
10. *Work together.* Patients with chronic pain are everywhere and have very similar issues. CCGs across the country are challenged by how to commission for pain management services. The same debates and conversations are happening across the country. We need to share audits, research, ideas and implementation strategies that have worked.



Implementing the pain pathways – Do you know enough?

Prof Nick Allcock *Chair, BPS Communications Committee*

In order to ensure the implementation of the pathways, four implementation groups were established and announced at the Annual Scientific Meeting (ASM) in Liverpool, to take forward the Pain Patient Pathways. The aim of one of the groups is to facilitate communication about the pathways to the BPS membership. As the current Chair of the Society's Communication Committee, I was asked to lead this aspect of the work and would like to take this opportunity to update you on progress.

The communication of the pathways to you as members of the BPS is vital if all the work that has been put into their development is to have the influence that we hope it will. The pathways will be of little benefit to patients and the pain community if they are not used by practitioners in the new commissioning processes that are currently being introduced in the NHS in England. It is important therefore that you, as members, have access to the information you need and feel confident to use the pathways in your engagements with commissioning groups. Rather than establish a separate committee, this work has been undertaken by the Communication Committee. In order to communicate effectively with the BPS membership we have planned a number of approaches.

Special edition of *Pain News*

This edition of *Pain News* is dedicated to the pathways and we hope this will give you a useful insight into the pathways.

BPS website

We are working on developing the information about the pathways on the Society's website to make it clearer and more accessible. This will include information on how to access the pathways and the work of the implementation groups.

Publication on the Map of Medicine

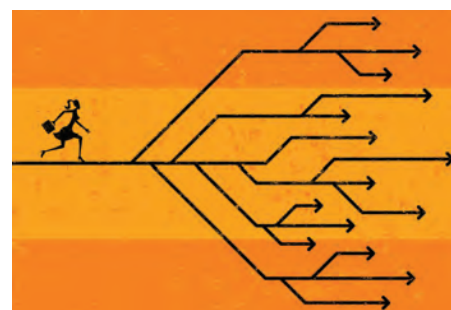
As pointed out in the introduction, the maps will be gradually released via the Map of Medicine (<http://www.mapofmedicine.com>). This is widely available to those in the NHS via Athens, however we are aware that not all members have access to this. Alternative access, for instance for those in academic posts and those who work in Wales, is being discussed with the Map of Medicine and there will be access to versions of the maps through microsites accessible via the BPS website.

Publication

The pathways will be published in the *British Journal of Anaesthesia* and we will ensure that members are informed of the relevant publication dates.

NHS Evidence accreditation

The Communication Committee of the BPS has for some time been working towards what we hope will be NICE accreditation for the BPS as a trusted source of information in NHS Evidence. We are working with NICE, which administers this process, to look at the possibility of accreditation of the pathways.



Workshops

The demand for places on a recent study day at the BPS on commissioning illustrated the interest from BPS members for information relating to the commissioning processes. We are currently working with the implementation group on commissioning guidance to plan a number of regional workshops, the funding for which is still being negotiated. We hope to be able to announce details of the workshops in the near future.

The purpose of this work is to ensure that you have the information that you need to use the pathways to support your practice. I hope that we are making good progress in our aim of ensuring that all the members of the BPS are aware of the pathways and have access to the information they need to use the pathways effectively. I would welcome any ideas as to how we can communicate with you more effectively and what would help you to implement the pathways. Please therefore feel free to contact me with your ideas and comments.

National commissioning of specialised services

Dr John Goddard

This article was originally published in Transmitter, the newsletter of the Faculty of Pain Medicine (FPM) of the Royal College of Anaesthetists, and has been reproduced here.

One of the key components of the Health and Social Care Act 2012 is the introduction of clinical commissioning. Most NHS services will be commissioned by clinical commissioning groups (CCGs), supported by the NHS Commissioning Board (NHSCB). The NHSCB is also responsible for commissioning specialised services directly.

During 2011 the Department of Health established a Clinical Advisory Group (CAG) to review specialised commissioning and advise on future prescribed services. Many of these will, for the first time, be commissioned nationally. Previously many specialised services were commissioned regionally by specialised commissioning groups, which acted on behalf of primary care trusts (PCTs), using Specialised Services National Definition Sets (SSNDSs). There is an SSNDS for specialised pain management services (adult) and paediatric chronic pain is included in specialised paediatric anaesthesia and pain management services, one of 23 parts of the SSNDS for specialised services for children.

The CAG considered the services that are set out in the 34 SSNDSs. All these services were tested against the four 'factors' in the Act to determine whether or not they should be commissioned by the NHSCB:

1. the number of individuals who require the provision of the service or facility;
2. the cost of providing the service or facility;
3. the number of persons able to provide the service or facility;
4. the financial implications for CCGs if they were required to arrange for the provision of the service or facility.

The CAG made initial recommendations to ministers in December 2011: while many services met the four factors, there was a need for further work on many services to allow for their separate and direct commissioning by the NHSCB. Sixty clinical reference groups (CRGs) were established to perform this function. The clinical chairs of the CRGs were recruited by advertisement from leading clinicians in their fields, with designated support from commissioning and public health colleagues. The other members of each CRG were nominated by the chair, CAG, commissioners and the patient and public engagement steering group.

Andrew Baranowski, Treasurer Elect of the BPS, is Chair of the Adult Pain CRG; I am a member, as are the president and many other members of the BPS. I had input on paediatric chronic pain to the paediatric surgery CRG by personal communication with the Chair, Julian Roberts, Consultant Paediatric Surgeon in Sheffield, and the Anaesthetic Representative, Kathy Wilkinson, President of the Association of Paediatric Anaesthetists.

Following an initial meeting in Bristol in March, a large amount of work has been undertaken, with much email communication. Deadlines have been exceptionally tight. The initial requirement was for the CRG to produce a scope of the service that should be commissioned. This is no easy task as diagnostic and treatment codes in pain are not well developed. Separating specialised from non-specialised activity can be difficult. Both occur in many centres, and this indeed was the reason for the CRG programme as this problem pertains to many services. In Bristol, a decision was made to describe the service rather than the patients it would manage. Another decision was to include children in the adult scope.

The CAG has now published its report, which has been accepted in full by ministers. Adult highly specialised pain management services will include multidisciplinary assessment including outreach. For specialised interventions, the service will include procedure costs (including devices), follow-up and rehabilitation. Highly specialised paediatric services will include multidisciplinary assessment and specified interventions including intensive inpatient or residential management programmes. Paediatric services remain within the paediatric surgery CRG, but closely cross-referenced with the adult service specification.

The Secretary of State will now consult with the NHSCB and publish parliamentary regulations, which are



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subject to the parliamentary timetable. Work is currently ongoing on a manual that will determine the exact wording of the regulations. Following publication of the regulations, the NHSCB will publish its own

understanding of what the regulations cover as service specifications. The CRGs are currently working on detailed service specifications. Further work will then be needed to determine where services are provided. The NHSCB

assumes responsibility for national commissioning from April 2013.

- The full report of the CAG is available at <http://www.dh.gov.uk/health/2012/09/cagreport>

News

IASP Acute Pain SIG update

Felicia Cox *IASP Acute Pain SIG Member*

Membership of the Acute Pain SIG now stands at above 400 which is a 400% increase from four years ago when Narinder Rawal was appointed membership advisor. This year's SIG symposium was organised by the SIG Chair Stephan Schug and the SIG newsletter Editor Esther Pogatzki-Zahn. The day was again well attended with presentations on imaging in acute pain, animal models, perioperative steroid use, the role of NMDA antagonists and alpha agonists in acute pain management. The afternoon programme focussed on treatment strategies and measuring the effectiveness of acute pain management and was facilitated by Pam Macintyre. Acute Pain SIG symposia always include a social event and this year was no exception with a drinks reception and canapés provided at the end of the day for attendees. This attention to providing an opportunity to socialise may well explain Narinder's success in increasing the membership.

The business meeting of the SIG was held separately later in the week and focused on appointing new SIG officers



AP SIG Officers: (L to R) Andreas Landler-Kiesling (Austria), Esther Pogatzki-Zahn (Germany), Jane Quinlan (UK), Brendan O'Donnell (USA) and Daniel Carr (USA)

and agreeing the symposium programme for the next World Congress in 2014. Congratulations to Jane

Quinlan, Chair of the BPS Acute Pain SIG, who was elected as the Secretary of the IASP Acute Pain SIG.



IASP (L to R)
Daniel Carr (USA), Mary Korula
(India), Gillian Chumbley (UK)





Dr Mick Serpell

Clulow Research Grant 2013

The British Pain Society invites proposals for the 2013 Clulow Research Grant competition. This year, for the first time, we are asking for proposals based on a specific theme. The BPS Research/Audit survey clearly demonstrated that members placed the theme “**prevention of acute to chronic pain transition**” as a research priority. We therefore invite submissions from BPS members, based on this theme, from a wide range of disciplines: from basic science to clinical services.

A grant of up to £50,000 will be awarded. The funds may be awarded for a variety of purposes in support of a research project (e.g. small project grant, salary support, capital equipment purchase, running costs or additional funding to an existing grant). However, should the Grant be awarded to cover a proportion of the total costs of a research project, it will not be released until funds covering the full costs of the project are in place. Applications will be peer reviewed and a decision made by the British Pain Society Science and Research Committee by October 2013.

A copy of the Society's research grant conditions can be downloaded from the British Pain Society website at www.britishpainsociety.org/members_grants.htm

Applications must be made online at www.britishpainsociety.org/mbc/mbc_form.htm

Closing date is Monday 13 May 2013

The Use of Information and Communication Technologies in Managing Pain

Meherzin Das *Dorset*

Interactive technologies appear to be the infinite frontier and developments in Information and Communication expertise are progressing at the speed of light; this presents new opportunities of working with patients, practitioners and commissioners for improved and innovative care, placing pain management literally at people's fingertips!

In order to provide a platform for some of the excellent work being done around the country and to demonstrate how contemporary technology supports the clinical management of pain, the BPS in conjunction with The Health Foundation will host a **Study Day on February 25, 2013 on The Use of Information and**

Communication Technologies in Managing Pain at Churchill House, 35 Red Lion Square, London. Booking information is available from the usual channels at the Society office and from the website.

The day will combine presentations on the use of interactive websites, social networking, apps and texting by service users and professionals already involved in designing interactive technology with live demonstrations wherever possible. Strategy workshops will provide time for the uninitiated to reflect on e-health choices for their own services, on the partnership between commissioners, service users and clinicians necessary

for the successful utilisation of technology and for the group as a whole to consider the way forward in this bewildering but exhilarating new branch of healthcare.

You might also be interested in knowing that the **launch of a Special Interest Group for the Use of ICT in the Management of Pain** is being considered as a way of creating a focal point for the BPS to provide direction and explore further developments ... if you would like to find out more about this and support the setting up of this group, please contact Meherzin Das, Clinical Lead, Dorset Pain Management Unit at meherzin.das@nhs.net



Use of medicines outside of their UK marketing authorisation in pain management and palliative medicine

Dr William Campbell

As part of the management of pain, whether acute or chronic and in palliative medicine, it is common practice to use medicines beyond their UK marketing authorisation. In 2005, Dr M Bennett, Consultant in Palliative Medicine and Dr K Simpson, Consultant in Pain Medicine jointly chaired a working group, which drew up a consensus document on behalf of the Association for Palliative Medicine of Great Britain and Ireland, and the Pain Society respectively.

Over the past seven years, some professional bodies have changed their recommendations when using medicines outside their UK marketing authorisation. The new consensus document incorporates these changes and to this end we considered it appropriate to completely rewrite the document. In particular, the

information for patients is in a simple, but we think valuable format. It can be easily printed off for patient distribution and details of the unlicensed medication with the reason for its use can be inserted, as well as the prescriber's contact details.

The new consensus document "Use of medicines outside of their UK marketing authorisation in pain management and palliative medicine" covers areas of good practice for nurses, pharmacists, podiatrists, physiotherapists, radiographers as well as doctors. In addition information is provided on paediatric and palliative care practice, as well as mixing two or more medicines within one syringe. I am indebted to my co-chair, Dr A Wilcock and the other six members of the working party who contributed so much to the preparation of this document.



The British Pain Society

Use of medicines outside of their UK marketing authorisation in pain management and palliative medicine

This is a consensus document prepared on behalf of the British Pain Society in consultation with the the Association for Palliative Medicine of Great Britain and Ireland.

September 2012
To be reviewed in 2017

Pain Less exhibition

Dr Andrew Morley

Pain Less - an exhibition on contemporary research in pain medicine and anaesthesia - opens on 7th November in the Antenna Gallery of London's Science Museum.

Pain Less will investigate how recent research on pain and consciousness might help us to overcome pain in the future. The exhibition will feature research by Professors Irene Tracey, Vilayanur Ramachandran and Geoff Woods - among

others. Two further gallery exhibits are the result of audience co-creation projects. The first is a film created by chronic pain sufferers working with the artist Deborah Padfield; the second, a computer game about pain designed by pupils from Langley Academy, Berkshire.

A new *Pain Less* section appears on the Science Museum website to accompany the exhibition, which will run for a year. A series of related events is

also planned, both in the gallery itself and after hours at the Dana Centre - the Museum's adult venue.

Pain Less is intended to enable researchers and the public to learn from each other, in accordance with the aims of the Wellcome Trust Society Awards. The project is largely funded by one of these, with additional support provided by several professional bodies including the British Pain Society.



Journal of Observational Pain Medicine

Dr Rajesh Munglani and his team have worked hard to release the first issue of the Journal of Observational Pain Medicine (JoOPM) (ISBN 2047 0800) successfully. This journal will publish papers covering all aspects of pain medicine and has been created in the recognition of the fact that not all information or advances in pain medicine can be presented in a randomised controlled fashion.

This journal will consider papers on clinical practice, basic science, ethics, including suffering, social, psychological and issues of education and resources limitations in pain medicine. This journal provides immediate open access to its content on the principle that making research freely available to the public supports a greater global exchange of knowledge. The first issue of this journal can be accessed freely at www.joopm.com



HCA Foundation Scholarships

HCA Foundation Scholarships have been running for the last five years delivered by an independent Charity. More details about the Foundation can be seen at <http://www.hcainternationalfoundation.com/> (http://news.hca-international-foundation.co.uk/LE35.aspx?MTA3NzoxNjUzOjE4NTk0I*!3972010). The Foundation grants scholarships to senior trainees and young consultants. It supports training in specific techniques or disease processes so that candidates can gain experience that they may be lacking in their normal training practice.

F1000 Research

The first articles on *F1000 Research* were published recently and details can be accessed at <http://f1000research.com>. F1000 is an alternative open access programme supporting all sound research. Cathy Price and Mick Serpell contribute to pain section also.

The 'Others'



THE BRITISH PAIN SOCIETY

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Recently I received a letter from a GP.
It went like this:

Dear Dr,

Miss. X came to me today after seeing you in the pain clinic. She is concerned about the "Lidocaine plaster" that you have prescribed. She found out that this plaster contains gelatin. She is not keen to try this plaster with gelatin because of religious reasons. Please advise on any other alternatives.

Now, tell me, how many of you knew that transdermal lidocaine plaster contained gelatin? Hand on my heart, until I saw that letter I didn't have a clue that lidocaine plaster contained gelatin. My curiosity, responsibility as a doctor and hunger for knowledge (you believed it?) drove me to find out more about this.

I Googled, spoke to my hospital pharmacists and contacted the manufacturer. The manufacturer and the pharmacists confirmed that lidocaine

plaster contained gelatin. Google search showed that 'Lidoderm' (the American version of lidocaine plaster) contains the following inactive ingredients: dihydroxyaluminum aminoacetate, disodium edetate, gelatin, glycerin, kaolin, methylparaben, polyacrylic acid, polyvinyl alcohol, propylene glycol, propylparaben, sodium carboxymethylcellulose, sodium polyacrylate, D-sorbitol, tartaric acid and urea.¹ The UK version of the same plaster contains the following: Self-adhesive layer: glycerol, liquid sorbitol, crystallising carmellose sodium, propylene glycol (E1520), urea, heavy kaolin, tartaric acid, gelatin, polyvinyl alcohol, aluminium glycinate, disodium edetate, methyl parahydroxybenzoate (E218), propyl parahydroxybenzoate (E216), polyacrylic acid, sodium polyacrylate, purified water. Backing fabric: polyethylene terephthalate (PET). Release liner: polyethylene terephthalate.²

It was truly astonishing to find that this medicated plaster contains so much 'other stuff', other than the active agent – lidocaine. Even more astonishing fact is that the same formulation of a similar drug 'across the pond' has different 'other stuff'. Okay, I agree that a medicated plaster is slightly more complicated than a simple tablet or capsule, so it might need lot of other stuff for its action. But what about a simple capsule or a tablet? Out of interest I checked what one 500 mg paracetamol tablet by the commercial company contains. In addition to the active ingredient (500 mg paracetamol) it also contains potato starch, maize starch, talc, silicone dioxide and magnesium stearate (E572)!

This raised a few points:

1. Do these medications need so many 'add-ons' or 'other stuff' in the final formulation?
2. How many health professionals know the add-on ingredients of every medicine they prescribe?
3. How many of our patients would be happy to consume medications if they knew about all the add-on ingredients, especially if these are incongruous to their dietary or religious beliefs?

Why 'add-ons'?

The 'add-ons' or 'other stuff' in drug formulations are called *excipients*. The word 'excipient' is derived from the Latin word called *excipere*, meaning 'to except', or simply 'other than'. So, anything 'other than' the active ingredient in any drug formulation is an excipient.

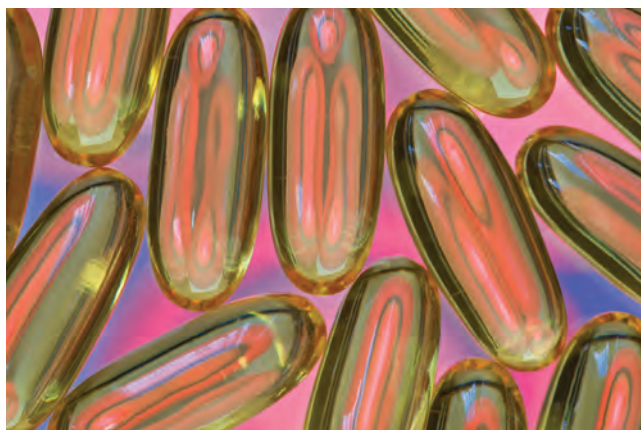
The medications come in different forms – tablets, capsules, patches and so on. The main purpose of giving any medication is to facilitate the active ingredient to reach the final destination. In many cases, the active ingredients in their pure form are not stable. To prevent this and to increase the shelf life of a particular medication, the excipients are added to the formulation. In some cases, the active substance may not be easily administered to or absorbed by the human body. To make these active ingredients easily absorbable and administrable, they have to be added to or dissolved into the excipients. Sometimes the excipients are added to bulk up the medication to give an accurate dosage or to mask an unpleasant taste. Occasionally the excipient plays a more

active role than just a bulking agent. It may help to facilitate or control the rate of absorption of a drug (e.g. slow-release formulation). In some formulations, excipients also hold the active ingredients of the drug together so that it can be dispensed properly, and help to identify and enhance the overall safety of the product. According to industrial experts, the excipients make up 90% of most of the drug formulation and \$3 billion of the pharmaceutical market.³

Apparently it is claimed by some that the companies keep this information about the excipients as a trade secret to give their brand an advantage over their competitors. So it is common for companies to use different add-ons (especially preservatives and colouring agents) in their brands compared to the competitors to make up the same drug. Therefore it is not uncommon to find the same drug of a similar formulation having different excipients (as shown in the case of the lidocaine plaster).

Before marketing, the manufacturers have to prove to the safety agencies that the excipients in the formulation are necessary for the particular formulation and are safe. The excipients in a formulation are supposed to be inert; but there is evidence to prove that this is not true. In some cases these excipients interact with active ingredients in the formulation to produce reactions ranging from a simple allergic reaction to serious life-threatening anaphylaxis.⁴ Because colouring agents are used more than any other excipient, the adverse reactions for this group are more common than any other, although in a small group of patients. Although colouring agents have been incriminated as a suspect for hyperactive behaviour in children, this has recently been disproved.⁵

Another commonly used excipient is gelatin, which is used as a common binding agent. Even though gelatin used for medical purpose is chemically transformed from animal products, some patients may consider the mere presence of gelatin in the medicine as unacceptable (as I found out in the case of the above-mentioned patient). Even though the excipients are supposed to be inert, I feel that these add-ons do make a difference when it comes to the overall experience of a patient with a particular medicine. My personal experience is the case of two different brands of ibuprofen; I am fine with one brand but end up with immediate gastritis if I take another brand. Many of



my patients have also told me similar stories about their medications: *'Doc, the tramadol you gave made me more woozy compared to the one my GP prescribed, even though it is the same dose.'*

Do we check for 'add-ons'?

From the incident that I mentioned at the beginning of this article, it is clear that I did not check for any add-ons when I prescribed. Do you check? If you say yes, you are a rarity. A recent study from Manchester showed that the majority of doctors are not aware of the excipients in every medication that they prescribe.⁶ It

is practically impossible to check every single ingredient in every drug formulation. But it is ethically important for every doctor to know about the ingredients especially if the excipient may not be acceptable by a patient because of dietary or religious reasons.⁷

What do patients think?

How many of our patients would be happy to consume medications that contain ingredients that are prohibited either by their dietary or religious beliefs? In the same study quoted above, researchers from Manchester tried to find an answer to this question. In their survey they asked the patients whether they would ask the prescriber about the content of their prescribed treatment. They also asked if they would refuse to take that medication if alternatives were available. The authors found that 43.2% of the study population would prefer not to take animal product-containing medication even if no alternative were available. The study also informed that 51% of men were found to have inadvertently been prescribed gelatin-containing products against their preferred dietary restrictions.⁶⁻¹¹

Oh, one last thing (thanks to Steve Jobs)

So far we have looked at the use of excipients in medications. Let me finish with a humorous note about one of the most common excipients used.

In 1960s a UK-born neurologist Adrian Upton showed that jelly made of gelatin emitted electroencephalogram (EEG) waveforms, which were conducive to life.¹² When Upton connected a jelly to an EEG machine, it showed EEG waveforms similar to that from the human brain. *If you take this literally, this means that the jelly made of gelatin was alive and had brain function.* But in essence he was trying to prove that EEG

The 'Others'

alone was not the only proof that the human brain is alive or dead; other corroborating evidence should also be taken before coming to a diagnosis of brain death. Later it was proved that the EEG machine was picking up signals from ventilators, the drip stand and the telephone through the jelly!

The author does not claim to be an expert in pharmacology. This article is written to improve awareness among health-care professionals about excipients in medications. This is by no

means exhaustive; if the reader wants to know more about the topic they are advised to consult the relevant experts or textbooks.

References

- 1 <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=16295>
- 2 <http://www.medicines.org.uk/emc/medicine/19291>
- 3 <http://www.pgg.org/download-files/ExcipCert-4-WhitePaperonExcipientsCertificationFinal.pdf>
- 4 <http://www.australianprescriber.com/magazine/34/4/112/4>
- 5 Rowe RC, Sheskey PJ, and Quinn ME, eds. *Handbook of Pharmaceutical Excipients*, 6th edn. London: Pharmaceutical Press, 2009
- 6 Vissemetti B, Payne S, and Payne M. Ethical and practical considerations in prescribing animal-derived medication. *Postgraduate Medical Journal* 2012; 88: 499–502
- 7 Corfield L, and Granne I. Ethical and practical considerations in prescribing animal-derived medication. *Postgraduate Medical Journal* 2012; 88: 497–8
- 8 <http://thechart.blogs.cnn.com/2012/02/27/the-animal-products-in-your-medicine-cabinet>
- 9 http://articles.businessinsider.com/2012-02-28/news/31106736_1_drug-companies-gelatin-vegetarian-society
- 10 <http://www.bbc.co.uk/news/health-17182625>
- 11 http://www.huffingtonpost.co.uk/2012/02/27/vegetarians-unwittingly-consuming-gelatin-medicine_n_1304282.html
- 12 <http://www.qi.com/this-weeks-qi/jelly>

Professional perspectives

Beyond words – A picture of pain

Molly Van der Weij *Illustrator, visual artist and communication designer, www.mollyvanderweij.com*

Long-term pain is a debilitating condition affecting one in seven people globally. It is an emotional and physical experience that varies with each individual. A major problem in getting it recognised and accepted is that the feelings, sensations and perceptions experienced are 'invisible' to all but the sufferer.

Imagine, however, having a visual record that could enable people to 'see' the pain experience, that could record its movement through the body and the impact it has physically, emotionally and spatially on the individual. Such an image could capture the physical location(s) of pain, the variety of sensations, the emotions, the progress of painful episodes and the desolate places it can take the sufferer.

Research is showing that chronic pain is considerably more than an unpleasant sensation. It changes the way people

feel in complex ways. It can also affect the way the sufferer perceives their body, and their sensation of where they are in space. This will affect the way they behave and how they respond to treatment.

The fact that pain is not visible and is therefore difficult to appreciate or understand (for the sufferer and others) not only makes accurate communication about the experience an essential part of trying to manage and make sense of it, but it can also help to focus treatment options.

When a person suffering from pain is unable to clearly describe, and thus share, his or her experience, it becomes a source of great frustration, anger and negative emotions, which can spiral downwards. Always having to explain 'what's wrong' is difficult and having to continually justify their behaviour and

feelings or levels of fatigue is draining. There is a feeling of nobody understanding the full impact of what they are going through.

Pictures often speak louder than words. Not everybody is gifted with the ability to express what he or she feels in words or conversation. Words can be interpreted in many ways. Also emotions can get in the way of finding the right words. Alternatives for expressing pain experiences, such as the use of images, might help in building a better and mutual understanding – a more comprehensive, accurate picture.

The most common visual tools currently used in the clinical setting are the outline figures upon which a clinician marks the location(s) of perceived pain, and visual analogue scales (VAS) where patients are asked to grade their pain.

They do not inform us about anything specific, and use a one-dimensional means of measuring a multidimensional experience.

My interest as a communication designer is on 'making visible'. 'Making visible' means giving form, thus defining content and context of often abstract and complex issues, such as feelings or perceptions. It gives form to emotions and sensations, which not only enables reflection and accurate communication but also enables them to be examined so that there is a shared understanding.

In order to design a visual tool that would help patients to more accurately convey their pain and to foster a better understanding of pain in society, it was necessary for me to know more about what exactly needed to be communicated. My research focused on what pain actually is. I asked the following questions. What does it do? What do we do with it? What is the 'pain experience'? Would it help the sufferer to see how pain affects their perceptions and behaviour? Can pain be visually communicated, shared, measured and monitored? Can a diagram help to manage pain by showing its pattern and behaviour? What is generic and what is specific to the individual? Can living with pain be anything more than suffering?

I worked closely with staff and patient volunteers at the Pain Clinic of the Royal United Hospital in Bath. Observations during a pain management programme and a series of in-depth interviews¹ using an iterative approach ensured an accurate end result, which patients confirmed as a complete picture of their pain. Using the method of visual notation to capture and record information helped to 'get inside their skin' and to create illustrations of how pain changes perceptions and lives.

In practice it meant that, during the interviews, paper and pencils were laid out on a table between or in front of us and I drew in full sight of the patient, what they were telling me about their

pain. I asked questions when necessary but mainly to bring the focus back to the pain experience itself in order to remain as precise as possible. I used questions such as: Where is your pain? Is it big? Is it there all the time? Does it move or change? What happens when the pain starts? Where and how does it start? Does it move? How does it dissolve or leave your body? And so on.

The visual notations were made by me (the interviewer): the patients did not do any drawing but it was very much a process of co-construction where the patient described their feelings and as a skilled visual communicator, I listened to and translated those feelings into drawings. Working together in an iterative process the initial drawings were refined through further dialogue until the patient was satisfied that the visual depiction was an accurate, holistic record of their pain experience.

From the material that the series of interviews resulted in, I distilled a set of exercises that could be used as more generic frameworks with which to capture aspects of the pain experience. There seemed to be a shared narrative about the pain experience, such as 'how it affects my life', or influences and interactions with external factors. I tested these frameworks with patients and found that they are relevant to use, showing clear characteristics and factors, leaving space for the personal within.

Other aspects of the pain experience can also be captured visually and can be used as a tool to identify patterns, processes or measure progression, frequency and intensity of pain – the complete picture. It could also be used as a tool for assessing the effectiveness of therapy and medication at a glance. Having a complete picture can help us to understand how pain influences daily life.

Visual communication techniques can graphically illustrate the complexity of pain and can help us to better understand the individual's pain experience. Images convey many things

simultaneously and give a more accurate, complete story than is possible through words alone. Descriptive words can be interpreted in numerous ways whereas graphic illustrations can provide an 'at-a-glance' understanding of each individual's unique experience.

A first evaluation with clinical staff has concluded that this innovative approach highlights valuable aspects of the individual's pain experience that may otherwise have gone unnoticed or unarticulated. There are no other examples of this approach of capturing meaning within published pain literature. This is a potentially valuable tool, not only for helping the individual pain sufferer to accurately convey their experience, but to help clinicians and academics to develop and individualise appropriate treatments, as well as inform pain research.

The posters illustrated in this article were displayed in the Scientific Exhibition of the Neuro Dynamics and Neuromatrix conference in Adelaide, Australia in April 2012. Copies are displayed in Professor Lorimer Moseley's lab at The University of South Australia, Adelaide, where they are attracting a lot of attention. The originals are displayed in the Pain Clinic of the Royal United Hospital in Bath, where they are also attracting the attention of patients and clinicians.

All illustrations are material from primary research undertaken as Artist in Residence at the Pain Clinic, Royal United Hospital, Bath, UK, in 2010, part of my research project on Envisioning Experiences of People's Pain for an MA in Communication Design at the Bath Spa University, School of Art and Design, which I passed with Distinction and was awarded with the University's Innovation Award in 2010.

Note

My approach towards doing the interviews can be placed in the tradition of client-centred therapy (Rogers 1967). It relies on a sense of trusting people's ability to be open for looking at their experiences and for me as interviewer to create the space for them to do so.

Beyond words – A picture of pain

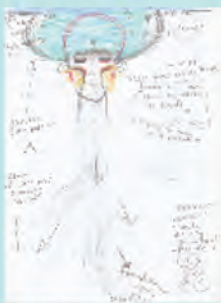
BEYOND WORDS - A PICTURE OF PAIN

Molly van der Weij, 2012

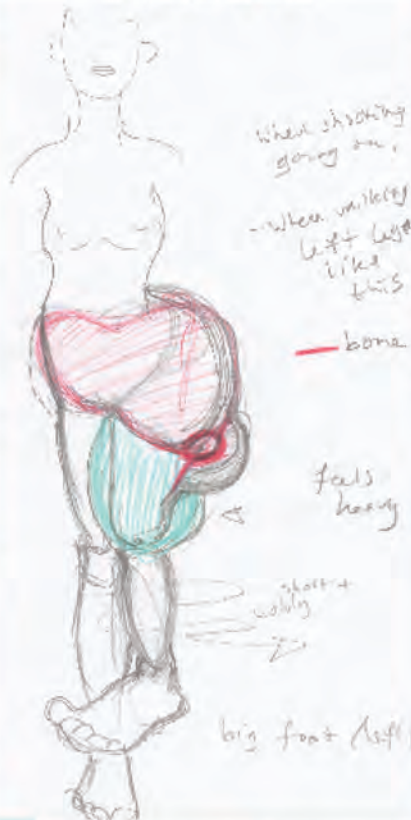
These drawings show how the process of pain moves through the body and how the experience is perceived.



The drawing above illustrates the moments before this young woman's pain episode begins. She experiences a strong sense of withdrawal and is conscious of closing down all contact with the outside world. She is still aware of what is going on but feels like she is in a cocoon; sounds are muffled and not clear. She feels unable to move her body but her hands feel restless.



The drawing above shows the patient's description of how and to where her pain progresses. Triggered by 'external' factors, such as noise or high pressure, the process begins with the feeling of having a huge, heavy, pulsating head. The pain then moves from her head to her face, eyes and ears; she starts to build up a heat; her hearing becomes acute and buzzing; the flesh on her cheeks feels like it is turning inside the bones; she is unable to see because her eyes have turned inward. They feel hollow. Her mouth is open and frozen. These sensations can remain for 1 - 1.5 days in this location before the pain then moves from the centre of her forehead down to her lower body.



Drawing on the left:
From the waist down:
She describes the area drawn in red as feeling like hard bone. The blue area feels fluid, like water, whilst her lower leg feels very short, loose, as if it is dangling freely. Her left foot feels big, heavy and is perceived as being unable to touch the ground. Functionally, she walks slowly with a stick and is always careful about placing her left foot.

Drawing below:
Asked to describe her back she feels her shoulders are wide and heavy. She perceives her hands as being very large.



The pressure from her head moves to her pelvis. Here, she describes the building up of pressure as the feeling of storm clouds forming. These are squeezed and she feels high tension on the left side of her pelvis. This tension is then released as sharp, fast, shooting feelings, like lightning from a thunderstorm, down her left leg. Her upper leg becomes restless and needs to move. This leads to a feeling of numbness in her left lower leg and foot. As a result she finds it very difficult to put her foot down or to touch the ground. The ground feels like air or her foot feels as if it is dissolving or sinking into the ground.



This graph shows how the process of pain moves over time. It records frequency and intensity of pain as experienced over 24 hours. For this person it clearly depicts six pain episodes during that time scale, how long they lasted and how quickly or slowly they came and went. Such a graph, gives immediate, valuable and relevant information about her pain episodes, their frequency, duration and intensity.

Poster 1 shows how a young lady perceives how her pain would look if one could see it, as deforming her body. To the rest of the world she is an attractive, normal-looking young woman. It illustrates the change of the perception of her body and with that

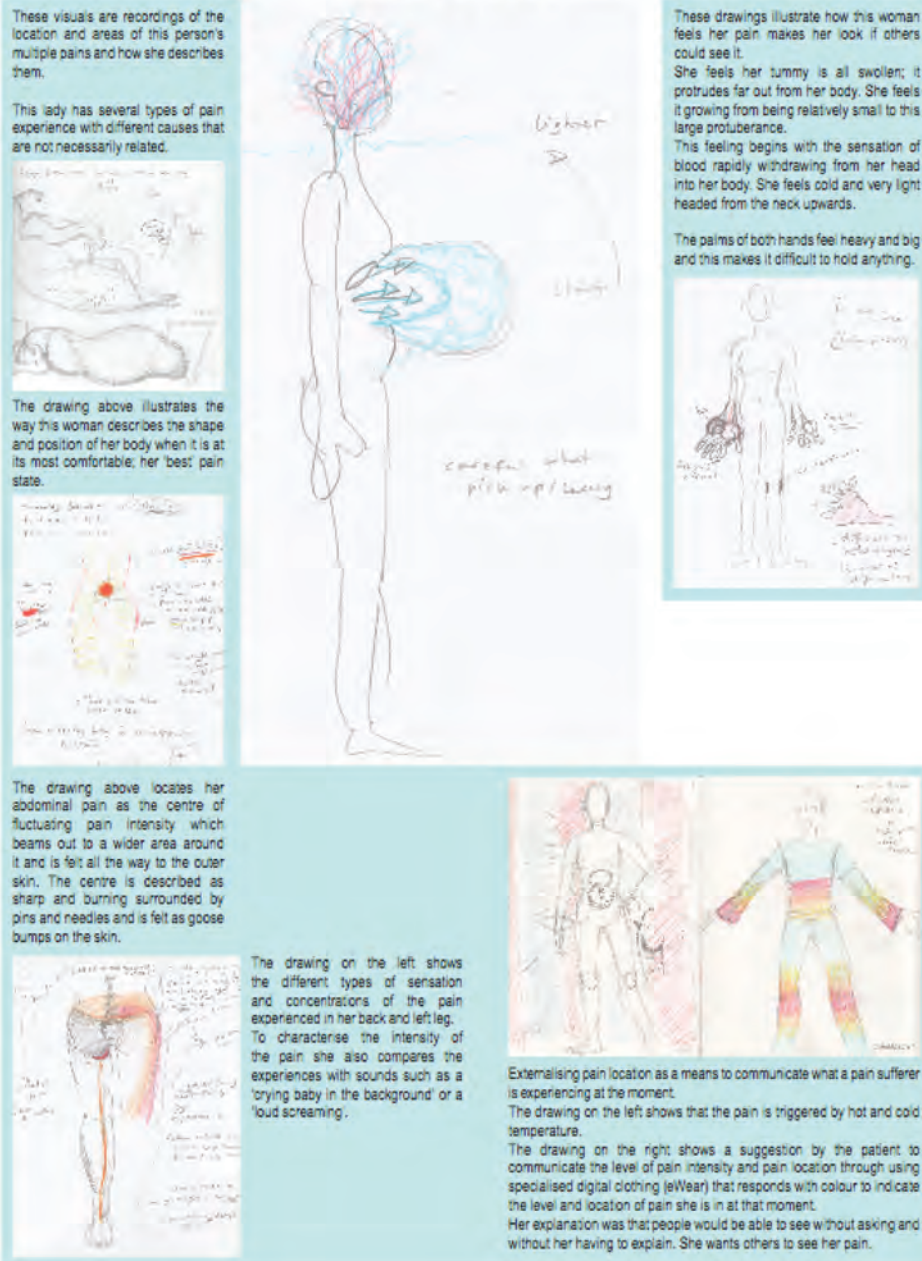
her spatial awareness, which is reflected in her behaviour, such as leaving space on her left side when sitting in a chair. Her overall pain experience is all-consuming, affecting her perceived body temperature, hearing, eyesight and ability to function.

This affects how she behaves and interacts with others.

It also depicts her pain behaviour over time (24 hours). The experience itself is not a constant or fixed state of being but in a constant flow between all-consuming and bearable.

BEYOND WORDS - A PICTURE OF PAIN

Molly van der Weij, 2012



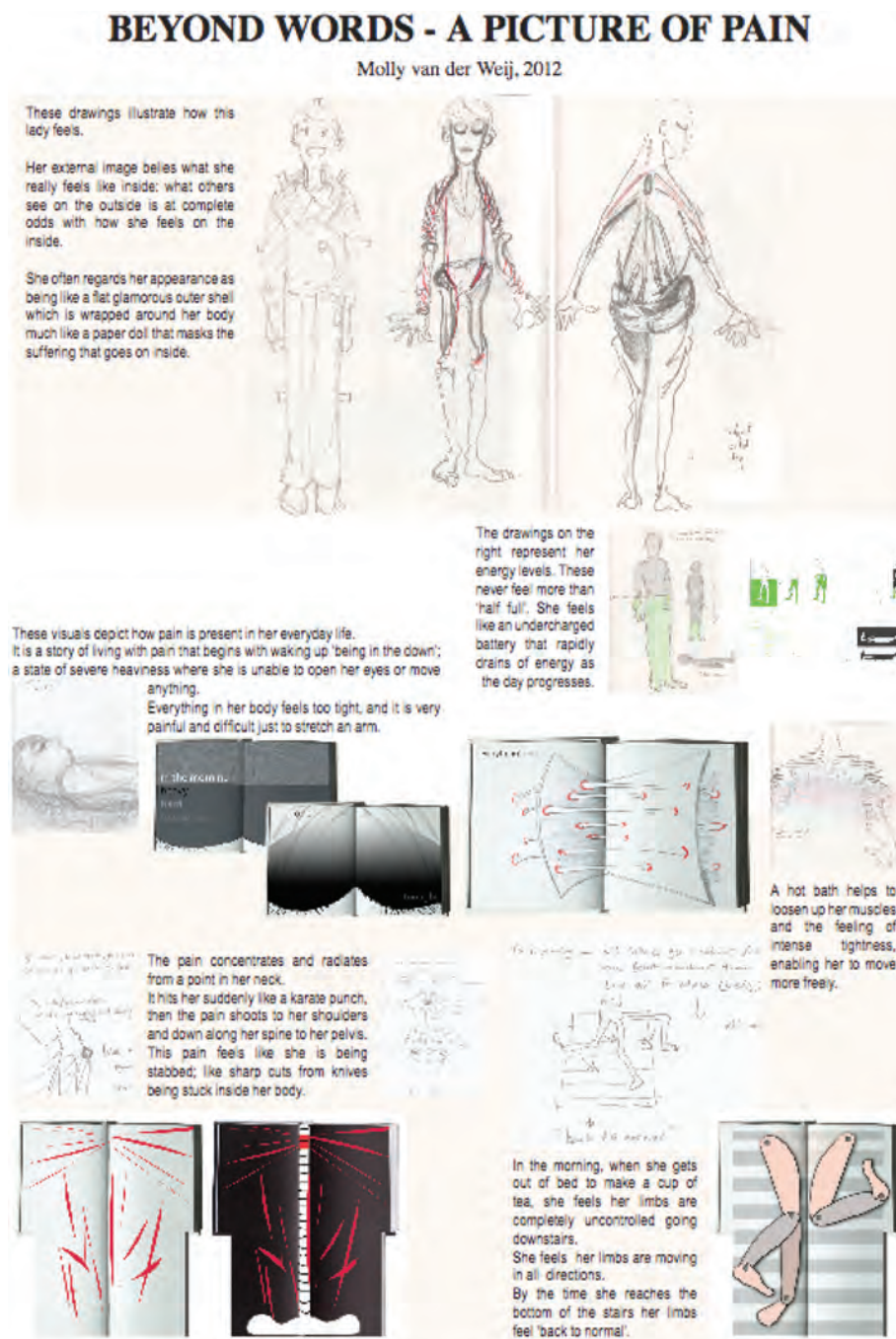
Poster 2 takes another person and illustrates the location and area of her multiple pains and how she describes them. It also illustrates the way this woman describes the shape and position of her body when it is at its most comfortable; her

'best' pain state. This could be valuable knowledge in her treatment approach.

In addition to conveying her pain experience, this person expressed a desire for researchers to develop a suit that would 'light up' in response to her

painful areas. She felt that this could be an effective means of externalising her pain and conveying her message to others. This desire also demonstrates the way pain dominates all aspects of her life including her very identity.

Beyond words – A picture of pain



Poster 3 depicts (partly) how pain is present in this woman's everyday life. It is a story of one day in the life of living with pain. It begins with waking up, 'being in the down'; a state of severe heaviness where she is unable to open

her eyes or move anything. Everything in her body feels too tight, and it is very painful and difficult just to stretch an arm. It feels like she is being stabbed with sharp knives all over her body.

To complete her pain picture, one of the drawings represents her energy levels. These never feel more than 'half full'. She feels like an undercharged battery that rapidly drains of energy as the day progresses.



Reducing the risk, improving the benefit: an opioid pathway for patients on long-term opioids for chronic non-malignant pain

LC Jaynes, H Riggs and C Waters

Introduction

Opioids offer useful analgesia but the attendant risks may deter many from offering this, especially to those deemed to be at high risk. Opioids should not be denied to patients in chronic pain,^{1,2} even those with a history of substance abuse or similar, if it is considered otherwise appropriate. The proper treatment of pain is less likely to lead to aberrant behaviour in recovering addicts than under-treatment.³ With a careful selection and monitoring process and a fully informed and empowered patient the risks can be reduced.

In 2010, the BPS published revised guidance⁴ on the use of opioids in the management of long-term non-malignant pain, which offers a useful framework to guide good clinical practice. Below is outlined a process set up at the West Suffolk Hospital. This was developed after reviewing and considering many different forms and processes, informed by the BPS document, has proven easy to use and offers a transparent process for all involved.

Background

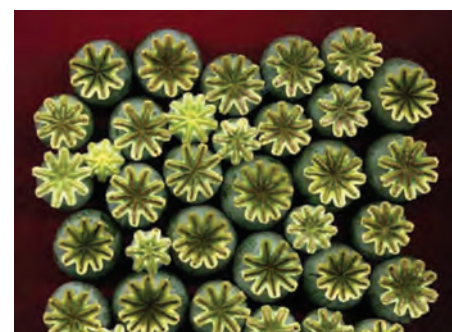
Over recent years there has been a more liberal use of opioids and with that, increasing evidence of associated harm if dosing and aberrant behaviours go unchecked. Opioids have long been known to cause tolerance, dependence and addiction^{5,6} but the risk in the chronic pain population is thought

to be relatively low. The effects on the neuroendocrine^{7,8,9,10} and immune system^{11,12,13} have been brought to light more recently. All risks, as well as benefits, need to be discussed with the patient as well as informing them of their responsibilities, before a trial of an opioid is considered. However, patients recall only a fraction of the content of any consultation (see accompanying article by Riggs and Waters). Therefore, documentation and a pathway were developed to improve this at the West Suffolk Hospital; we feel that this will ensure that all the risks are discussed and patients are able to give informed consent.

The pathway

Once a patient has been identified as someone who may benefit from a trial of strong opioids they are commenced along the Chronic Opioid Therapy (COT) Pathway as outlined in Figure 1. For the purposes of this clinic, a strong opioid was considered to be a dose exceeding 240 mg/day of codeine or the equivalent.

At the initial consultation the patient is given a BPS patient information leaflet to read, along with a Screener and Opioid Assessment for Patients with Pain (SOAPP) 14 form, an agreement form and a consent form. The consent form and agreement form are then completed by the patient together with the pain clinical nurse specialist (CNS). These forms were developed from those published by the American Academy of Pain Medicine and



The British Pain Society's

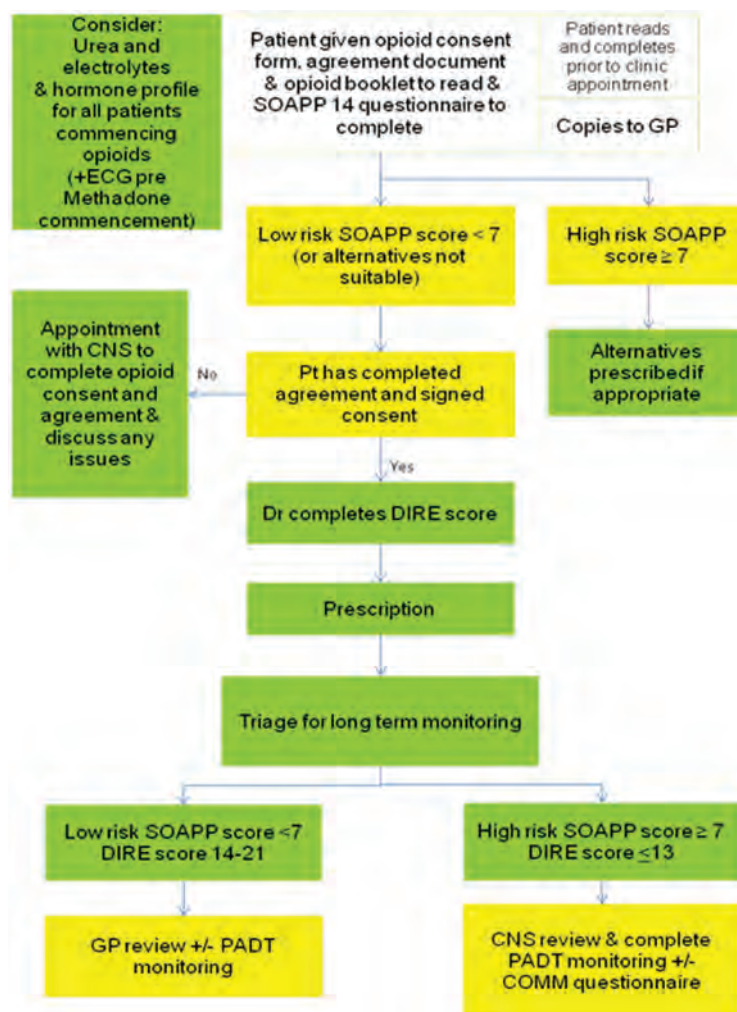
Opioids for persistent pain:
Good practice

A consensus statement prepared on behalf of the British Pain Society, the Faculty of Pain Medicine of the Royal College of Anaesthetists, the Royal College of General Practitioners and the Faculty of Addictions of the Royal College of Psychiatrists

January 2010
To be reviewed January 2013

outline the risks involved, what constitutes acceptable behaviour and sets out the patient's responsibilities. These documents have been through a readers' panel and are clear and quick to complete. All concerns raised and any questions the patient has are answered at this point with reference to the BPS patient information leaflet. Realistic goals are agreed with the patient and documented. The forms are signed by the patient, witnessed by the CNS, then reviewed by the prescribing doctor and countersigned. Copies of all the documentation are given to the patient and sent to the GP, with another copy

Figure 1. Outline of the opioids pathway



SOAPP = Screener and Opioid Assessment for Patients with Pain; DIRE = Diagnosis, Intractability, Risk and Efficacy score; PADS = Pain Assessment and Documentation Tool; COMM = Current Opioid Misuse Measure

being kept in the patient's notes. At this point the doctor completes the Diagnosis, Intractability, Risk and Efficacy (DIRE) score. Once the paperwork has been completed and the patient and medical staff feel that an opioids trial is appropriate, baseline measurements are taken.⁷ These include:

- blood pressure (unpredictable effect on ambulatory venous pressure (AVP))
- weight and body mass index

- bloods (see Table 1)
- bone densitometry (only if high risk and thereafter as per local rheumatology guidance)
- electrocardiogram (ECG) in patients being considered for methadone to assess the corrected QT interval (associated with prolongation of the QT).

If these are all within normal range, the patient is then provided with a

prescription for the opioids and a telephone appointment is booked for the following week. The patient is also given the contact details of the clinic should they have any queries in the interim. It is clear, and there is documentary evidence of, what risks and goals have been discussed with the patient and, at the point the patient is deemed to have had a successful trial of opioids, the 'high risk' group remain under the supervision of the pain clinic and both the Pain Assessment

Reducing the risk, improving the benefit: an opioid pathway for patients on long-term opioids for chronic non-malignant pain

Table 1. Summary of blood tests undertaken at screening

Test	Which patient?		
	Men	Pre-menopausal women	Post-menopausal women
U&E	✓	✓	✓
LFT	✓	✓	✓
FBC	✓	✓	✓
ESR	✓	✓	✓
CRP	✓	✓	✓
Testosterone	✓		✓
SHBG	✓		✓
Oestradiol		✓	✓
FSH	✓	✓	Only if not sure patient is menopausal
LH	✓	✓	
DHEA	✓		✓
TFT	✓	✓	✓
PRL	Only if galactorrhoea		
Fasting glucose	If obese or weight gain, due to ↓insulin production on long-term opioids		
Cortisol, ACTH, GH	If recurrent infections, significant depression or lethargy and seek advice		

U&E = urea and electrolytes; LFT = liver function tests; FBC = full blood count; ESR = erythrocyte sedimentation rate; CRP = C-reactive protein; SHBG = sex hormone-binding globulin; LH = luteinising hormone; FSH = follicle-stimulating hormone; DHEA = dehydroxyepiandrosterone (a precursor for androgenic sex hormones); TFT = thyroid function tests; PRL = prolactin; ACTH = adrenocorticotrophic hormone; GH = growth hormone.

and Documentation Tool (PADT) and the Current Opioid Misuse Measure (COMM) are used. Those highlighted as being 'low risk' are handed over to primary care with the GP and practice nurse clear of the goals and limits of the opioid dosing, encouraging the use of the PADT for ongoing monitoring. Supporting the pathway is a weekday advice line that the GPs or patients can call if there are any concerns or questions, and the patient can be escalated to the higher level of monitoring within secondary care if adverse circumstances or risk factors develop and necessitate this.

The screening tools

Screener and Opioid Assessment for Patients with Pain (SOAPP) 14

This was published by Akbik et al.¹⁴ in 2006, based on expert consensus of a panel of pain and addiction medicine specialists, and subsequently,

recommended by the International Association for the Study of Pain (IASP) in 2008. There are 14 questions answered by the patient that are then 'scored' to give a value that offers a guide to the abuse potential for patients considering long-term treatment with opioids. It is quick and easy for the patient to complete and has good psychometric properties.¹⁵ The scores are easy to interpret, have demonstrated reliability and predictive validity¹⁴ with good sensitivity and specificity¹⁰ as a screening tool. High scores have been shown to correlate well with an increased likelihood of aberrant drug behaviour in the future,¹⁷ and it is very good at predicting the low-risk patient. It does, however, require the patient to be honest.¹⁶ The tool was originally designed for use in chronic pain patients being considered for strong opioids to assess opioid abuse, and the plan is to move the format out into primary care in the future.



The British Pain Society's

Opioids for persistent pain:
Information for patients

A statement prepared on behalf of the British Pain Society, the Faculty of Pain Medicine of the Royal College of Anaesthetists, the Royal College of General Practitioners and the Faculty of Addictions of the Royal College of Psychiatrists

January 2010
To be reviewed January 2013



Diagnosis, Intractability, Risk and Efficacy (DIRE) score

This was published by Belgrade et al.¹⁸ in 2006. It is completed by the doctor contemplating the prescription of the opioids to give a measure of the risk:benefit ratio, taking into account the underlying diagnosis as well as many psychosocial aspects. It is very easy to use and quick to complete, has been validated and demonstrates high sensitivity and specificity for compliance and efficacy.¹⁸ However, while it has been validated by experts, it lacks prospective validation.¹⁵ It is only a guide; a high score highlights the possibility that the patient is at higher risk of problems but should not be considered an absolute exclusion.

The monitoring tools

These offer transparency, with the demonstration of aberrant behaviour if any and documentary evidence of ongoing benefit.

Pain Assessment and Documentation Tool (PADT)¹⁵

This tool aims to measure analgesia, activities of daily living, adverse events and aberrant drug-taking behaviour.

The questions were developed following a literature search and subsequent review by an expert panel and then modified after use

in a pilot group to create the 41-item tool. It is quick to complete, easy to use by the patient and assists identification of benefits and risks and offers a standardised form for clinicians to use.

Current Opioid Misuse Measure (COMM)¹⁹

This tool aims to measure current aberrant behaviour, developed from consensus of 26 pain and addiction specialists. The questions were selected through a process of concept mapping, scoring and finally empirical evaluation in patients. It is a self-assessment, easy to use and quick to complete.

Discussion

The format of the pathway has worked extremely well for us. The workload associated with these types of pathways can be significant, particularly at the outset, however this pathway has proven very useful in the

stratification of risk; it gives us more confidence in the identification of the low-risk patient; the transparency of the process facilitates the delegation of the ongoing monitoring within primary care. We believe that the whole process is a useful tool and should be used in light of good clinical judgement and these forms are not a substitute for that.

A patient highlighted as being high risk is not excluded from a trial of opioids if it is deemed clinically necessary, but a 'high-risk score' ensures a much higher level of monitoring and support for this patient group and all those involved in the patient's care are aware of the issues from the outset. Opioids are discontinued if goals are not met or there is evidence of harm and patients are escalated to the high-risk group if the monitoring suggests it to be necessary. Both patients and CNSs are empowered and, serendipitously, of those already on long-term opioids entering the system, many have made a positive decision to reduce and in some cases stop the opioid altogether, improving overall compliance; frequently this has also improved compliance in other areas, such as physiotherapy. We are auditing the outcomes of this new clinic and hope to present the data in due course, but the initial feedback from both patients and staff is extremely positive as is outlined in the accompanying article by Waters and Riggs.

References not included but can be obtained from the author.



A pathway for chronic opioid therapy – Users' experiences

Christine Waters *Lead Clinical Nurse Specialist*

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Historically, as clinical nurse specialists we have encountered uninformed and distressed patients, suffering from unacceptable opioid side effects who were entangled within a health system inadvertently contributing to their iatrogenic complications.

In the previous article, the Chronic Opioid Therapy (COT) Pathway recently introduced within the Department of Pain Medicine at the West Suffolk Hospital was discussed. This article will discuss preliminary quantitative and qualitative outcomes from the perspectives of both users and clinical nurse specialists (CNSs). The findings of a clinical audit will be briefly presented prior to a synopsis of qualitative feedback from patients.

A personal anecdotal evaluation of the COT pathway will follow.

Aim of the clinical audit

To compare patients' experiences of commencing opioids for chronic non-malignant pain, before and after the introduction of a standardised opioid pathway.

Methods

Following organisational approval, retrospective audits were undertaken before and after the introduction of a pathway for chronic opioid therapy to determine compliance with the audit indicators as outlined in Table 1. Initially,

100 patients were recruited into the pre-audit, and subsequently 75 patients were recruited into the post-audit. Data were retrieved from medical records and postal questionnaires between December 2010 and September 2012.

Results

In total, 26 (26%) and 35 (47%) patients returned the pre- and post-questionnaire, respectively. For all of the indicators outlined in Table 1, the required standard of compliance was 100%. Prior to the introduction of the standard opioid pathway the results revealed suboptimal compliance with the 10 audit standards. Compliance varied

Table 1. Compliance with audit indicators pre- and post-questionnaire

Audit indicators	Standard	Pre	Post
1 All patients will report that the benefits of opioids were discussed prior to initiation	100%	74%	97%
2 All patients will report that the goals of opioid therapy were discussed prior to initiation	100%	70%	94%
3 All patients will report that adverse effects of opioids were discussed prior to initiation	100%	59%	100%
4 All patients will report that they were informed that opioids may affect the body's defence system (immune function)	100%	26%	74%
5 All patients will report that they were informed that opioids may affect their sexual drive and function	100%	59%	91%
6 All patients will report that they were informed that opioids may cause an increase in their pain	100%	41%	82%
7 All female patients of child-bearing age will report that the effects of opioid therapy on the newborn were discussed	100%	7%	50%
8 All patients who drive will report that cautions relating to driving when commencing opioid therapy were discussed	100%	37%	72%
9 All patients who drive will report that they were informed of their responsibilities to inform the DVLA when commencing opioids	100%	15%	75%
10 All patients will report that they felt involved in the decision-making process as to whether opioids should be commenced	100%	67%	100%

Box 1. Examples of patients' qualitative remarks

'Glad to finally be in the correct department as had a very difficult two years dealing with long-term opioid treatment and subsequent side effects prior to finding this helpful department.'

'I would like to come off opioids ASAP even if this involves an increase in pain. Please arrange for me to start decreasing ASAP.'

'This is the first time in 10 years I feel I now have a goal to aim for and that I am now being helped by people who know what they are doing.'

'The Pain Clinic staff at West Suffolk Hospital are second to none in my opinion. The follow-up appointments are clear, concise and they listen. Keep up the good work.'

'GP information on opioids is not up to date and has caused problems.'

'The Pain Team at West Suffolk Hospital have changed my life. I can now enjoy my family life and son, thank you.'

'Follow-up calls and support was second to none. I feel that the treatment and help I am receiving is the best I have experienced in the many years of pain I have had.'

'After 10 years of pain, I am now getting the help I need thanks to the pain clinic. I really appreciate it.'

between 7% and 74% with only three audit indicators^{1,2,10} obtaining results above 60%. Following the introduction of the standardised pathway, results demonstrated a significant improvement, with compliance only falling below 70% for audit indicator 7.

Qualitative feedback from patients

Verbal and written feedback from patients relating to their experiences of the opioid clinic has generally been exceedingly positive. Box 1 contains a summary of evaluative statements.

CNS experiences of using a pathway for chronic opioid therapy

As previously discussed, the preliminary audit results following the introduction of a pathway for COT demonstrates a marked improvement in the awareness of adverse effects and safety issues. The

benefits, however, of a pathway for COT extend far beyond this.

First, the screening process for risk assessment and stratification has led to a significant improvement in predicting the potential risk for opioid abuse, which is clear to all involved in the care of these patients. Risk stratification has also enabled decision-making as to whether responsibility for opioid monitoring lies within the realms of primary or secondary care. Secondary care monitoring of opioids by a named CNS is predominantly restricted to patients who are predicted to fall within a higher-risk category, with the level of monitoring tailored to meet clinical need. Interestingly, we have observed a considerable reduction in patients displaying aberrant behaviours. We propose that the risk stratification process and the individualised monitoring are potential factors influencing these observed behavioural changes.

The reduction in aberrant-related drug behaviours may also be attributed to the consent process. Implicit within the pathway is informed consent comprising of written information, namely the Opioid Consent Form and the BPS's publication *Opioids for Persistent Pain: Information for Patients*. In addition, verbal information accompanies a standard PowerPoint presentation that provides supplementary information. Patients are asked to read the information, then sign a consent form and an agreement document that unambiguously sets out ground rules for behaviour.

The agreement document, discussed in the previous article, has also served as a medium for introducing discussions on potentially sensitive issues, including acceptable and unacceptable patient behaviours and the consequences of stepping outside agreed boundaries. Anecdotal observations of the CNSs suggest that it is uncommon for patients not to agree to act within these boundaries. One patient reported: 'Just the simple act of signing a piece of paper has a very powerful effect. The key to taking control and improving my well-being is accepting and taking ownership and responsibility and not hiding behind ignorance or excuses.'

Consequently, patients are no longer uniformed passive passengers within a paternalistic medical model of opioid prescribing. We have seen the emergence of empowered individuals who are engaging with us in meaningful conversations regarding risks, benefits and practicalities of opioid therapy. Their role as active partners in decision-making has also developed, as they weigh up the risks and benefits to them on a personal level. This has been demonstrated by patients frequently suggesting alterations to their opioid schedules, more commonly requesting dose stabilisation or dose reduction rather than dose escalation. Maybe we

A pathway for chronic opioid therapy – Users' experiences

are reaching the stage of what Bannister (2010) implies is 'informed cooperation'?

The implementation of the pathway has also led to improved monitoring of the four A's (analgesia, adverse effects, activities and aberrant behaviours) through the use of the Pain Assessment and Documentation Tool (PADT). Clinically, improved monitoring has benefited both high-risk patients and those undergoing opioid switching, the latter group reporting improved patient outcomes from a pain, function or side effect perspective. An additional benefit of improved monitoring is that the dose of opioids is not increased beyond an upper limit in the absence of demonstrable clinical benefit. This has minimised the risks associated with unchecked dose escalation of opioids.

Finally, the pathway has led to enhanced communication and collaborative working between medical, nursing and pharmacy staff. Although the pathway for COT is coordinated by the CNSs, our pain clinicians remain actively involved within their roles as referring clinician, lead clinician and primary decision-maker. Furthermore, the pathway has also provided a dynamic structure for promoting the delivery of best practice. Clinical standards can thus be agreed between pain clinicians and

the CNSs before being incorporated within the pathway.

Naturally, there has been, and continues to be, hurdles for us to overcome. Time appears to be the greatest challenge. To overcome such challenges we have reorganised our clinics. Standardised documentation has also been developed to help the CNSs with assessment and correspondence. Furthermore, referrals into the pathway by our pain physicians initially led to an excessive overload of certain team members. This difficulty was addressed through an agreement to train all the CNSs within our integrated service to be pathway facilitators.

In summary, these early findings suggest that a standardised opioid pathway influences the professional practice of health professionals in following good practice for opioid prescribing in persistent pain. The implementation of this pathway for COT has provided a useful structure for facilitating both multidisciplinary teamwork and informed consent and



agreement, and consequently may minimise risks to patients and society.

Although this project is ongoing, much has been achieved. It is hoped that there will be widespread interest in developing pathways for COT. We envisage that the answer for improving opioid risk management in the UK lies, in part, with pain clinicians recognising the value of working both collaboratively and proactively with patients, nurses, pharmacists and primary care staff to ensure that the benefits of opioids in persistent pain outweigh the risks. I leave you with this to reflect on.

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The digital footprint of chronic pain: are we keeping up with the rest?

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Introduction

Internet-based resources are an increasingly prominent source of health information for both professionals and the public.^{1–3} The role of the internet in educating and managing chronic conditions is likely to continue to expand in coming years, and its impact in chronic pain is also emerging.^{4–5} This has already been commented upon in *Pain News*: 'Social media, by engaging, educating and empowering our patients, can provide an emphatic voice to their rights to pain relief...'⁶

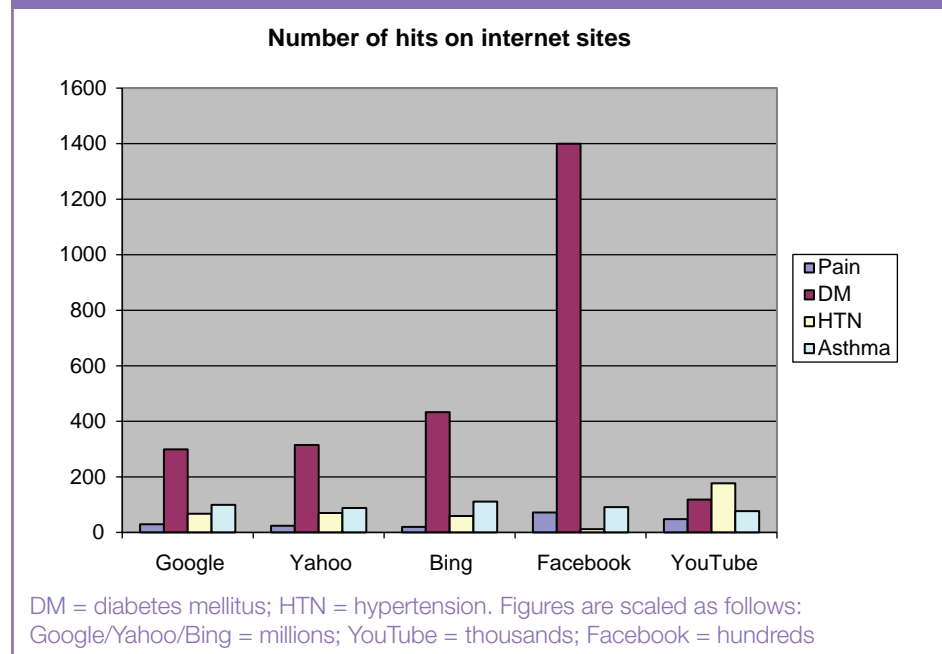
Chronic pain remains under-recognised by the public, particularly when compared with other common chronic conditions, such as diabetes mellitus.⁷ This is despite chronic pain having a prevalence of approximately 13% in the UK compared to 5% for diabetes mellitus.⁸ This disparity in prominence may also be present in the online arena. I decided to compare the digital footprint (quantity of online information) of chronic pain with other common chronic medical problems.

Method

The following search terms were inserted into the search engines Google, Yahoo and Bing: 'Chronic pain', 'Diabetes mellitus', 'Hypertension' and 'Asthma'. This was performed daily from 21 to 28 November 2011 with the highest number of hits being accepted. Searches with the same terms were also performed on Facebook and YouTube.

Results

Figure 1. Number of hits on internet sites



Discussion

Google is the most commonly used search engine in the world⁹ and this is likely to be reflected amongst patients. Diabetes mellitus produced almost 10 times the number of hits compared to chronic pain, despite the prevalence of chronic pain being approximately double that of diabetes; asthma had over three times the number of hits and hypertension had 2.5 times more. These differences were consistent across all

search engines. This illustrates the disparity between the burden of chronic pain and the digital footprint it possesses. Expansion of the internet-based information could result in improved awareness among the public, including those suffering with chronic pain. There have been concerns about the quality of medical information available on the internet, including information on chronic pain.¹⁰ Therefore it is crucial that professional pain

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organisations are at the forefront of this expansion of internet information.

Facebook is a popular social media site that has the capacity to be a patient information site and a virtual support group. Chronic pain returned more Facebook results than hypertension but this was only 5% of the hits for diabetes mellitus. Two effective aspects of social media sites such as Facebook are discussion forums that can influence public perception and the ability to act as a virtual meeting place for those suffering from similar pain conditions. While it is likely that these online support groups will not replace more traditional face-to-face groups, they could undoubtedly assist in the support process needed by chronic pain patients.

YouTube is an online media site that contains uploaded video clips. Medical interest in the use of YouTube has focused on professional education,³ but future directions may include public education. Currently, chronic pain had only a quarter of the number of videos compared to hypertension. This is

despite the ample opportunities for chronic pain to develop video-based education tools based on patient blogs and video diaries, as well as professionally based video guides to common chronic pain syndromes.

The digital footprint of chronic pain is not comparable with that of other chronic medical conditions, particularly in relation to the number of search engine hits. There is room for a large expansion of internet-based resources for the public and patients with chronic pain. This expansion should be driven by professional pain organisations that can regulate the quality of information provided.

Author note

This research has been presented, in part, at the British Pain Society Annual Scientific Meeting 2012.

References

- 1 Moessner M, Schiltenswolf M, and Neubauer E. Internet-based aftercare for patients with back pain: A pilot study. *Telemedicine Journal and E-Health* 2012; 18: 413–9
- 2 Rini C, Williams DA, Broderick JE, and Keefe FJ. Meeting them where they are: Using the internet to deliver behavioral medicine interventions for pain. *Translational Behavioral Medicine* 2012; 2(1): 82–92
- 3 Farnan JM, Paro JA, Higa J, Edelson J, and Arora VM. The YouTube generation: Implications for medical professionalism. *Perspectives in Biology and Medicine* 2008; 51: 517–24
- 4 Ruehlman LS, Karoly P, and Enders C. A randomized controlled evaluation of an online chronic pain self-management program. *Pain* 2012; 153: 319–30
- 5 Macea DD, Gajos K, Daglia Calil YA, and Fregni F. The efficacy of web-based cognitive behavioral interventions for chronic pain: A systematic review and meta-analysis. *Journal of Pain* 2010; 11: 917–29
- 6 Vijayanand P. Social media and pain are now friends. *Pain News* 2012; 10(1): 21–3
- 7 Breivik H, Collett B, Ventafridda V, Cohen R, and Gallacher D. Survey of chronic pain in Europe: Prevalence, impact on daily life, and treatment. *European Journal of Pain* 2006; 10: 287–333
- 8 The Information Centre. *Health Survey for England 2010*. London: The Information Centre, 2011
- 9 Wang L, Wang J, Wang M, Li Y, Liang Y, and Xu D. Using internet search engines to obtain medical information: A comparative study. *Journal of Medical Internet Research* 2012; 14(3): e74
- 10 Showghi NN, and Williams AC. Information about male chronic pelvic and urogenital pain on the internet: An evaluation of internet resources. *Pain Medicine* 2012; 13: 1275–83



Pain in the developing world- Conflict anaesthesia with Medecins Sans Frontieres

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The Editor thanks Clare Roques, Chair of the Pain in Developing Countries SIG, for all her help with regards to this article including proof reading.

It would be unthinkable in the UK for a patient post major surgery to have only basic analgesia post operatively however this is the reality for much of the world's population. The resources available to treat chronic pain are even scarcer. Access to pain relief is seen as a basic human right not only by the IASP but also the World Health Organisation (WHO) (2). The WHO analgesia ladder is very familiar in the developed world and studies have proven that it is effective at providing pain relief for 45-100% of patients (3). In September 2008 the WHO estimated that 80% of the world's population had no access to treatment for moderate to severe pain (4) and in 2006 that 80% of cancer patients had no access to the pain relieving drugs they required (5).

There are obviously many other causes of acute and chronic pain in the developing world, for example 60-80% of patients with HIV/AIDs will suffer from moderate to severe pain in the course of their illness (6). In the war zones that I was working in, I treated many patients who had lost limbs as a result of conflict. In many of the world's war zones, thousands of people lose limbs during conflict. In some countries deliberate amputation has been used as an implement of war and MSF estimate that in Sierra Leone from 1991 to 2002, four thousand people had limbs amputated deliberately (7).

I worked as an anaesthetist for MSF in 2009. I was sent to four different missions all in areas of armed conflict: Sri Lanka (Point Pedro), Yemen (Al Tahl and Mandabah) and Pakistan (Peshawar). MSF have specific pain protocols for both acute and chronic pain:

Acute Pain Protocol MSF

Level One (mild pain)

Paracetamol 1g PO or IV if available

Ibuprofen 400mg PO or diclofenac 50mg PO / 75mg IM

Level Two (moderate pain)

Codeine 30mg PO

Tramadol 50mg PO / 100mg IV

Level Three (severe pain)

Oral morphine 10 mg

Slow release morphine tablets 10 or 30mg

Along with Local Anaesthetic Infiltration

Protocol for Chronic Pain MSF

Men

Week 1 – Amitriptyline 25mg / Carbamazepine 200mg at night

Week 2 - Amitriptyline 50mg / Carbamazepine 200mg morning and night

Week 3 - Amitriptyline 75mg / Carbamazepine 200mg three times a day

Women

Week 1 – Amitriptyline 25mg / Gabapentin 400g at night

Week 2 - Amitriptyline 50mg / Gabapentin 200mg morning and night

Week 3 - Amitriptyline 75mg / Gabapentin 200mg three times a day plus medroxyprogesterone SC

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number had risen to 23,783 vials and 15,564 tablets for 20,000 surgical procedures. The reason for the low number in 2000 is multi-factorial. Access to strong analgesia is a big problem and there is limited medical knowledge of the use of opiate analgesia in the developing world. The medical personnel I worked with were scared to use such medication as they saw morphine as a drug of abuse and dependency. In addition, the governments of many countries in the developing world are often overly restrictive with regulations regarding opiate analgesia.

Pain management in MSF's surgical missions is not always straightforward even after these issues have been addressed. Pain is expressed in varying ways according to culture which can lead to a misinterpretation of pain based upon assumed ethnic differences. Cultural and language differences between patients and staff always seem to favour the underestimation of the intensity of pain. Several MSF projects that I worked in did not have access to analgesia stronger than tramadol as we were not physically able to bring it into the country. As well as these problems, logistically it is not always easy to get drugs that are needed to a project in the field. Often projects are remote with poor internal infrastructure and may be in areas of natural disaster or armed conflict. My four projects were in such areas of armed conflict and therefore we could only receive supplies when it was safe to do so. In Yemen, the supplies relied on the government allowing our trucks to move. Without the 'green light' from the Ministry of Internal affairs, nothing was allowed into or out of the governorate we were working. As the area we were working in was remote and in the centre of a civil war, we saw many more 'red' than 'green lights'. I suspect also that for an independent and neutral NGO treating everyone that needs medical care including the rebel fighters and their families, governments are less helpful in letting medical supplies through.



The team in charge of anaesthetics for MSF France, under the watchful eye of Xavier Lassalle (Head of Anaesthesia for MSF France), have spent the past decade trying to implement these protocols. In the year 2000, Xavier asked

the supplies department how many vials of morphine had been used in the field for that year. Shockingly for 10,000 surgical cases in various different countries only TEN vials of morphine had been used. Thankfully by 2008 this

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In my own personal experience, I generally had access to oral paracetamol and ibuprofen, although I did run out of

paediatric paracetamol and ibuprofen syrup for a month in Sri Lanka. I had a good supply of intravenous tramadol and

ketamine and a variable supply of lignocaine and bupivacaine. I had the odd ampoule of morphine which I saved for the patients in the most severe pain and patients with severe life threatening heart failure. I carried out over a thousand anaesthetics during my time working for MSF and used less than twenty ampoules of morphine. In Yemen we were the only neutral actors that the local people could get medical assistance from. It was well publicised by foreign media that during the sixth war (which broke out during my time there) the punishment for taking arms against the government was death. MSF offered a place of safety where all sides in the conflict, as well as their families and the innocent civilians caught up in the fighting, could seek medical help. With all this going on, patients were highly grateful to get medical help and highly motivated to get out of hospital. Pain for them was almost expected and dealt with in a quietly dignified way. This made me feel much worse about not having the access to the resources that I needed. I would try and use spinal anaesthesia (plain bupivacaine) for any lower limb/lower abdominal surgery unless the patient was severely haemodynamically compromised. For the laparotomies and other major surgeries, I used to give oral analgesia pre-operatively and used ketamine for induction. I would give intravenous tramadol intra-operatively combined with local anaesthetic infiltration where possible.

If acute pain is difficult to treat in the developing world, chronic pain is almost impossible. In the war context that I was working, there wasn't the time or resources available to even contemplate asking about chronic pain in everyday practice. However, chronic pain is a massive and by and large untreated problem in the developing world. I attended the wonderful talk about Hospice Africa by Dr Karen Frame at the last BPS ASM in Liverpool. As part of her

talk she showed a slide depicting the areas of the world where opiate analgesia was available. Interestingly large swathes of the developing world don't have access to strong analgesia. Worryingly for me is that when people think of Africa and although there is great need in Africa for the basics of survival, it is not exclusive to Africa that this is lacking. Afghanistan and Yemen have the highest rates of chronic malnutrition in the world. Acute malnutrition affects 30% of Yemen's population, twice as high as the internationally recognised emergency threshold and close to the levels seen in South Somalia (8). If the population cannot access basic nutrition then you can see why analgesia is beyond scarce. MSF do have protocols for treating chronic neuropathic pain (see the table on page 237) and encourage the use of the WHO analgesic ladder for other chronic pains such as cancer pain, but as I have already mentioned it is not always possible to get strong analgesia into the country and even harder to get it to the field. MSF does run some long term projects; my Sri Lankan project had been running for over twenty years, because with ongoing conflict there had been ongoing need.

However when the acute need is met, the security situation is too difficult for access to be continued or MSF are thrown out by the government for voicing their human rights concerns, (Ethiopia -1985, Darfur-2009, Rwanda-2007) projects are closed. This is a problem for these patients with a chronic condition because when projects are closed, their means of accessing treatment is removed. It is in only by liaising with the countries' own health providers or more development based NGOs that these issues can be overcome. I did however initiate treatment for patients with chronic pain in all of my missions partly as it is part of MSF's remit and partly because I have a special interest in chronic pain. The majority of the patients that I treated



with chronic pain were either amputees with phantom limb pain secondary to conflict violence (usually bombing) and diabetes or cancer patients in the end stages of their life. I treated the phantom limb patients using the MSF protocol and although it is possibly not what would have been offered in a UK clinic it is better than no treatment. I got very good results with the traumatic amputations but less good with the patients who had limbs amputated secondary to diabetic complications. This fits with the current research into the treatment of phantom limb pain. Diabetes, like all other chronic diseases in the developing world (especially in Sri Lanka where the rates of type two diabetes are quite high), are untreated. MSF have run several projects looking at treating phantom limb pain in amputees in Sierra Leone (7). In these projects they looked at working on improving acute pain relief in hospital surgical work so as to reduce the incidence of chronic pain, and in a specific amputee camp at providing help to those with phantom limb pain. When

MSF followed up this work in Sierra Leone, they showed that it was possible to run an effective intervention for neuropathic pain in a developing world context although the improvement in the pain and mood scores of the participants were not statistically significant (9).

One patient sticks in my mind that I treated. A very young girl came to our field hospital in Yemen to have an external fixation device removed from her left leg. The device had been put on by a surgeon almost three years earlier but due to continuing conflict in the country she had been unable to get to a hospital to have it removed. The injury had been caused when a mortar had landed on her house causing her massive leg injuries. She had the right leg externally fixed and her left leg amputated. I chatted to her with the help of a translator and found out that she had been house bound since the incident as she was scared by the 'phantom sensations' she was feeling and debilitated by the pain. I managed to speak to her and her family and

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explained a bit about phantom limb pain then started her on amitriptyline. I saw her weeks later just before I was due to leave and although she still had the phantom limb sensations and some pain she was feeling much more positive and had begun to see a future for herself.

I know that during my time working for MSF, I tried my best to help as many people as I could with the limited recourses available to me. I found that coming back to treat people in the developed world extremely difficult and frustrating! I still believe that as a general rule people in the West do not appreciate how lucky they really are. I still find it hard to treat patients in chronic pain clinic with pains that I believe are not 'as bad as they are making out'. I wish that they could see what one day in the life of some of the people I met working for MSF is like. I came back with an overriding feeling that the world is 'not fair'. I saw at first hand the frustrations of the operational centre in Paris and teams in the field had trying to get essential life saving personnel and medication into the

projects that need it. Yet despite this, they are still fighting to get adequate analgesia for all. The solution is obviously multi-factorial and not simple. However if the barriers put in place by the governments of these developing world countries to bringing opiate analgesia into the country are lifted, things will improve. If opiates are available in these countries, the experience of the health care providers will improve and patients may begin to get adequate analgesia for acute and chronic pain conditions. Until then, organisations like MSF will continue to do everything they can, for those with the greatest need in the world.

Recent Updates

Things are improving in MSFs surgical missions. Out of the current 15 projects, only two have no access to strong opiates; the majority of patients are now having their postoperative pain assessed e.g. 90 % of patients in MSFs project on the Pakistan-Afghan boarder are assessed for pain twice a day.

The projects I worked in were all in areas of conflict which are notoriously bad for access to analgesia; these projects are now closed.

References

1. The Declaration Montreal: Access to pain management is a fundamental human right. IASP. Pain 152 (2011) 2673–2674.
2. Azevedo Sao Leao Ferreira K, Kimura M, and Jacobsten Teixeira M. The WHO analgesic ladder for cancer pain control, twenty years of use. How much pain relief does one get from using it? Supportive Care in Cancer 2006; 14(11): 1086–1093
3. Cousins MJ, Brennan F, and Carr DB. Pain relief: a universal human right. Pain 2004; 112:1–4
4. Lipmann A. G. Pain as a human right: The 2004 Global Day against Pain. Journal of Pain and Palliative Care Pharmacotherapy 2005; 19(3): 85–100
5. Vogl D, Rosenfeld B, Breitbart W, Thaler H, Passik S, McDonald M, and Portenoy RK, "Symptom prevalence, characteristics, and distress in AIDS outpatients," Journal of Pain and Symptom Management. Vol.18 No. 4 (1999): 253.
6. Broughton M. Controlling Phantom Limb Pain in Sierra Leone. Lancet 2001 Apr 21; 357(9264):1273
7. Tran M. We urgently need to tackle malnutrition in Yemen says UNICEF. The Guardian 22nd June 2012.
8. Field research in humanitarian medical programmes. Transactions of the Royal Society of Tropical Medicine and Hygiene (2003) 97, 619–621.



What's the benefit? The impact of the overhaul to the benefits system on chronic pain patients – Should we be doing anything about it?

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It's a typical day at work in a community pain management service. A new patient sits in front of me. He looks fraught and irritable, and the red blotches on his face suggest that his skin matches his mood. There is a standard time slot for these appointments and I have a list of things to get through, but I'm having trouble keeping the patient on track. He has started a rant about his benefits, or rather the lack of them. He scored 0 on the Work Capability Assessment and has been assessed as being fit to work and therefore is likely to lose his incapacity benefit. Anger seethes out of him, but barely conceals his desperation at the fear of losing his sole income or being forced into a job that he knows will be unsustainable. He is now talking about giving up on his claim. I suppose that when you are degraded and humiliated in such a way then it stands to reason that you would not want to go through this experience again. After all, what does a score of 0 normally equate too?

I wonder what it must be like to be in his position –not to know how you are going to keep your house and support your family or to fear that you will be made to do something that you feel incapable of doing. It crosses my mind that I need to do a risk assessment. I feel that I can offer little in the way of help. It is clear that his anger is making things

worse, and that he has little chance of taking on board any pain management strategies in his current state. I try to convey understanding and sympathy for his situation, and I steer the assessment on to other topics. I note that if we are to get anywhere with this patient then we will have to address his anger about the potential loss of his benefits.

Does this sound familiar? It is something that we see every day, and from talking with colleagues in other services it seems that these issues are taking up an increasing amount of everyone's time. Concerns about the benefits assessment process for people with mental and chronic health conditions has been receiving a lot of coverage in the press and condemnation from a number of charities and health professionals. At an annual conference for GPs this year there was a unanimous consensus that the Work Capability Assessment (WCA), the test designed to determine an individual's eligibility for benefits, should be brought to an end with immediate effect and that it should be 'replaced with a rigorous and

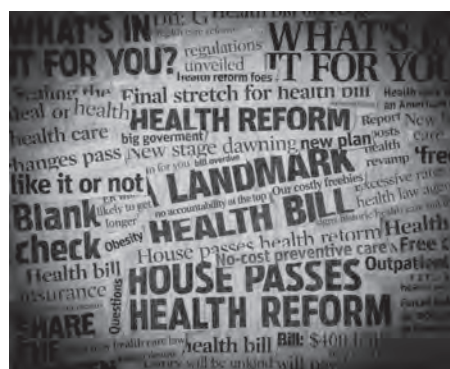


safe system that does not cause avoidable harm to some of the weakest and most vulnerable in society' (Guardian, 23rd May 2012).

In the drive to reform the welfare state there would be very few, we imagine, who would disagree with the idea of supporting and enabling people with chronic pain to return to work. We often hear from patients that they would love this opportunity, but that they struggle to consistently meet the physical demands of work or that employers are unable to make the necessary adjustments. The current WCA demonstrates no recognition or awareness of the condition of chronic pain and therefore many patients are being unfairly treated when their benefits are stopped. This starts a

Patients often hope that we will be able to help them with getting their benefits reinstated. Time and again we have to explain that we do not have any input into these decisions, other than to fill in the forms if they come our way. But in the back of our mind lurks the question whether there might be something else we should be doing. As health professionals we have a duty of care to our patients. We tend to think about this in terms of individuals, but what about this at the systemic level? When we see a system that is clearly not working, which seems to have no understanding or acknowledgement of the condition of chronic pain, and which is adversely affecting many of our patients and making it harder for us to do our jobs, is it not our role as health professionals to draw attention to it and to speak up? This is the conclusion we arrived at with a group of our colleagues. With the help of Dr Frances Cole, GP and Past Chair of the PMP SIG, and Neil Berry, Consultant Clinical Psychologist and a co-opted member of the BPS Council, we approached the British Pain Society to see if they could take the issue forward; we were pleased to find that our concerns were immediately listened to and were shared by many on the Council. Dr Martin Johnson, RCGP Clinical Champion for Pain, has agreed that he will take the issue further via The Patients Association. Dr Beverley Collett,

There are already many voices speaking out on behalf of people with long-term health conditions. The MS Society, Parkinson's UK and others have urged that the WCAs are made fairer for people with illnesses where symptoms vary over time. These charities along, with four others, have recommended a number of changes to the current



It is not only patient organisations that are unhappy. Auditors have found weaknesses in the contract between the government and Atos, the private firm paid to carry the assessments. With four out of ten appeals upheld at tribunal, it is being claimed that the quality of the assessments is to blame for the number of wrong decisions (BBC News, 17th August 2012). The appeal process is estimated to cost £60 million a year, on top of the £112 million contract for Atos (BBC News, 17th August 2012). It is therefore difficult to

As health professionals, we are in a position to comment on what we are seeing. We are encouraged to see that Paul Burstow, Care Services Minister, has conceded that chronic pain be considered as a long-term health condition (House of Commons, Hansard Written Answers for 01 Feb 2012). It is good news that vehicles such as the Chronic Pain Policy Coalition and the Pain Summit are driving this agenda forward. But it is early days, and there is more work to do before there is proper acknowledgement within the Parliament and policy of the condition of chronic pain. We hope that through writing this article we will encourage others with similar concerns to join us in calling for a fairer work capability assessment process that takes into account the specialist nature of long term health conditions including chronic pain. We are heartened that the Council of the Society has taken this issue seriously, and we would welcome comments from members as to their experience and thoughts.

1. BBC News, 11th May 2011. Benefit tests find sick fit to work, say charities. Downloaded on 16th September from <http://www.bbc.co.uk/news/uk-politics-13353669>
2. BBC News, 17th August 2012. Watchdog finds 'weaknesses' in sickness benefit system. Downloaded on 16th September from <http://www.bbc.co.uk/news/uk-19244639>
3. Guardian News, 23rd may 2012. GPs call for work capability assessment to be scrapped. Downloaded on 20th August from <http://www.guardian.co.uk/society/2012/may/23/gps-work-capability-assessment-scrapped>
4. House of Commons, Hansard Written Answers for 01 Feb 2012. Downloaded on 4th October 2012 from <http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120201/text/120201w0002.htm#12020185003330>

A patient's version: from 0 to 12!

This is a version of patient's story; the editor has anonymised patient details.

After an accident while working for Royal Mail, I became unfit for work and was pensioned off. During the following two years, I was also seen by two doctors working for the Department of Work and Pensions and considered by them, also, to be 'unfit' to work.

As we are all aware, during the last two or three years, there have been some big changes in the benefit system – quite rightly so, some may agree – but one particular part of this system 'reform' involves the Atos company, employed by the government to cut the number of people claiming incapacity benefit.

Two years ago, I was invited for an interview with one of the Atos so-called professional nurses. After filling in a tick-box form, I was asked a few questions

about my condition. I was then asked to 'perform', very much like an air stewardess giving instructions on how to react if the plane you are travelling on is about to crash! During this rather uncomfortable display, I lost my balance and had to be helped to regain my composure by this so-called professional Atos nurse.

Now the problems I have had over the last 10 years are severe lower-back and upper-neck problems, which, despite all the treatments and medications only respond temporarily to the pain-block steroid injections that my pain consultant gives me. My condition is, without question, deteriorating and extremely debilitating, so you can imagine my surprise when the Atos nurse scored me 0 points after my interview.

I was given the option to appeal the decision, which was the obvious

choice, so the next step was to appear before a magistrate and a doctor. They were armed with the same questionnaire as the Atos nurse; however, they apparently scored me 12 points (the 'magic' score, apparently, being 15). However, to go from 0 with the Atos nurse to 12 with a qualified doctor and a magistrate was encouraging. I was at last given some hope that, combined with the fact that my condition is now worse than it was two years ago, I may eventually be able to claim at least a basic benefit. After all, these government-employed agencies have no idea what people have to endure, beyond a simple 'interview' with the Atos nurses, whom I believe have certain targets to hit in order to satisfy the government criteria in cutting their benefits budget.



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SAGE

The ethics of care

Peter Wemyss-Gorman

These are transcribed lectures from the Philosophy & Ethics SIG meeting

The two featured talks and the subsequent discussion overlapped to such an extent that I have attempted to present them as a single article. This inevitably involves even more omission of valuable material than the abstracts that I have prepared for the previous issues; as usual, readers are encouraged to buy the booklet of the complete transcript, which

will be published in 2013. I had to resort to paraphrase, rephrasing in my own words, and rearrangement of material and I crave forgiveness for any misrepresentation. (The editor conveys apologies for further summarising the transcript submitted for the want of space in this issue of our newsletter. He strongly advises to

obtain the full transcript of this interesting lecture and discussions as suggested by Dr Wemyss-Gorman.)

Our two speakers were The Revd Bryan Vernon, Senior Lecturer in medical ethics, Newcastle, and the Revd Dr Jeremy Swaine, retired GP, Priest and author (an entirely fortuitous conjunction – this was not a religious conference).

The ethics of care

I shall refer to them by their first names for the sake of brevity.

Bryan explained that the ethics of care have been mainly developed by women, and referred particularly to the writings of Carol Gilligan and Nel Noddings:

[They] and other feminist writers characterise the approaches of men and women to ethics as being different. They do not claim that all women avoid analysis and universalisation of ethical principles, nor are they denying that men may see moral problems through the lens of caring. However, because a large number of women explain their ethical choices in what Gilligan calls a "different voice", it seems reasonable to adhere to these stereotypes in what I am going to say. But these are broad generalisations.

Kohlberg described moral development as a six-stage process from the infantile punishment and obedience orientation through the adolescent adherence to prevailing norms to secure others' approval and love. Adults understand that there are different views of right and wrong, but that law is a social contract based on majority decisions involving compromise. Stage 6 is the 'universal ethical principle' orientation involving self-imposed universal principles regardless of official rules and laws. Kohlberg observed that women tended not to reach stage 5 and often not even stage 4. You might therefore conclude that women are not all that good at ethics and that ethics is really for men rather than women, which is clearly a mistaken view. There are indeed major differences, especially in the area of rights, a concept of which was central to the emergence of western feminism. Kohlberg's approach is flawed because it devalues the experience of half the human race. In particular, the ethics of care is attentive to the feelings of all those involved in a decision.

Ethos and ethics

Jeremy averred that:

We cannot discuss the ethics of any human activity unless we are clear about the ethos that underlies them and the fundamental importance of ethos in establishing ethical principles; this is more important in health care and medicine than anywhere else. The current definition of ethos in the *Concise Oxford English Dictionary* is: "The characteristic spirit of a culture, era, or community as seen in its beliefs and aspirations." In its evolution from Ancient Greek through Latin, ethos became the origin of the modern English word ethics – the moral principles governing or influencing conduct. Ethics, then, are a process of reasoning by which a decision is made about our treatment of or behaviour towards a person or group of people.

Care

Quoting Bubeck, Bryan described care as:

The meeting of needs of one person by another where face-to-face interaction between care and cared for is a crucial element of overall activity, and where the need is of such a nature that it cannot possibly be met by the person in need herself.

To care requires us to be receptive to the cared for. It is demanding and makes the caregiver vulnerable. Care is the starting point for ethical action. It is grounded in the relationship of a mother with her child. This is the root of the moral life and we can all identify from this experience what it is to be a care receiver. There is an explicit inequality between the giver and receiver of care and the ethics of care are committed to identifying differences in power relationships.

Criticisms of the ethics of care

Bryan described some of the criticisms of the ethics of care, which have been described as too parochial in that traditionally women have encountered ethical problems that they have had to resolve in the private sphere of the home and the family. It has also been contended that:

Care can turn the caregiver into a slave, and reinforces views of the ideal woman as someone who sacrifices herself. But the one caring can include her among those for whom she cares: indeed failing to care for her jeopardises the care she is capable of giving to the cared for.

It is difficult to judge whether an action is or is not caring. Many actions take place in the belief that the one caring is indeed doing that. Do what I need because it is your job but with no concern for me and I will feel short-changed. On the other hand you may caringly do something for me which I actually don't want.

Care ethics and scientific medicine

The title of Jeremy's talk was 'Cum Scientia, Caritas', the motto of the Royal College of General Practitioners (RCGP). He expressed concern that the *scientia* of present-day medicine may not be conducive to the *caritas*; although they are necessarily complementary, the two are not always compatible; our preoccupation with a very narrowly defined biomedical science has undermined our capacity for care. He asked:

Are healing and vocation concepts that are seen even as relevant, let alone primary in the motivation of health-care practitioners, and doctors in particular; and most importantly of teachers and students in contemporary medical education? How much has medical education and medical science to do with human values? What priority is given

to the ethos of *caritas* in the education of today's and tomorrow's doctors? In the film *Patch Adams*, the dean's speech of welcome to the students at the beginning of the new term concludes with the words: *"It is our mission here to rigorously and ruthlessly train the humanity out of you, and make you into something better. We're going to make doctors out of you!"* Is that caricature absolutely alien to medicine today? Is there an ethos of care in medicine clear enough and strong enough to ensure that medical science is always its servant? Do the biomedical, and indeed the economic priorities that dominate clinical practice allow for the good intentions and humane perspectives that medicine aspires to? Has medicine's ability to control and manipulate disease processes blinded us to the opportunity and the responsibility to heal? Is it the present-day application of science that is inimical to the ethos of care? And if there is conflict between the two, what can we do about it?

What is now the ethos of science? Jeremy quoted EF Schumacher:

Has science for manipulation, which he says tends to degenerate into the search for power; subverted science for understanding, which leads to wisdom so that the "problem" before us becomes a biological abstraction that can be reduced to a clinical target, rather than a person with a problem that cannot be separated from the context of that person's life?

And Jacob Bronowski:

There are three human values which stem from the practice of science, Bronowski lists three: creativity, the habit of truth, and the sense of human dignity. Of these he says "...[they] are not rules for just and unjust conduct", in other words, they are not ethical principles;

"but are those deeper illuminations in whose light justice and injustice, good and evil, means and ends, are seen in fearful sharpness of outline." But he also asserts that there is also a fourth human value which does not stem from the practice of science: the human value of tenderness, of kindness, of human intimacy and love.

And Iona Heath: *'At the heart of the doctor-patient relationship must be an experience of our shared humanity.'*

He gave two examples of the problem as he saw it. They illustrate first the difficult relationship between the ethos of care and the ethics of care and the problems that arise from the achievements of medical technology; second, the dissociation of medical management from compassionate whole-person care.

In a recent British Medical Association (BMA) symposium on morals and medicine, we were shown an enactment of the conflict between the family of a woman in a persistent vegetative state following brain injury and the doctors caring for her; the former wanting to bring to an end what appeared to be a life of no quality and unmitigated suffering, and the latter who felt that her life did have quality and should continue to be supported artificially. There was a debate at the end of which a vote was taken as to which course should be taken. The audience was divided almost equally, with a slight majority in favour of continuing to sustain her life. The *ethos* of care was unmistakably one of respect for life and human dignity, and deep compassion for the patient and all concerned with her. But the *ethics* of the situation remained controversial, and the role of science ambiguous because of what medical technology can achieve when the outcome cannot be foreseen; and then continues to make possible thereafter. And of course this applies in other situations of end-of-life care as well.

Science and technology have complicated and sometimes compromised the attitude, philosophy or

set of values that constitute the ethos of care. They have made the spirit of our medical culture difficult to apply, not only in poignant situations such as this one but in many everyday health-care encounters. Our conduct towards patients, which in most instances would never be considered unethical, can be difficult to reconcile with the ethos of care.

The second example involved the experience of Havi Karel (who spoke later in the meeting). In *Living with Lymphangioliomyomatosis* she wrote:

This first-person perspective became important to me. I felt that during my frequent dealings with the medical and health-care professionals it was neglected. No one asked me what had changed in my life or what I had to give up because of my illness. Overlooking the lived experience of illness is a mistake because there is so much important knowledge to be gleaned from it – for example, that the most effective intervention might be helping the patient to regain their everyday life despite their illness. But it is impossible to do this without knowing about the patient's usual life and how it has been affected by illness.

Quoting James Markum, he described the harm that results from medicine's tendency to represent the patient as a *fragmented body*, reduced to its disordered component parts, a *standardised body* to which our body must be encouraged to conform, and an *estranged body*, alienated from the self, from the lived context of the illness, and from other people, with an effect on the patient that is literally de-meaning.

Jeremy's examples illustrated our ambivalence about expressing an ethos of care and the place of empathy within our professional role: *'In my first example, the palpable empathy for the patient, the husband and the doctor, the experience of shared humanity, didn't assist the ethical decision. In the second example, empathy is either absent or completely discounted.'*

The ethics of care

We might assume empathy to be a core component of the ethos of medicine. But are we sure what we mean by it? In a recent article Daniel Sokol, quoting William Osler, contrasts empathy, of which he is sceptical, with imperturbability, by which he means 'outward calm and reassuring coolness'. But he represents empathy as 'displaying outward effusions of emotion'. That is absolutely not what empathy is. It is not the same as sympathy or kindness, which require outward expression. It involves a feeling response, but it is rarely best expressed by a show of emotion, and may indeed often require to be mediated by imperturbability. It has been described as 'to sense accurately and appreciate another person's reality and to convey that understanding sensitively.' It helps us to discern what is going on in the patient's body, mind and spirit. It is essential to a proper understanding of the patient's narrative and powerfully enhances the contextual aspect of the therapeutic encounter. If Daniel's view represents a prevalent misunderstanding of the nature of empathy, then our ethos of care has lost one of its core components. This compounds the knowledge that empathy diminishes among medical students on their way through medical school and the



observation that, to quote from a letter to the *British Medical Journal*: 'Although empathy is often cited as a core value in the health profession,

yet its lack in modern medicine seems to be widespread.'

Bryan made a parallel observation:

The emphasis on relationships is vital. The autonomous self, free of constraints from others, seems more like a psychopath than a member of society. Women are much better than men at defining themselves in relation to others so it is heartening that the ethics of care retains this emphasis on relating, when there is such a strong temptation to discard it.

He further made a comment:

Al Jonsen defined ethics as "the moral limitation placed on power" and the ethics of care engages with the power relationships involved in the setting of an ethical dilemma. The relationship between a health care professional and a patient is not an equal one. Some models of partnership between doctors and patient can put too great a strain on patients. This can lead to the question "What would you do, doctor?" which seriously wrong-foots junior doctors reared in an ethical tradition that champions autonomy.

The ethics of care carry an imperative to act in response to another, in contrast to a legal case of medical negligence where a duty of care must first be established. There is an emphasis on avoiding harm and on doing good. The ethics of care can deepen what these mean by its emphasis on relatedness. Concern for the particular is important;

each case is unique as each episode of care is unique, but they may also share many similar factors.

I am wary of the trump card in ethics. Insights come from a variety of systems of ethics. The Ethics of care are a valuable addition to the ethicist's armoury – but they are not the end of the story. They exemplify an approach to ethics that is grounded in the experience of women, just as traditional ethics have been grounded in the experience of men. We can choose to continue in these parallel universes or see how each can enrich the other in our attempts to develop an ethical approach for the whole human race.

And in his conclusion, Jeremy asked the audience to consider these questions:

In your own practice, how often is some compromise between science and care imposed upon you by guidelines, targets, cost implications, time, or other constraints, personal or institutional? Or by the misplaced expectations of patients, for interventions and outcomes that medical science and medical practice have led them to expect, and that have become a coercive influence on what we do? When this occurs, how do you reconcile yourself to it; how do you cope with it?

And finally, if the concerns I have raised are justified what do we, collectively, as a health-care community do about it? How radical a change in the culture, how much remodelling of medicine and of medical education, is required to redress the imbalance between *scientia* and *caritas*? And how do we get there?

At this year's meeting, we spent much time talking about *what* needs to be changed but did not adequately address the problem of *how* attitudes and practices could be changed, or how we could persuade people of the need for change.

We decided to devote the 2013 meeting of the Philosophy and Ethics SIG (at Launde Abbey on 10–13 June) to this important and interesting concept with the title 'Changing the Culture of Pain Medicine'. Among the speakers will be Dr John Loeser, the distinguished 'elder statesman' of pain medicine. Please make a note in your diaries now.



Jeremy Swayne. *Remodelling Medicine*

Glasgow: Saltire Books, 2012,
ISBN 9781908127006

Reviewed by Dr Peter
Wemyss-Gorman

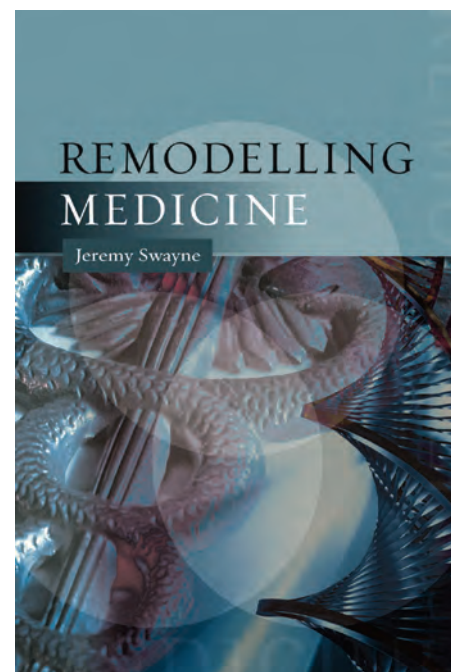
It has often been said that in his 'pastoral' capacity the modern doctor has taken on a function that for previous generations was provided by the priest. The Revd Dr Jeremy Swayne, retired GP, has occupied both roles. Readers may be reminded of this as they peruse this timely and important book, which had your reviewer mentally punching the air and shouting 'Yes!' on many a page. Although Dr Swayne writes from the perspective of general practice, it could be argued that pain medicine, more than almost any other speciality, shares a common ground with general practice in its acknowledgement of the need to combine the benefits of modern biomedicine with ministering to patients' fears and hopelessness, lack of understanding and need for explanation, frustration, resentment and all the many other consequences of a life dominated by suffering. Although this book is of relevance to all the 'healing professions', practitioners of pain medicine may find it particularly valuable.

Dr Swayne's basic message is that science-based 'biomedicine', which has become the dominant model over the last century or more, has lost touch with the need to see illness as a disorder of mind and soul as well as body. In the priority of treating the disease, it has neglected the need for healing the whole person in his or her personal, family and social context. He does not deny the huge advances and enormous benefits

of scientific medicine, but rather advocates a coming together of this and a 'holistic' approach – a reconciliation in the broken marriage of medicine and healing.

The limitations of scientific medicine need to be acknowledged in its insistent search for proof and certainty medicine has ignored anything which lies outside the apparent boundaries of knowledge. Paradigms – conceptual frameworks that help us make sense of things – and models are powerful tools but must not become rigid determinants of our thinking, precluding exploration of the worlds that exist beyond those boundaries. The modern medical paradigm is the analytic scientific method that has made staggering advances possible but that may limit our view of the bigger picture. It also operates under the assumption that it is entirely detached and objective – which elementary observation of doctors' and scientists' thought and behaviour will frequently reveal as a delusion. The scientific evidence on which our practice is supposed to be based may often fail to illuminate the whole scene of human suffering; it may have even led us into therapeutic blind alleys.

I used the word 'soul' above, and the concept is central to Dr Swayne's philosophy. This may be a problem for some readers but need not be taken in a narrowly religious sense. He writes rather of a spiritual 'dimension' of people's lives that is fundamental to their well-being; a concept of healing that ignores this is incomplete. His approach to the task of defining soul, psyche and spirit, while helpful, is difficult to summarise, which perhaps reflects their essential elusiveness. (*The Oxford English Dictionary* suggests for spirit 'the non-physical part of a person which is the seat of emotions and character', but



this is barely adequate). Dr Swayne contends that 'psychic' energy and sensitivity, often erroneously associated with the occult, are normal aspects of human nature. They are components of all therapeutic relationships and not just the domain of 'faith' or 'spiritual' healers.

Dr Swayne argues that the new model for medicine must be open to insights from unconventional sources. He has long combined homeopathy with conventional medicine in his practice. Some readers may find this (and his advocacy of complementary and alternative medicine in general) a little hard to swallow and may be tempted to dismiss his approach as woefully unscientific and not worth taking seriously. But that would be to miss the point of his inclusion of the topic. He argues that although homeopathy does not conform to the biomedical paradigm (and makes little obvious sense from a 'scientific' viewpoint) it could play an important role in 'integrative medicine' in

Book review

its respect for the principles of self-healing, self-regulation and enhanced healthfulness, rather than control of disease. The practice of taking all contributory factors into consideration, the family and personal history and other 'constitutional' factors as well as the aetiology of the condition, in a comprehensive 'pathography' of the patient is not of course exclusive to homeopathy, but sceptics may allow that even without accepting its basis we can perhaps learn valuable lessons from it regarding the nature of illness and the care of the ill person that a narrowly disease-oriented and intervention-oriented approach may be in danger of missing.

Dr Swayne acknowledges that there is a paradox at the heart of medicine that lies in a frequent contradiction between the clinician's imperative to do something and the necessity to respond to the bigger picture of the patient and their illness. Wanting to engage with the patient is one thing; being able to do so is another. Constraints of time can make this particularly difficult (a problem not shared by practitioners of homeopathy), although this difficulty can be partly overcome by attention to the 'quality' of time – and listening – rather than 'quantity'. Medicine has to respond to the demands of society as well as those of individual patients, but these may be

unrealistic, especially given the current state of the NHS, and resources may be disproportionately diverted from the management of chronic conditions to the 'quick fixes' of surgery and acute medicine.

Dr Swayne reinforces his arguments with such a remarkable wealth of quotations from other writers that one could almost find the book worth reading for these alone, and it could save the busy clinician from having to read all the originals.

The book is generally well written and readable, but there are many pages where the Dr Swayne's passion for his subject shines through in passages of memorable and inspiring prose. To take a random example:

This is the nub of the healthcare dilemma – to reconcile medicine's struggle with the precariousness of existence with the affirmation of meaning in life that transcends the precariousness and the pain ... Medicine must be responsive to need but discourage dependence, be an enemy of disease but a respecter of persons, a friend of hope but a manager of expectation, an enabler as well as a controller, an interpreter rather than a manipulator, a seeker after truth but at home with uncertainty.

So how is the culture of medicine to be changed? This question continues to challenge not only medical educators but all of us who strive to persuade our colleagues and trainees of the need. This book represents an important contribution to this process.

It should be a required reading, not only for medical students but all health professionals at any stage of their careers, but at more than 450 closely argued pages this is a challenging read. (The author helpfully provides a list of key points at the beginning of each chapter; these should provide an aid to skimming for those without sufficient time, but it is to be hoped that they will tempt many to the much more rewarding task of reading the whole book.) There is a certain amount of repetition, although when some topics do come up several times this is always in a different context, looked at from a different perspective, or used to reinforce a previous argument. It would be a great pity, though, if its length and consequent price (£45) were a deterrent to its gaining the readership it deserves. May I suggest to impecunious readers of *Pain News* that they ask their hospital or medical libraries to obtain a copy? It should undoubtedly be on their shelves for the benefit of all their colleagues. In addition, there is sufficient use of quotation by the author to make it a valuable reference source.

Course review

Leeds Hands-On Cadaver Workshop

Reviewed by Rajiv Malhotra
Specialty trainee in anaesthetics

I am an advanced pain trainee, taking my first baby steps into this specialty. I have often watched various images

on the radiology screen and been told of this 'scotty dog' that I should be looking for. Half of me thought I could see it; the other half was not sure. The need for further information, clarity and hands-on practice is what led me to look for an interventional pain course. Due to this need, I stumbled upon the cadaveric course in Leeds and attended it recently.

The course was held in the Worsley Medical and Dental Building, which is located on the University of Leeds campus. It is fairly easy to find, as it is two minutes' walk from Leeds General Infirmary. There are car parks nearby, but with so many affordable hotels near the Worsley Building, I ended up walking to the course each morning.



The pre-course information was detailed and emailed out well in advance of the course. Also, course participants receive the book *Spinal Interventions in Pain Management* as part of their pre-course pack; this was a nice surprise and as it is a pocket-sized book, most people brought it to the course.

The course was spread over two days, almost all of it spent in the cadaveric room. There was an introductory lecture, a lecture covering radiological anatomy and one on the complications. There were four interventional stations, each with a draped cadaver and a

radiographer with a C-arm fluoroscope. Two faculty members were at each station and they showed each group how to perform certain procedures; then each group member performed a procedure on the cadaver, with direct supervision and helpful tips. Procedures covered included lumbar and cervical medial branch block, transforaminal epidural, lumbar sympathectomy, spinal cord stimulation and discography.

Coffee and tea was available at breaks; lunch was a large selection of sandwiches, with a variety of cakes for dessert. The breaks were a good opportunity to meet other pain trainees and also discuss any burning interventional questions you had with the experienced faculty. On the first evening, the faculty and the participants went to a nice local restaurant for a course meal. This was a good way of getting to know the faculty over a free meal with excellent wine.

The course participants were mainly advanced pain trainees, but also included chronic pain consultants and even the odd orthopaedic surgeon. Participants came from as far away as

Brazil, which shows the popularity of the course. Groups consisted of six to seven participants and were split into those with little and those with lots of experience. This meant that some groups could concentrate on the common interventional procedures, while others could move on to more complicated ones.

The main disadvantage of this course is the cost: £800. However, I personally feel that this was value for money given the resources invested and the variety of procedures that can be practised. However, in times of financial downturn and reducing study leave budgets, this may be an issue.

On reflection, this course is ideal for advanced pain trainees who wish to learn and practise interventional procedures on an intensely practical course, under the watchful eye of an expert panel. There is a real focus on basic principles, such as how to square the vertebral end plates and manipulate the C-arm, which will provide trainees with a strong foundation from which to build experience and develop expertise.

Review: Medico-Legal Conference – A barrister's view

Julian Benson *Barrister, Guildhall Chambers, Bristol*

www.guildhallchambers.co.uk; www.abarristersguide.org.uk



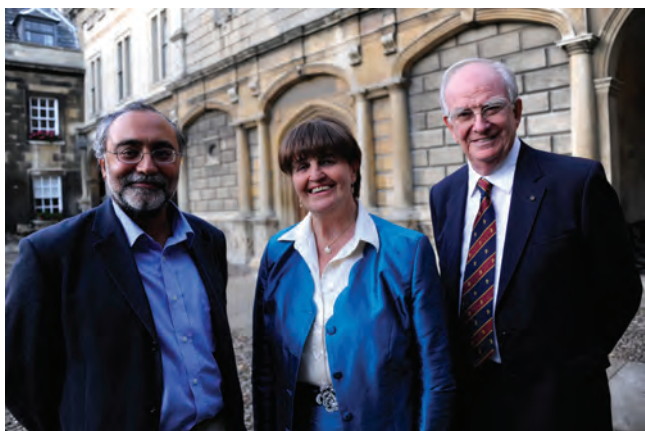
On 13 September 2012 I was fortunate to attend the second annual Medico-Legal Conference at Peterhouse College, Cambridge. The course occupied one very full day, with an excellent opportunity to mingle with speakers and delegates at registration, and during a delightful reception and dinner.

The programme of no less than eight guest speakers focused on many issues that occupy medics and lawyers in equal measure, namely making an accurate diagnosis and proceeding to treatment and prognosis, sometimes in the presence of volitional, but more often non-volitional, 'inaccuracy' from a patient, or claimant.

Dr Stuart Turner opened proceedings by exploring themes of diagnosis in the context of post-traumatic stress disorder (PTSD), a theme taken up later by

Dr Simon Dolin in discussing the fear avoidance model in the context of litigation. Later, Dr Christopher Bass considered issues relating to conscious and unconscious exaggeration, commenting intriguingly about the concept 'amplifiers' in the mental process, as well as commenting with characteristic robustness on the shortcomings of DSM-IV. Dr Kari Carstairs then offered us an interesting insight into an objective system for detecting exaggeration (MMPI-2).

In amongst these learned medics, a few lawyers raised their heads. Marcus Grant provided a refreshingly realistic context for discussions of exaggeration within litigation, and Mark Tawn reminded us, from his standpoint as a specialist in pain work, about the most essential elements of expert involvement in



Dr Rajesh Munglani, Consultant in Pain Medicine and Organiser of the Cambridge Annual Medico-Legal Conference with Baroness Caroline Cox who gave the after dinner speech in the Peterhouse Hall and Sir John Meurig Thomas, Former Master at Peterhouse, who gave an interesting talk at dinner about Peterhouse's history.



Left to right: Mr Mark Tawn, Partner, BLB Solicitors, Dr Christopher Bass, Consultant Psychiatrist, John Radcliffe Hospital, Oxford, Dr Simon Dolin, Consultant in Pain Medicine, Goring Hall Hospital, West Sussex, Dr Chris Wells, Consultant in Pain Medicine, Mr Marcus Grant, Barrister, Temple Garden Chambers, Ms Alice Nash, Barrister, Hailsham Chambers, Dr Stuart Turner, Consultant Psychiatrist, Trauma Clinic, London, Dr Kari Carstairs, Consultant Clinical Psychologist, Carstairs Associates Ltd, with Dr Rajesh Munglani (far right) , Consultant in Pain Medicine, Cambridge and Organiser of the Cambridge Annual Medico-Legal Conference.

litigation. Alice Nash rounded off the trio of lawyers with an arresting discussion of the approach to assessing clinical negligence in light of developments in practice.

Finally, we were treated to a delightfully murderous excursion into the life and times of John Bodkin Adams by Dr Chris Wells, a subject that delegates might like to pursue in Lord Devlin's fine account of the trial – *Easing the Passing*.

My particular highlight was the generous opportunity for discussion that followed each keynote presentation, expertly moderated by Dr Munglani. This novel and particularly welcome opportunity enabled delegates (among them solicitors, barristers, orthopaedic surgeons, rheumatologists, pain clinicians) to comment upon the talks in an unhurried manner, as well as raising direct (even pointed) questions to the speakers and one another.

Two things struck me about the contributions from the floor: first, the depth of knowledge that underpinned them, including a casual familiarity with national and international literature; second, the lack of ego on display,

and a refreshing sense of professionals wearing their learning lightly – something upon which barristers should reflect. There was also real sense that the vast majority of contributions were intended to develop knowledge in the area rather than peddle (to coin an unpleasant phrase) one view or another.

Chronic pain is a particularly hot topic in personal injury litigation and, as I now understand, within medical circles as well. I came to the conference as a barrister with a larger than average practice in chronic pain work, particularly cases where initial solicitors (often large impersonal practices) have been replaced. My particular concern has been the polarisation of experts in this field, enabling practitioners to reel off the 'claimant' and 'defendant' experts in psychiatry, rheumatology and pain medicine. That is a great shame. It distorts the process of resolving litigation with impartial expert evidence.

Of course one reason why experts become associated with one 'side' or another is because they have provided useful evidence in the past. In a litigation environment in which a party must disclose the opinion of an initial expert in order even to apply to replace him/her, it is imperative that a party chooses its expert with care. All too often that cycle produces 'the usual suspects' on opposite sides, a natural but unfortunate consequence of the system.

In the sphere of litigation, a finding by the court that an individual has developed severe complex regional pain syndrome (CRPS), or neuropathic pain, can lead to compensation that comprehends significant daily care needs, career earnings losses, and a high level of aids and equipment. Such cases can run into seven figures. Alternatively, if the court decides that the accident in question did not cause or materially contribute to the claimant's ills – or that a claimant has significantly, consciously or unconsciously, exaggerated his/her symptoms – the award may be very modest indeed.

Much as in brain injury work, the very worst cases make for rather easier litigation. Severe examples of CRPS have sufficient objective signs to make consensus between experts highly likely. The more difficult cases to litigate are those in which the signs are less evident (and/or change over time), lead to less conclusive diagnosis (typically those at the interface of pain disorders and syndromes), or depend in essence upon the claimant's subjective report (often in

the presence of a significant pre-accident history that arguably predisposed him/her to develop a pain disorder/syndrome).

From the medical and legal standpoint alike, the conference provided a fascinating multidisciplinary forum in which to discuss such issues openly, and in depth, fostered by Raj Munglani's light but skilful touch, guiding contributions into the most interesting areas.

To finish the day, we were fortunate enough to be addressed by Baroness Cox, an indefatigable champion of the underdog through the charity Human Aid Relief Trust (HART). It was at one and the same time a talk about the hilarity, humanity and tragedy of ordinary people triumphing against often desperate odds in some of the world's worst trouble spots, such as South Sudan, Nagorno-Karabakh and Myanmar; a bitter-sweet way to end a fascinating day.

Review: Medico-Legal Conference – Medical Student's view

George Couch *Stage 1 Clinical Student, Downing College, Cambridge*

Medico-Legal Conference Peterhouse Cambridge 2012

The law is firmly integrated with medicine, from legal obligations of medical professionals to litigation cases raised against them. I have had many conversations between medicine and law, my father being a solicitor and Deputy District Judge, and am aware that arbitrariness is endemic in compensation systems¹ (both fault and non-fault based systems) and medics have a role in reducing that. Hence, the opportunity to attend this conference on the medico-legal interaction was extremely welcome, promising a better understanding of this vital interface. The promise of a buffet lunch, champagne reception, and three-course supper in Peterhouse's 13th century hall was an

additional incentive.

The conference was organised and chaired throughout the day by Dr Rajesh Munglani, consultant in pain medicine – an established medicolegal expert who has long desired to increase understanding between medics and lawyers. It focussed on patients' litigation and compensation cases which require a medical expert's statement, of specific interest to those involved in pain medicine and psychiatry. Each lecture was followed by a generous question and discussion period, during which many important issues were raised. The day opened with consultant psychiatrist Dr Stuart Turner's talk on PTSD, which discussed factors affecting severity, epidemiology, and treatment, continuing into reasons for and prevalence of over-diagnosis (due to patients' secondary goals and diagnostic tests' biases), and the effect of litigation on this (and indeed, of this on litigation).

Exaggeration of symptoms through to outright malingering was a theme that recurred throughout the lectures. Patients seeking comfort in a label, or harbouring vested interests (such as for financial gain through compensation or the benefits associated with

the sick role), will always be prevalent, varying by the amount they act upon these secondary motivations. Mr Marcus Grant, a barrister in Temple Garden Chambers, spoke on the topic of exaggeration in personal injury, noting how much lower awards to claimants are in the UK (approximately one tenth of that in the USA), but also how difficult it can be to judge if a claim is valid.

This was followed by Mr Mark Tawn, of BLB Solicitors, who focussed on the interaction of medics and lawyers via the expert's statement, and how to provide comprehensive and concise evidence. There was an interesting discussion on how much clinical opinion could be placed in these statements. Most medics said they erred on the side of caution



The audience was made up of Pain Consultants, Consultant Psychiatrists and Psychologists, Solicitors specialising in Personal Injury and Barristers with an interest in Pain problems.



and included none, having been told it is the place of the Judge alone to make judgements. However, clinical expertise is valued and providing a professional opinion based on patient history, observable signs, and test results would only help judges make their decision.

Dr Simon Dolin (Consultant in Pain Medicine) gave a lecture outlining psychological progression pathways, whereby patients can amplify their condition (catastrophising) or escape down the path of recovery. In the subsequent discussion time, interesting comments were made about the growing, evidence base surrounding the compensation hypothesis – the idea that interaction with the compensation system can worsen medical symptoms, for example by promoting patients to delay recovery so that their symptoms are still obvious when their case goes to court. Compensation pay-outs can potentially even be more damaging than getting nothing, due to reinforcing the sick-role label and providing a reward for lack of recovery. However, evidence is still very conflicted on the compensation hypothesis, and is riddled with confounding factors, especially reverse causality (worse medical symptoms increasing likelihood of seeking compensation) and selection bias.²

There was also a short, but both heated and facetious, debate on the merits of existing evidence on the involvement of brain reorganisation in pain chronification.³ Some were very supportive, others totally dismissive, but there is an expanding evidence body which could have important ramifications

for forming an opinion on exaggeration by patients.

Consultant psychiatrist Dr Christopher Bass spoke on the medico-legal focus on conscious intent to deceive, and how the difference between “conscious malingering [and] subconscious functional overlay” is usually impossible to discern – “motivations for ‘factitious presentation’ may never be knowable.” He noted, however, that it is often difficult to conceive how the patient can fail to consciously be aware of the secondary gains such behaviour may yield, mentioning the construct of volition.⁴ This regularly causes great difficulty in whiplash cases, with symptoms that extend long beyond site-specific biological signs. The problem is not new – in the 19th century, an analogous disease resulting from low speed collisions, ‘railway-spine’, was just as prevalent in compensation cases as whiplash is now. Additionally, excessive medicalisation and sub-categorisation of disorders could have done more harm than good, due to potential desirability of the sick role or a biomedical label.

Dr Kari Carstairs, consultant clinical psychologist, gave a talk that addressed a method of investigating these problems pragmatically with the MMPI-2, which in combination with patient history can give an objective, statistically-based indication of consistency, accuracy, and exaggeration through a variety of validity scales. For example, it can be very useful in determining genuine PTSD from malingerers. It does however depend on

the population and a presumed base rate of exaggeration in said population. It was explained that combining results with other tests give best results.

As well as the practical issues, there were lectures addressing historical perspectives. Ms Alice Nash, a barrister in Hailsham Chambers, spoke on past and recent development of medical negligence law, and its interaction with continually advancing medical practices.

2011’s conference had a talk on Dr Harold Shipman, and for 2012 Dr Chris Wells, Consultant in Pain Medicine, gave the audience tips on how to acquire their patients’ wealth and Rolls Royces. By this I, of course, refer to his speech on the trials and tribulations of John Bodkins Adams (21/01/1899 – 04/07/1983), infamous for becoming “probably the wealthiest GP in England” in 1956 through befriending and borrowing extortionate amounts of money from patients, and getting himself inserted into their wills shortly before they, coincidentally, passed away. He liberally administered opiates and hypnotics to patients, was likely a kleptomaniac, and during his time as an anaesthetist would fall asleep or leave patients awake, aware, or hypoxic. By July 1956 he had been mentioned in the wills of over 130 patients, and it is now thought he was responsible for the deaths of a very similar number of patients to Shipman.

The conference culminated with an inspirational after dinner speech by Baroness Cox. The day was hugely educational, with interesting conversation to be had at every turn. It was truly my honour to attend.

References

1. Lytton T. D., Rabin R. L., and Schuck P. H. 2010, Boston College Law Review, 52:267
2. Spearing N. M., Connelly L. B., et al., 2012, PAIN, 153:1274
3. Baliki M. N., Petre B., et al., 2012, Nature Neuroscience
4. Spence S., et al., 1999, Cognitive Neuroscience, 4:203



A potential partner in pain management

Dr Sau-Hsien Yap Queen Elizabeth Hospital, King's Lynn

There have been major advances in the world of pain in terms of understanding mechanisms of pain. We now know a lot more; it seems that the more we know, we discover that there is a lot more we do not know. In terms of the 'bio' part of the biopsychosocial model of chronic pain, the types of drugs available now is fairly limited. I think most of us would agree that the drugs available to treat chronic pain are far from ideal. Although there is a lot of research into the receptors and new compounds to treat pain, the speed of new medications becoming available is agonisingly slow. The search for ideal pain medication is still a distance away. However, the race for the future treatment is no doubt under way. We need to look forward to move ahead but we also need to look backwards to improve.

In my quest to enrich my armamentarium to treat chronic pain syndrome, I have decided to look back to what my ancestors had to offer. Acupuncture has been well accepted in the modern world as a treatment modality in chronic pain. However, the acupuncture commonly practised in the UK (available in the NHS) is 'western medical acupuncture'.

For several thousand years, Chinese people have been using acupuncture often in combination with several modalities of Chinese medicine (including herbs, moxibustion and cupping) to treat a myriad of medical problems. Isolating a treatment modality and applying it without diagnosis using the principles of the medical system, just because it is easier

to learn and teach, severely restricts the treatment scope of that modality and may be potentially dangerous. In my opinion, this is what has happened in the case of western medical acupuncture. To many, the understanding of acupuncture is minimal and they would not be aware that there is a difference. Therefore, problems that could potentially be treated using Chinese acupuncture/medicine are often dismissed when they have gone through western medical acupuncture without a positive outcome. This is especially so when the problem is so-called 'medically unexplained'.

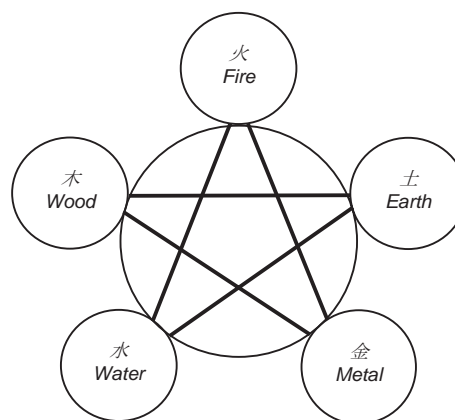
To me, the term 'medically unexplained' is inaccurate in this age of political correctness, as it implies that the conventional/western medical system is the only medical system in the world, which most of us know is not true. In fact, many or even most 'western medically can't explain' problems could be explained

and treated successfully by Chinese medicine (or other complementary/alternative medicines) at a much lower cost. This is one of the reasons why I am investing my time and effort into researching and applying Chinese medicine in chronic pain management. There is also a lot that Chinese medicine can contribute in acute pain management and the prevention of development of chronic pain from acute pain, which will reduce medical cost even further, but this is beyond the scope of this article.

How does Chinese medicine work? The basic principles of Chinese medicine consist of interactions between yin/yang, five elements, qi, blood, essence and body fluids. To explain how this ancient medical system works would result in me writing a book. To get a glimpse of what Chinese medicine is about, please refer to my suggested reading list at the end of this article.



▪ 阳 Yin-Yang



五行 Five Elements (simplified)

How does one explain pain using Chinese medical theory? The basic cause of pain is stagnation or obstruction of qi and blood flow (do not confuse with thrombosis). The causes of qi and blood stagnation or stasis are many, ranging from poor lifestyle/habits to neoplasms. The symptoms and aggravating factors often give clues to the cause and nature of qi stagnation and/or blood stasis. It is the cause that we aim to treat at the same time as treating the stagnation and stasis to relieve pain.

An example to illustrate this is post-herpetic neuralgia (PHN). Instead of trying to understand the Chinese medical terminologies used, try to see the reasoning of the pathogenesis and treatment strategy. Infections such as herpes zoster are considered heat toxin in Chinese medicine and can obstruct qi flow. This is experienced as burning pain and hyperalgesia or even allodynia. The patient may have stabbing pain and this is seen as blood stasis. Often these patients are elderly and tend to be frail, thus more likely to have infections and feel tired or lethargic. This is seen as qi (genuine and defensive) deficiency, which can also lead to blood stasis. Many elderly people would also have yin (as in yin/yang) deficiency, which can cause heat and blood stasis and even qi stagnation. These causes can be further affirmed by other diagnostic methods typical of Chinese medicine, consisting of tongue observation and feeling of the pulses. Therefore, treatment strategy in such cases would be to resolve blood stasis, eliminate heat toxin, tonify (boost) qi and relieve stagnation, and possibly nourish yin. If the patient has other problems instead, such as dampness retention or blood deficiency, then the treatment strategy would be different and tailored to the patient. For best results, a combination of acupuncture and herbal treatment would be used. Unfortunately, to my frustration, I can only provide acupuncture treatment within the constraints of the NHS.

In the example above, one would realise how different Chinese medicine is compared to Western medicine and it is

only 'a flake of crystallised water in the tip of an enormous iceberg'. It also illustrates my opinion that Western medical acupuncture may not be able to treat such problems because the in-depth concept, diagnostic methods and treatment strategies of Chinese medicine have not been taught. One could also see that Chinese medicine could be a potential 'partner' alongside Western medicine in treating painful conditions.

With this in mind, where is the evidence? One of the strongest pieces of evidence for me is personal experience of treated and witnessing cases with my own eyes and ears. Throughout my course of studying Chinese medicine, I have witnessed many cases of positive results when Western medicine has failed to result in the desired response. Even just using Chinese medical acupuncture in my own practice has produced some good results (which could be better with a combination of herbal treatment and western medical acupuncture has unsatisfactory results, either no symptomatic improvement or having intolerable side effects. Although there is no strong evidence in the form of randomised controlled trials (RCTs) supporting the cases that I have witnessed and treated successfully by Chinese medicine, these positive and often drastic improvements cannot be ignored. Sceptics would argue that this can be due to placebo effects and I agree to a certain extent. However, normalising of hormonal titres, infertile couples managing to conceive and produce healthy offspring, improvement of skin appearances after treatment by Chinese medicine (often after failure of western medical interventions) are visible changes that cannot be due to placebo effects alone.

If we look into the available evidence, there are indeed not as many papers written in English as there are in Chinese. We cannot take this as lack of evidence just because we are unable to read Chinese. There are translated journals that are not easily available, but the situation is improving. In the journals that

I have looked into (all areas of Chinese medicine) the general trend shows that the best outcome are often with the combination of using both Chinese and western medicine compared to either treatment alone. Very few indeed, if any, are RCTs. Thus far however, there is very little research evidence of using Chinese medicine to treat chronic pain conditions. This of course does not mean that Chinese medicine is not effective in treating pain. In fact, causes and treatment of pain have been recorded in *HuangDiNeiJing (Yellow Emperor's Canon of Internal Medicine)*, the first Chinese medical textbook written more than 2,500 years ago.

In order to understand the reasons for lack of RCTs in Chinese medicine, it is essential to understand Chinese medicine and clinical research methodology. Due to the fact that Chinese medicine has differing concepts, RCTs should not be used as the gold standard to assess its effectiveness and safety. This would also apply to other complementary medical systems. From the example above, one can see that the pathogenesis can vary from person to person. Therefore, a single disease in western medicine such as PHN can be secondary to or contributed by several different Chinese medical syndromes or conditions. Vice versa, a Chinese medical syndrome could manifest as different diseases in different people due to individual predisposition or susceptibility, which may be genetically determined. RCTs commonly compare a single-study compound with placebo in treating a single disease. In contrast with Chinese medicine, treatment by using a single compound/molecule does not exist. In fact, almost always a combination of acupuncture points and a concoction of different herbs is used to treat a single disease. In addition, how would one make up a placebo when the herbal decoction with an unmistakably strong taste and smell is the subject of the trial? With my explanation thus far, hopefully one can understand why RCT is an inappropriate tool to evaluate and judge Chinese medicine.

In the past, many Chinese medical researchers have applied the concept of RCT in their research in desperation to gain acceptance by the western medical world. This resulted in poor-quality RCTs and backfired, further strengthening the common opinion that Chinese medicine is all but a scam and is as good as placebo. This is further fuelled by the practice of unscrupulous 'cowboys' where 'herbal practitioners' are unregulated and herbal manufacturers that adulterate herbs or herbal combinations in order to make quick and large profits. However, these practices have now been clamped down significantly worldwide due to new regulations. Unfortunately, the damage has already been done.

My proposal is to perform research without placebo but to compare western medical treatments (drugs) and the combination of both treatments, then evaluate the symptomatic and functional improvements in patients

with a disease or label based on western medical diagnostic criteria. In these trials, the treatment principles of Chinese medicine should not be compromised. We have to accept that each study subject receiving Chinese medical treatment would receive individualised acupuncture and/or herbal combination that may be adjusted over the study period. This is also applicable to the western medical treatment arm where the drugs established in treating the named disease can be used in combination and dosages altered. Thereafter, validated outcome measures can be applied to evaluate each arm and a crossover trial may be conducted. Of course this is not perfect and I am most grateful for other opinions. Compilation of cases with appropriate outcome measures would serve as evidence but would take many years and many practitioners, preferably with dual qualifications (western and Chinese

medicine), to build this up and is not immediately practical.

Chinese medicine is not perfect, neither is any medical system in the world, but it has a lot to offer, not just in pain management but in other areas as well. The western medical world should ideally make an effort to understand it and collaborate to move forward. Judging Chinese medicine (indeed everything), without a full understanding is poor practice. I know, however, that this may still be too much to ask at this moment in time. Undeniably, it is still an uphill struggle for Chinese medical doctors and people of similar interests who feel that it is better to integrate, form a partnership and be part of a multifaceted strategy to improve disease treatment, while at the same time reducing cost.

Reading list

Beinfeld H, Korngold, E. *Between Heaven and Earth: A Guide to Chinese Medicine*.
Kaptchuk TJ. *Chinese Medicine: The Web That Has No Weaver*.

End stuff

Letters to the editor

Peter Wemyss-Gorman

Sir,

Your editorial '*Physicians, heal thyself*' grasps a nettle which has been allowed to grow unchecked for far too long. Roy Miller gave a paper at the inaugural meeting of what became the Philosophy and Ethics SIG in 2001 on **stress in pain practitioners**; there is an article on Pressure, Stress and Burnout by Chris Spanswick in the Spring 2003 issue of the Newsletter; there was a poignant account in a previous edition from a consultant who suddenly found he could

no longer cope, abruptly left in the middle of a clinic, drove home and ran weeping into his wife's arms – and had the courage to write about it.

A decade later there seems little evidence that the problem is being taken seriously, and may even be getting worse. As well as the increasing pressures that you have identified, the proportion of patients with complex problems, for whom physical interventions may be of doubtful value, has increased as GPs and other specialists have become more

sophisticated in their management of simple ones. Recognition of the importance of 'whole person' medicine has brought its own problems. A comment recorded at that 2001 meeting seems particularly apposite: **'Good communication skills can be a double-edged sword: if you listen better you are going to hear more things you don't want to hear. Empathy can be painful. The therapist who listens can feel exposed and vulnerable, and needs much support.'**

End stuff

Some things have improved; at one time most pain doctors were working alone, but the majority of pain services are nowadays provided by teams who can give one another mutual support. But the rapport between the team members may not always be ideal. Psychologists, psychotherapists and palliative care professionals insist on formal mentoring and supervision of one another. Are the needs of pain practitioners so very different?

Perhaps the first step might be to try to quantify the problem to establish its importance, although as you say there is every reason to suspect that it should be at least as great or probably greater among pain practitioners as among the general medical population, for whom statistics are available. But arguably the figures are of less importance than recognition of the reality that one individual suffering 'burnout' is not only a personal tragedy but a loss to the profession, probably of one of its most

conscientious and empathetic practitioners.

Roy Miller and I submitted a proposal to Council for the establishment of a mentoring network within the Society, which was sympathetically considered but turned down. Although we were concerned at the time mainly with lone, sometimes inexperienced doctors, there seems to be still at least as great a need for some kind of systemisation of support for everyone working in our demanding but rewarding profession.

New Members

Ratified at the September 2012 Council Meeting

Name	Position	Institution
Mr Gourav Banerjee	Researcher	Leeds Metropolitan University
Dr Julie Hui	ST6 Anaesthetist	Sheffield Teaching Hospital
Mrs Sarah Kelly	Staff Nurse	Spire, Cambridge lea Hospital
Dr Emily Lear	ST3 Anaesthesia	Royal Liverpool & Broadgreen University Hospitals
Dr Michael Spencer	Honorary Consultant Psychiatrist	West Suffolk Hospital
Mrs Jane Stone	Inpatient Pain Nurse Specialist	Frimely Park Hospital
Mr Ian Taylor	Head of Physiotherapy	Learning Disabilities, Kent Community Health NHS Trust
Mrs Sarah Medlicott	Pain Specialist Nurse	Royal Cornwall Hospital Trust
Dr Cressida Darwin	Clinical Psychologist	Solihull Hospital
Mrs Donna-Marie Sugden	Specialist Nurse in Chronic Non-Cancer Pain	Interface Medical Limited
Dr Jeanette Potter	Consultant in Palliative Care	The Hillingdon Hospital
Mr Narender Nalajala	Extended Scope Physiotherapist	Camden MSK Service

Future Study Days



Harnessing interactive technologies in Pain Management (28th Study Day)

http://www.britishpainsociety.org/meet_bps_study_days.htm

Bursaries available

Monday 25th February 2013
Churchill House, London

Communication technology is progressing at the speed of light and presents opportunities to harness new ways of working with patients and healthcare practitioners for improved and innovative care. The aim of this study day is to provide a platform to disseminate some of the work being done around the country using contemporary information and communication technology, including apps, interactive websites, social networking and other media, used in the management of pain and some long term conditions. The day will combine a mixture of presentations from people already involved in designing interactive technology in health care, with demonstrations and strategy workshops.

We would encourage people already involved in the development of such technologies to come and share their work and those thinking of doing so to attend in order to engage in discussion on this fascinating topic.

Commissioning Pain Services (29th Study Day)

http://www.britishpainsociety.org/meet_bps_study_days.htm

Bursaries available

Monday 10th June 2013
Churchill House, London

Changes to the NHS mean changes to the way in which pain services are to be commissioned. This course will lead the attendee through the commissioning process and give practical advice on how proposals can be developed, how they may be judged, and how to understand the commissioning process better. The day will be presented by leading clinicians working in the commissioning of pain services.

To apply for either of these meetings or for more details please visit the website or email
kenobbard@britishpainsociety.org



Pain in older adults study day

The population is aging fast, it has been suggested that the number of older people will be at an all time high by the year 2050 rising from 7.4% to 16.4%. Furthermore, pain is a common problem for older people with chronic persistent pain affecting at least 50% of community dwelling older adults and 80% in nursing homes. This study day is an exciting opportunity for staff to hear expert speakers from around the UK bringing the latest evidence on the assessment and management of pain in the older population. Any health care worker regardless of professional background will be interested in this study day as we encounter older adults in all areas of practice.

CPD points applied for.

