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# PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY  
50TH ANNIVERSARY ISSUE



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THE BRITISH PAIN SOCIETY  
PAIN NEWS

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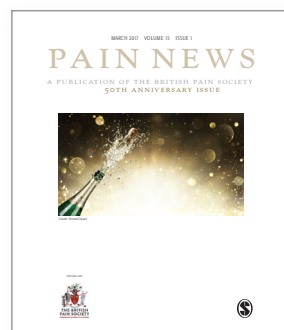
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<https://www.britishpainsociety.org/for-members/pain-news/>

# British Pain Society Calendar of Events

To attend any of the below events, simply book online at:  
<https://www.britishpainsociety.org/mediacentre/events/>

## 2017

### 50th Anniversary Annual Scientific Meeting

Wednesday 3<sup>rd</sup> to Friday 5<sup>th</sup> May 2017  
 Birmingham

Put the dates in your diary now for this flagship event – the 50<sup>th</sup> Anniversary Annual Scientific Meeting of the BPS. We are putting together an exciting and stimulating programme and will be announcing plenary speakers and parallel session topics in the near future. The ASM is a great opportunity to:

- Network with colleagues
- Keep up to date with the latest cutting edge research and developments relevant to pain
- Raise questions, partake in debates and discuss outcome
- Meet with poster exhibitors and discuss their research

For regular updates please visit: <https://www.britishpainsociety.org/2017-asm-birmingham/>

### Living Well Right to the End

#### Philosophy & Ethics SIG Annual Meeting

26<sup>th</sup> to 29<sup>th</sup> June 2017  
 Rydall Hall, Cumbria

How to live well at all can prove elusive and has been much debated for thousands of years.

Is it to do with physical health or pleasure or a general sense of wellbeing or happiness or fulfilment or meaning or is it merely the absence of suffering?

Can we somehow enable those we care for to achieve a level of wellbeing even as they become ill and perhaps face death?

Can we achieve a measure of wellbeing in our own lives?

Our meeting this year takes place in the beautiful surroundings of Rydal Hall amongst the lakes and fells of Cumbria where we will be considering all of these issues.

### Gonnae no dae that! – exploring patient and clinician fears

#### Pain Management Programmes SIG Biennial Conference

14<sup>th</sup> & 15<sup>th</sup> September 2017  
 Glasgow Caledonian University, Scotland

**Speakers including:** Amanda C-de-C Williams, Tamar Pincus, David Gillanders and Johanns Vlaeyen.

#### Social events:

- Wednesday evening: drinks reception in the iconic Glasgow City Chambers.
- Thursday evening: Scottish gin and real ale tasting, plus the chance to play the bagpipes at the National Piping Centre!

**Further details for all our meetings can be found on our events listing page:**

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

# Editorial

Dr Arasu Rayen *Editor*

pns.rayen@gmail.com



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**SAGE**



By the time you read this editorial, summer is around the corner, but most importantly the 50th anniversary of British Pain Society (BPS)

Annual Scientific Meeting (ASM). At this important juncture, it is our immense pleasure to bring you the special edition of *Pain News* to commemorate the 50th anniversary of BPS ASM. After reading the above statement, you should have realised that BPS is the oldest Pain Society in the world. It is the only Pain Society which has been in existence for the past 50 years. What was once called Intractable Pain Society, started by handful of clinicians to promote knowledge and skill and encourage networking, changed its name to Pain Society and later grew into The British Pain Society (BPS) with nearly 1300 members from multidisciplinary

background. We should be proud that we are part of such a long-standing legacy.

To celebrate this occasion, we have a few special articles and guest editorials from the past Presidents of the BPS and the former editors of *Pain News* and a photographic feast from previous ASM. One such article is from Dr Tim Nash. Dr Nash was one of the Pain Management consultants who worked at the Walton Pain Management Centre. I remember him from my attendance at Liverpool pain courses during my training days. When I tracked him down and requested an article about his association with the BPS, he was so enthusiastic about the idea. He completed a wonderful article which gives us real insight into the 'big bang era' of BPS. It was also a pleasant surprise to know that he was the first editor of the newsletter of the Intractable Pain Society. This is the same newsletter which had evolved into our current *Pain News*. So, he is actually the first editor of *Pain News*. I really have to thank him for taking so much effort in not only writing the article but also for sending me copies of the first newsletter and getting in touch with his associates of yesteryear to get more information. Please read his

article which is very interesting and informative about how the BPS came in to existence.

Another person I have to thank is William Campbell. Tirelessly, he responded to a barrage of my emails and calls about various aspects and personalities of the BPS from previous years. He also takes the credit for sending nearly 50 photographs from his collection of photographs from previous years. Now I understand why we see him with his camera all the time during ASM and asking delegates and speakers to pose for his photographs.

There are special editorials from Mike Basler, Ruth Day and Thanthullu Vasu. They have looked back at their associations with the BPS and look ahead at the future of the BPS.

May I take this opportunity to remind you about this year's special ASM in Birmingham. This year's ASM has an exciting line up of speakers and programmes. I hope that lots of you have already utilised the early-bird offer and booked to attend the ASM. If not, please book and attend this special ASM to make it very special and memorable.



# Guest Editorial 1: Post Truth, Glass - cliff, Woke, Adulthood and BPS?

**Thanthullu Vasu** *Consultant and Head of Pain Management Services, University Hospitals of Leicester NHS Trust; Former Editor, Pain News*



I can't believe that it is 3 years since I was the Editor for *Pain News*; it was a pleasant shock when the present Editor asked me to write a guest editorial for the newsletter that faces the 50th Annual Scientific Meeting (ASM).

In my first editorial,<sup>1</sup> I quoted,

*plus ça change, plus c'est la même chose*  
*[the more things change, the more they remain the same]*

I am sure you will agree that the pain services and the National Health Service (NHS) are still facing the same challenges and constraints as we had before. As pain clinicians, we are constantly engaging with the Commissioners and Managers to sustain our pain services. Commissioners have used variety of reasons, including some perfidious, to ration our services. Although we engage locally within our geographical limits as clinicians, we should be really proud that we have a British Pain Society (BPS) that looks into the wider needs of the pain community. We should also be proud that we have a true multidisciplinary Society that caters to our needs as we face our 50th ASM in Birmingham in May 2017.

On another note, it is really worrying that the membership numbers are going down slowly. In my first issue as Editor (Summer 2011), our Honorary Secretary reported that there were 1467 members, whereas in March 2016, this number has fallen down to 1280.<sup>2</sup> So, why are members losing the interest to work with the Society? It is a million dollar question, but I wish to analyse with a concept of 'word of the year'. For those who are not aware, this refers to the most important words in the public domain during that year. I wish to select the Oxford dictionaries 'word of the year 2016' to analyse this.<sup>3</sup>

## Post-truth

Post-truth is selected as the 'word of the year 2016'. It is explained as 'condition in which objective facts are less influential in shaping public opinion than appeals to emotion or personal belief'. Though this word navigated a lot in public domain due to facts like Brexit, US elections and so on, I feel there is a strong link with our position in the BPS. When I was an elected Council Member, some colleagues used to comment that the Society has not done much for them individually. I replied back that they form the Society and it is not just the Council which sits in Red Lion Square running the show:

*You are not stuck in traffic; you are the traffic*

The office bearers represent us but individuals should also take responsibility. Are members leaving because of emotional and personal beliefs rather

than objective facts? I am not in a position to comment, but be assured that this is a Society which has a strong multidisciplinary tradition and represents each one of us when needed. We should be aware that unless we stay together, it is easy for commissioners or service-buyers to compromise our services! Please look at the objective facts rather than personal beliefs: BPS has more than 1200 members and promotes education, training, research and development in all fields of pain. It has raised both professional and public awareness on pain management. It has published evidence-based guidelines that we still use when engaging with the commissioners. If clinicians want to stand away and hope the Society could work, it is not a rational view.

Few other words in 2016 that were short-listed include the following.

## Glass-cliff

This is an interesting concept used in reference to a situation where a woman or minority person ascends to leadership in challenging circumstances where the risk of failure is high. In 2003, Elizabeth Judge wrote an article<sup>4</sup> where she compared 10 companies which had mostly women on their boards with 5 companies with no women on their boards. The companies with women didn't do well, but looking into detail, this trend was there even before these women were appointed. So, 'glass-cliff' was termed to explain why minorities raising to leadership did not perform well due to pre-existing hostile environment. One similar concept is that our BPS has had similar challenges for a long time and members might expect that

these issues should be swiftly resolved. Considering these are long-term problems, we may not have immediate solutions; I can reassure that the Council members work hard to overcome these obstacles. BPS has reached glass-cliff where already existing restrictions are causing obstacles. We need to support the Society at this difficult time rather than exiting!

### Woke

'Woke' is an US informal alert to injustice in the Society. It means '*being aware – specifically in reference to current events and cultural issues*'. Though it was applied in the United States to racism, the concept could be applied to other situations. We should all be 'woke' now that the Society needs our support. Without us, the Society can't function. All other Societies have grown in number and this is the time to reflect why it is important for us to stay together as a Society!

### Alt-right

This is an ideological group (mainly online) with extreme conservative or reactionary views, rejecting mainstream politics and disseminating deliberately controversial content. Luckily, our BPS does not face much criticism, but still we could see various online or social groups of comments about our Society. I presume that all these discussions will benefit and make our BPS stronger. I am sure that these controversies arise as the expectation from BPS is higher and it will stand stronger to do the needed.

### Hygge

'Hygge' is cosiness and comfortable conviviality that gives content and feeling of well-being (represents Danish culture). Some members feel that it is okay to stay away from the Society with comfortable hygge, but times are more complex and demanding that we need to include ourselves rather than the opposite.

Please get involved with the Society as it is made by you rather than formed for you!

### Adulting

'Adulting' refers to a person behaving as a responsible adult, especially in doing routing mundane but necessary tasks. This is a cheeky word honouring a dull task that needed doing. Let us all do adulting, in that being a vital part of the BPS is a necessary task.

In the next section, I am only going to express *my personal views*. These are my thoughts that should be objectively analysed and debated for the benefit of our Society:

### ASM pattern

Each year, we get reports that the ASM was a huge success. Fourteen years ago, when I started as a pain trainee, ASM was like a festive period. I still remember the whole pain department going to ASM and finding it difficult to get an anaesthetic consultant to hold the fort till we all came back. Now, the situation is different! Not many from our department go to the meeting and it is rare to find trainees who are interested. Many reasons could be debated; but the two important facts include the following: (1) cost of the ASM which should be reduced; for a consultant, he or she will lose the whole study budget in one meeting itself, and (2) though the ASM committee works hard, members have anecdotally commented that the topics are monotonous and more basic science based; why not challenge this with more clinically applied topics rather than science/research alone? Considering the fact that there are more clinical members, ASM agenda should represent this with apt engagement of frontline clinicians.

### Membership benefits

Members get *Pain News* and *British Journal of Pain*, but the number of other

publications and leaflets might have reduced in number now, possibly because of cost-effectiveness. To keep in pace with modernisation, BPS can judiciously use the online platform to inform and involve the members. ASM topics and education days could be webcasted later for those who could not attend. This could also involve important case discussions; Google *Pain Consultants* group has proved hugely successful how online discussion can help and benefit our patients and this should set a model. I request the Executives to do the necessary to make sure that the benefits of membership are realised by members.

### Feeling part of Society

I personally feel that more needs to be done to make us feel a part of the Society. Charity-runs, Christmas cards and coffee-day for charity are some examples. All charities have a section which deals with these activities and BPS should consider this to motivate the members.

### Spreading good news

Although I have great appreciation for all the work done by the Communications Committee of BPS, I still feel that we should be spreading more good news and appreciation. Even small appreciation for a pain service should be given due importance and projected to create awareness of our good work. Faculty of Pain Medicine has a webpage advertising all the good work in pain management and this could be a simple example.<sup>5</sup> If we don't appreciate our colleagues, who else will?

### Is multidisciplinary cause for concern?

There have been concerns from doctors that there are not many medical representatives on the BPS Council. As more than 50% of the membership is

from anaesthetic faculty, this concern could be understood. However, being multidisciplinary is vital to work together for the benefit of our faculty. Every discipline should be reassured by the BPS that they will be taken care of and represented in an even way.

I am very fortunate to have been elected as a Council Member of our prestigious Society in the past and served as the Editor of *Pain News*; my personal example clearly proves that if you want to serve the Society, there are always options to be part of it. Please think again how you could help the Society. In my last issue as the Editor (March 2014), I finished with a quotation from Albert Einstein:

*Strive not to be a success, but rather to be of value*

I am confident that we, as individual members of the BPS, will add huge value and continue to make it a great success.

In the cover page of *The Lancet*,<sup>6</sup> there was a valuable comment: 'Physicians, disillusioned by the productivity orientation of administrators and absence of affirmation for the values and relationships that sustain their sense of purpose, need enlightened leaders who recognise that medicine is a human endeavour and not an assembly line'. You could be that leader or at least part of our BPS which takes this leadership role for pain management!

If you have any comments on these controversies, please don't hesitate to email the Editor at [pns.rayen@gmail.com](mailto:pns.rayen@gmail.com) and interesting comments could be published in the next issue.

#### References

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## Guest Editorial 2: Able navigators in uncharted seas

Dr Mike Basler



I do not have a high tolerance for mission statements, acronyms or any of the managerial bilge that has frequently been fired into my

inbox over the last 20 years as a Pain Consultant in the NHS; but I make one exception. In the last 5 years, my hometown has changed its mission statement from saying we smile a lot (try to believe that in the hail, rain and wind that frequently passes these shores in the middle of the summer) to the simple phrase that 'People make Glasgow'. This sound bite may seem even more idiotic than the former slogan, but if you speak to anyone who lives or has worked here in Glasgow, they know exactly what it means.

In the midst of the ever-widening gap between despair and hope, and poverty and riches, Glaswegians have a directness, an intolerance of bunkum, a strong sense of humour and an unflinching belief that we are all 'Jock Tamsons Bairns', that are hugely valuable strengths in troubled times. I am sure these strengths are not unique, but I would say that Glasgow would give anywhere in the United Kingdom a good run for their money if they suggested that these attributes were more prevalent in their area.

Why do I write this? In these cynical times where walls are being built, truth is not necessary and a serial bankrupt with an incendiary twitter account is leading the Western world, there is often a belief that many of those involved in regularity

bodies and positions of authority are only interested in self-aggrandisement. I often held this viewpoint. What I can say is, that after my time on Council and my period as Editor of *Pain News*, is that those I met in the British Pain Society (BPS) are quietly unflinching in their support for those on the ground in our hard-pressed specialty and I would happily propose them as surrogate Glaswegians!

It is not until you attend Council meetings and see the volume of governmental, regulatory and educational traffic that requires someone to stand up and ensure that the voice of pain management (and more importantly that of our patients) is heard. It is also clear that the task of ensuring that there is multidisciplinary consensus to a variety of issues can often be difficult – and that those involved put significant effort to ensure that the strength of the whole team is respected and acknowledged.

When I first started out in medicine, the old green and yellow Oxford Handbook of Medicine (the house officer's friend) had a section with a few pieces of philosophical wisdom. 'If you have strong views – question them'. Nowhere was this more apparent in some of the Council discussions and this open dialogue was a good thing.

I made good friends on Council and was exceptionally grateful for the help of the members of the BPS administration team, who were not only highly proficient but also lovely people. We should be grateful for 50 years of BPS work. For many of us, it's work, innovation and advocacy has helped define our working careers.

The role of *Pain News* has always been a strange one and when I started as Editor, I sent out a request asking for comments about editorial direction. As expected, there were only a few comments but my favourite reply said that it was 'not worth the paper it was printed on'. From this point, I knew that I had a challenge to engage the readers and was forever indebted to those who took time to write in publication that was unlikely to be scrutinised in a research assessment exercise. Given that it was not a scientific journal, it was likely that I could not expect any kudos for what was at times a fairly arduous task. The lack of scientific scrutiny did have some advantages, as it gave me freedom to ask people to write what they *really* thought about issues (rather than what they would write to achieve a publication) and that spark often generated healthy discussion. This was very apparent in the issue that surrounded the controversy over the first NICE (National Institute for Health and Care Excellence) back pain guidance and I would hope that this, and a few other editorials, possibly meant that *Pain News* in my time was more useful than toilet paper.

Amos Tversky a famous psychologist once said 'A part of good science is to see what everyone sees but to think what no one else has thought?' *Pain News* occasionally has the freedom to do this, and I would encourage all in the Society to use it as a vehicle to call out the Emperors New Clothes – both clinically and in the wider NHS. Pain Medicine travels through choppy and uncharted seas – clinically, academically and managerially and in these difficult



times, we need to be able to stand up and point out where false channels, rocky outposts and new horizons may lie. The BPS has had an important role in navigation.

For a variety of reasons, I had to travel down different routes than the

BPS after I left my editorship, but I am thankful for the opportunity I had, the people I met and the insights I gained. People make the BPS, and in the last 50 years, it has worked hard to ensure that pain management has headed in the right direction. Tversky also said 'it

*is probably easier to make the world a better place than to prove you have done it*'. Don't take the BPS or *Pain News* for granted. They can be important. I look forward to a further journey of discovery in the future 50 years and wish all success.



For further information please visit  
[www.britishpainsociety.org/2017-asm-birmingham/](http://www.britishpainsociety.org/2017-asm-birmingham/)  
follow us on twitter: [#BPSASM50th](https://twitter.com/BPSASM50th)



## Guest Editorial 3: Words - I love them

Ruth Day



My inbox pinged – there it was: ‘As a former editor of *Pain News* would you please write something for this

special edition?’ How could I resist? Especially as I love words. Sometimes it’s the sound the word makes in my head, sometimes it’s making up daft rhymes when I’m walking the dog, other times it’s the combination of music and words. Before I was the editor of *Pain News*, I edited a little known publication, *News of Hymnody*. It’s circulation is so small that, unlike *Pain News*, it hasn’t made it into the BBC comedy programme ‘Have I got news for you?’ Bit of a shock when that came up on my screen.

*Hymns and pain* – I guess some of you may be thinking there are no links between these publications, but here are some:

- Both have a pink theme. NOH (*News of Hymnody*) is printed on pink paper and PN (*Pain News*) was very pink in its early 2-colour days.
- They have both shared me!
- They both share subject matter which intrinsically has a tension between public and private.

Faith, like pain, relies on self-report. In the same way as someone might doubt the existence of another’s pain (‘Did you see her zooming round the supermarket last week? And she says her pain’s so bad she can’t get to work!’), it is difficult to see someone’s faith (‘And he calls himself a Christian!’). Perhaps, there is an image with both too – that someone can talk about either forever.

A friend of mine used to say that people internalise their theology through hymns – the addition of words to memorable tunes helps them stick. How many of us remember the carols we learned at school and sing them (without looking at the words) every year? But there are not many hymns that speak about human physical pain, so I was pleased to combine the two

when, at Epiphany this year, we sang that we are given:

Insight, to see what God has done  
In changing water into wine,  
In healing bodies racked with pain,  
In warming hearts; yes, even mine.  
(Jeremy Davies)

The following week, another hymn, another connection:

Through our calling closely knitted,  
daily to your praise committed,  
for a life of service fitted,  
let us now your love proclaim. (Fred Kaan)

Yes – knitting. As an avid knitter, I was delighted to read Betson Corkhill’s book *Knit for Health & Wellness* last year and to see that much of her work has been done in the area of pain management. Knitting regularly can improve your happiness, calm, confidence, concentration and problem-solving. Why don’t we see more of it about? I’ve been known to knit discreetly during the Annual Scientific Meetings (ASMs) – this year, I plan to be more open and hope you will join me. And I promise not to sing hymns at the same time.

# From The President

## Dr Andrew Baranowski



Dear Colleagues, I am writing this just before Christmas and you will see it in March, very confusing!

### Time for reflection

Christmas is

always a time for reflection for me and probably for many of you. Today I have been thinking about our beginnings as a Society and the huge progress we have made – or have we?

### Memories of the early days

Mark Mehta (Consultant, Norfolk and Norwich) wrote in *Pain*, 8 (1980), 121–122 about the early days. He noted that the Intractable Pain Society, from which the British Pain Society (BPS) emerged, ‘met for the first time in Salford in November, 1967, at the invitation of Dr Mark Swerdlow (Manchester)’.

He wrote, ‘The initial group consisted of 17 enthusiasts ...’. I love that term ‘enthusiasts’; it encases passion and entrepreneurship, two aptitudes that have helped Pain Medicine to develop and resulted in the field being recognised as a ‘cornerstone’ of our health service by NHS England. By 1980, he suggests there were 178 ‘pain relief centres in Great Britain and Ireland’ and he comments that ‘Most hospitals provide the simpler methods of pain treatment ..., but a few regional centres exist where a multidisciplinary approach ... are available’. He identified areas of activity that included the following:

- Representation on the Medical Research Council (MRC) for financial

support of ‘responsible and approved projects’;

- Negotiations with commercial firms for the development and design of suitable equipment;
- The public and indeed medical profession, need to be made more aware of the problems of chronic pain, though:
  - Lectures;
  - Publications;
  - Media;
- Higher professional training;
  - Submissions to the Association of Anaesthetists;
  - Recognised by questions in the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS; when the anaesthetists were a faculty within the Royal College of Surgeons);
  - Compiling a list of suitable training facilities.

Mark’s summary could be written today:

- ‘Advances in the management of chronic pain still lag far behind advances in other branches of medicine’;
- ‘The subject is largely ignored in the undergraduate curriculum’;
- ‘Few people realise the extent of unnecessary suffering ...’ and ‘support from the DHSS is not as great as it should be’;
- ‘The prospects for further development in this field are not enhanced by the swinging cuts in the National Health Service budgets’.

### So was it all bad then and are we any better now?

I am not sure that I am able to make judgement. But I will try to look at some of the initiatives under way so you can judge and I have asked a few colleagues to comment as well.

### Research

Sam Eldabe, kindly gave me the following:

Clinical Pain continues to be underrepresented in research funding especially when we take account of the recently published incidence and severity of the condition. Few National Institute for Health Research (NIHR) calls have been specific to chronic pain research.

However, there are signs of an overall improvement. For example, of the total of 51 studies on the National Institute of Health Research Portfolio for Anaesthesia Perioperative Medicine and Pain, 12 are Pain studies with varying funding from the NIHR Efficacy Mechanisms and Evaluation (EME) Research for Patient Benefit (RfPB) to MRC and National Institute of Academic Anaesthesia (NIAA).

The vexing issue of the role of opioids in chronic non-malignant pain has given rise to a specific NIHR Health Technology Assessment (HTA) call on the topic in 2015, and the I-WOTCH (Improving the Wellbeing of people with Opioid Treated CHronic pain) study was funded to explore the issue. This is due to start in April 2017.

At this year’s Annual Scientific Meeting (ASM), the BPS Science and Research Committee lead a parallel session on the



funding of clinical pain research with talks from funders and successful applicants.

Arthritis Research UK recently announced the Pain Challenge fund. The focus of which is on fundamental biomedical discovery pain research, to increase our understanding of the fundamental biological mechanisms and pathways, which underlie musculoskeletal pain and/or lead to the prevention of musculoskeletal pain, or identification and development of new treatments for pain.

### Relations with companies

Times are difficult ...

The BPS is committed to providing opportunities for trade stands and satellites at our ASM and opportunities for advertising through our journals providing appropriate guidelines are met. Unfortunately, support of the BPS by industry has shrunk over the past few years. Some may say this is appropriate as it reduces inappropriate interference, and others will say that the contribution by industry along the lines of that in the 1980s is essential. Whichever side of the line that you stand, this downturn has had financial consequences for the Society. I suspect the Society will move forward being less dependent on industry hopefully developing new relationships.

### Education

The BPS and members collaborate with many agencies around education. There are still gaps that our Education Committee under the guidance of Paul Cameron aims to fill for 2017, we have had an exciting programme of events to date. We look forward to this continuing as Paul reconstitutes his committee's membership. Our Special Interest Groups (SIGs) are also very active.

### e-Pain

Our members have been integral to e-Pain, a joint collaboration with the

Faculty of Pain Medicine (FPM). This multidisciplinary e-learning programme in pain responds to the need for improved knowledge, skills and attitudes of all staff in the NHS who deal with patients who have acute or chronic pain. Please take a look at <https://www.britishpainsociety.org/british-pain-society-publications/e-pain/>

### EPM Lite

EPM Lite is the Essential Pain Management Programme (EPM) and was originally developed in Australia and New Zealand by Roger Goucke and Wayne Morris as an educational tool for health care workers in low- and middle-income countries. The UK FPM took on introducing EPM Lite as a project in 2014. A representative from the Pain in Developing Countries SIG of the BPS is a co-opted member of the EPM UK working group (of the FPM). EPM Lite has successfully been delivered in 11 UK medical schools with 4 more schools interested and there are plans to expand its role out.

### Pain News and the British Journal of Pain

Our membership survey indicated that these were highly valued by our members, and when I was at the International Association for the Study of Pain (IASP) World Congress, we received positive comments from overseas indicating how far the *British Journal of Pain* (BJP) reaches. As the BJP gains recognition, we will be able to reflect that increased value by placing it behind a paywall so that those who are not BPS members must pay for it. We are heading in the right direction, because of the efforts of the editorial team and those of you contributing high-quality papers; hopefully, we will soon see the journal bringing in funds for the Society.

### The National Awareness Campaign

At the beginning of the year, we started releasing our posters electronically; these

are being circulated to members for you to use not only locally but also through Facebook and Twitter. A measure of success will be how often the posters are shared and how far afield. Please share and re-tweet and keep doing so. I appreciate there are many problems in the world, but pain is also one of them and to my knowledge, there are no professional multidisciplinary team (MDT) bodies that are spreading the word. The posters feed back to our new look website and as the site develops, we will see more information for our members and those with pain. For the BPS to continue to provide support around our MDT mandate, we need income and the National Awareness Campaign (NAC) links in to how people can contribute – not only financially but also through providing resources as well.

### Ambassadors and Trustees for the BPS

It is still early days as I write this, but the Society is also looking at how we can engage the public. We have our highly successful Patient Liaison Committee and Patient Reference Group led by Antony Chuter. However, we are also beginning to explore the possible roles of Ambassadors and Trustees who would be able to support the Society in the public domain. More to come in the future, I suspect.

### Social media

Social media did not exist in the 1980s – many people may wish it did not now! But it is a fact of life and we have had some excellent articles from Drs Damien Smith, Stephen Humble and Arun Bhaskar in recent issues of *Pain News* encouraging us to take part and providing us with a knowledge base to do that.

Our Social Media Team has now developed a formal relationship with our Media Team under the Communication Committee led by Arun Bhaskar. Ann Taylor and Sam Ahmedzai are keeping



From The President Dr Andrew Baranowski

our followers informed of events as we hear of them, and Alan Fayaz, Roger Knaggs and Austin Leach are involved in providing horizon scanning, strategic overviews and more in-depth analysis.

### Higher professional training

This is now established for those with an anaesthetic background with our partner, the FPM. There are several MSc courses that appear to go from strength to strength, and I hope that the BPS will be able to offer CME training sooner than later. So, we are getting there!

As our strength is the MDT mandate, we must look to further collaboration with other agencies that support the field. I am pleased that Council has representation from the following:

Royal College of Nursing;  
The British Psychological Society;  
The Physiotherapy Pain Association;  
The Chronic Pain Policy Coalition (CPPC);

The Association of Palliative Medicine;  
The Faculty of Pain Medicine; and  
The International Association for the Study of Pain.

### The National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) Low Back Pain and Sciatica guidelines were published at the end of 2016, following a consultation earlier in the year. The BPS has supported the emphasis on the multidisciplinary (bio-psycho-social) approach to pain management, with early assessment and stratifying patients into groups with differing risks of developing ongoing problems to target treatments and resources appropriately. We hope the guideline will support clinicians to make important decisions about specific investigations and/or treatments using a patient-centred approach. Certain groups and individuals have raised concerns about various aspects, and the BPS remains committed to reviewing any

feedback we receive, particularly constructive input that will help to further support best practice.

NICE has also informally indicated that it is considering looking towards drawing up guidelines on the management of chronic pain. The BPS will actively monitor the situation, and we will involve our members where we can as these guidelines will be of major importance affecting most of our work. We have been informed that the guidelines will be one of the largest projects that NICE has undertaken.

### The future

Events over the past few years have shown we can't predict the future. What history tells us (or at least tells me) is that the nature of the problems we will face are the 'same as in the past', but hopefully, we can build on the positive progress made by the enthusiasts to support multidisciplinary approaches to providing best care and support for our patients.

# From the Honorary Secretary Professor Roger Knaggs



## Looking back and looking forward

Although it will be several months before this issue of *Pain News* arrives on your doorstep, I am writing this column between

Christmas and New Year. Traditionally, it is a time to reflect on the year that has just passed and look forward to what the New Year may bring.

Outside of the National Health Service (NHS) and the world of pain, the world seems very different and less secure than at the beginning of 2016. At home, the consequences of the vote to leave the European Union (EU), subsequent procedural legal challenge and the economic implications will be with us for some time. However, it is clear that there are similar nationalistic feelings in other European countries and further abroad too and how these will affect the stability in the EU will become clearer with time. The impact of the election of Donald Trump in the United States remains unclear.

Over the last few weeks, the healthcare system has been creaking with hospital beds at an increasing premium and colleagues in primary care are working at full capacity. It is clear that the financial austerity is having negative impacts on productivity and morale within the NHS. It appears that commissioners are beginning to look at pain services with closer scrutiny in ways to make savings. As a community, the British Pain Society (BPS) is well placed to demonstrate the multidisciplinary contribution that pain services make to improve the lives for people living with pain. Do be prepared to share your experiences with colleagues and council members who you may know, so that we can support each other and colleagues throughout the country.

## Honorary Members

One of the issues I have been keen on for some time is to include members more in the decision-making processes of the Society where possible. For the first time this year, members had the opportunity to nominate people for Honorary Membership. We were uncertain as to how many proposals would be received; however, it was pleasing to see several nominations that were reviewed by a new Awards Committee chaired by Dr William

Campbell. Those people selected will be presented with their award at the Annual General Meeting later in the year.

## Elections for Council Members

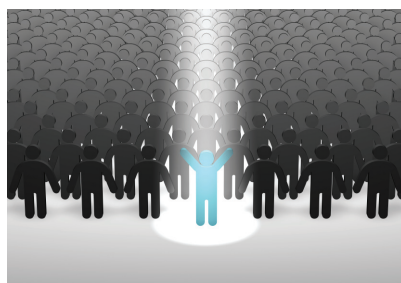
Over the course of the next few weeks, you will be receiving notification of the election process for this year with a call for nominations, and instructions for online voting subsequently. Although the member survey suggested that online voting was preferred to the previous paper voting forms, the number of members who vote remains relatively small. This is one of the ways that you may contribute to democracy and influence BPS' direction and strategy.

## 50th Annual Scientific Meeting

By the time you read this, our 50th Annual Scientific Meeting will be approaching very rapidly. In case you have forgotten the important dates are 3rd to 5th May at the International Convention Centre in Birmingham. The plenary speakers who have accepted our invitation include several international and national leaders in pain. In addition, the range of workshops will have something that appeals to everyone. If you have not been for several years, do think about coming. No doubt you will meet old friends and perhaps learn a few things too!

# Spotlight – Alan Fayaz

Alan Fayaz *University College London Hospitals NHS Foundation Trust*



*The width and breadth of BPS membership is testimony to the diversity within the organisation and in the pain world. The Editorial Board would like to acknowledge this richness by shining a spotlight on some of our members. In this edition, we speak to Dr Alan Fayaz*



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

By chance, I saw an invitation to participate in an epidemiology work stream, initiated after the National Pain Summit identified significant gaps in our understanding of pain demographics. It happened to marry very well with my MD(Res) Thesis, so I was fairly stoked to be involved.

## 2. What was your role in the BPS? What excited you about this role?

The work on pain epidemiology was quite public/media focussed; this led to my involvement with the Media team. The idea is to strengthen the BPS brand, in particular as a voice for the pain community. I think there's a huge gap in medicine (not just pain), between what professionals know and do, and what the public perceives. It has been very exciting to help bridge this gap.

## 3. What are/were you best known for professionally?

My research. In particular, the work on pain prevalence in the United Kingdom which seemed to capture the public's interest.

## 4. How do you think the BPS has changed from when you first became a member to now?

Tremendously, and this reflects how Pain has changed over the past decade or so. It feels far more integrated, far more inclusive and as a result far more interesting. The last ASM I attended was an excellent demonstration of this.

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

Panic. I have no idea how Andrew does it. If the panic settled before the day was up, I would love the BPS to help develop a documentary about chronic pain patients.

## 6. Where can we find you in your spare time? What is your favourite

## way to spend a weekend or a Sunday afternoon?

With friends, in East London, probably at a hipster pop-up restaurant. Food is my vice.

## 7. What would be impossible for you to give up?

I want to say 'nothing' – but my fingers keep typing 'bread'.

## 8. Any life achievements you are particularly proud of?

I have a tendency of trivialising things as soon as I've completed them, so it is hard to be objective. All of the above would certainly feature.

## 9. Anything else you'd like to tell people about yourself?

I hosted a dating show in the 1990s for a cable TV station in East Anglia. It was pretty amazing/awful, but thankfully the episodes predate Youtube.

## Have your say and contribute to *Pain News* today

*Pain News* is the newsletter for members of the British Pain Society and we welcome member and non-member contributions to share your news with the wider membership and beyond.

*Do you have a news item to share?*

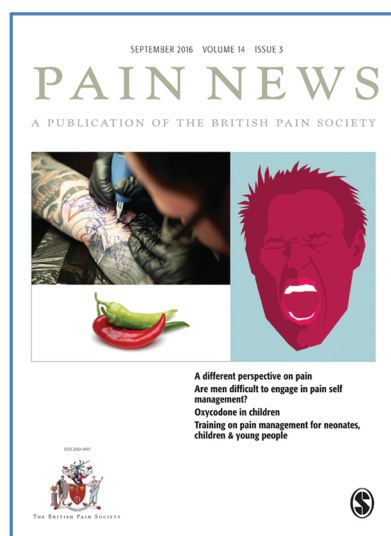
*Perhaps a professional perspective, or informing practice piece?*

*Maybe you would you like to feature as our 'Spotlight' member?*

We'd love to hear from you so drop the Editor an email today at: [pns.rayen@gmail.com](mailto:pns.rayen@gmail.com)

Upcoming submission deadlines:

Issue	Copy deadline
June 2017	31 <sup>st</sup> March 2017
September 2017	30 <sup>th</sup> June 2017
December 2017	29 <sup>th</sup> September 2017





# Standing on the shoulders of the Giants

Arun Bhaskar *Chair, Communications Committee, British Pain Society*



*'If I have seen further, it is by standing on the shoulders of giants'*

Sir Isaac Newton famously stated this quote originally written by John of Salisbury in

Metalogican describing Bernard of Chartres when he was lauded for his scientific achievements. The millennials would also recognise the above quote as the motto of Google Scholar. It holds true in the field of Pain Management, a relatively young speciality, where the journey started as a group of interested clinicians who got together and set out to develop their common interest for relieving pain which in a short time has evolved into a multidisciplinary multi-professional Society. The British Pain Society (BPS) is one of the first pain societies in the world and many of things we take for granted in our clinical and academic work related to pain management has been due to the tireless efforts of these pioneering individuals and their vision.

## History of the Society

Pain relief clinics were pioneered in the 1930s in the United States and focused primarily on nerve blocks, and the concept spread to Europe after the Second World War. The first of these clinics in the United Kingdom were set up in London, Plymouth and Liverpool by 1947. Over the next two decades, further clinics developed and there were about

29 clinicians (mainly anaesthetists) practising this all over the United Kingdom. The Intractable Pain Society of Great Britain and Ireland (IPSGBI) was formed in 1967, 5 years before the International Association for the Study of Pain (IASP), which was founded in 1973, making it probably the oldest Pain Society in the world.

The first ever meeting of 17 of these pioneering clinicians took place at Salford Postgraduate Medical Institute, Salford University, and at the Christie Hospital in Manchester. This meeting was organised by Dr Mark Swerdlow (Manchester) and was appointed as the first chairman of the Intractable Pain Society. Prof William Mushin (Cardiff) was elected as President, Dr Mark Churcher (Plymouth) was appointed as Secretary and Dr John Challenger (Bristol) was appointed as Treasurer. Other early members included Dr Mark Mehta (Norwich), Dr Tim Nash (Basingstoke), Prof Iggo, Dr J Hannington-Kiss, Dr John Lloyd (Abington), Dr Hugh Raftery, Dr Keith Budd (Bradford), Dr Andrew Diamond (Bristol), Dr Ed Charlton (Newcastle), Dr Dick Atkinson (Chesterfield) and Dr Ken Hardy (Wales). The Society was established to attempt to treat and prevent the development of persistent pain as opioids, and other pharmacological options were still not widely practiced. The early members were mostly anaesthetists and also included physicians such as Dr R Maher, who pioneered the use of intrathecal phenol for cancer pain. It was felt at the time that the Society could be considered as a meeting of minds for like-minded individuals sharing ideas and experiences.

The Society was initially started as consultants only (mainly anaesthetists doing pain interventions) and over time, the membership of the Society changed to become a multidisciplinary society. By the late 1970s, the Society had more than 200 members including several neurologists, neurosurgeons, pharmacologists and psychiatrists. The Intractable Pain Society became the Pain Society of Great Britain and Ireland in 1988 with the joining of the scientists and other disciplines and became a Chapter of IASP. The Irish Pain Society started their own society in 2001, and the Pain Society adopted the current name of the British Pain Society (BPS) in 2004.

## The Society/the personalities

I joined the BPS when I was a Pain Trainee in 2004 and over the years have heard so many interesting anecdotes; it was an absolute privilege and a humbling experience talking to some of the former Presidents of the Society and other senior members of our Society. I haven't missed a single Annual Scientific Meeting (ASM) since joining the Society, and it pales in comparison with the 38 consecutive meeting attendances by Dr Tim Nash whose unparalleled run was broken only due to being in hospital for a hip replacement. Dr Nash also started the Newsletter for the Intractable Pain Society and also served as President of the Society.

Dr Ed Charlton was another former President and eminent clinician who collaborated actively with the Seattle group and was instrumental in developing the IASP Curriculum. Along

with Dr Chris Wells, he started the Neuropathic Pain Special Interest Group (SIG). He used to fly regularly to the United States to perform pain interventions to Prof Bonica, who suffered from severe back pain from injuries sustained during his earlier years as a professional wrestler. Dr Charlton is fondly remembered by his peers and colleagues for his no-nonsense straight talking and sense of humour. In one of his trips to the IASP headquarters in Seattle, he was reported to have suffered a pulmonary embolus when flying. This meant that he was unable to fly back on time to attend the BPS meeting back in the United Kingdom. In his own inimitable style, from the hospital, Dr Charlton sent a fax message with an image of his lung fields demonstrating the lack of blood due to the pulmonary embolus and his fax message simply said, 'Apols, Ed'.

Prof Sir Michael Bond is widely considered as a 'father figure' of the BPS, for his key role in founding the Society as well as both of his terms in office as President and also for taking on the role as Interim President in 2009 at short notice when Prof Paul Watson stepped down as President and steered the Society through some trying times. He was one of the main figures behind the IASP definition of pain and has also served as IASP President and Vice-Principal of the University of Glasgow and Dean of the Faculty of Medicine. Sir Michael's colleagues recollect how he was able to get through 36 agenda items at the BPS Council meetings in 3 hours, but still ensuring that everyone present was given the opportunity to speak and make their point. Prof Sir Michael Bond was knighted in 1995 for services to medicine and was the first recipient of the new Medal of Distinction that the Society introduced in 2010.

The Medal of Distinction is given occasionally for distinguished service to the Society's work. The next recipient was Dr Doug Justins in 2013, who was

a former president of the BPS and first Dean of the Faculty of Pain Medicine of the Royal College of Anaesthetists (RCOA). He served with distinction on the Council of the Royal College of Anaesthetists and was the Chair of the Pain Management Committee. He was also instrumental in setting up the joint BPS/FPM e-Pain educational modules. The third time the President's Medal was awarded to Dr Beverly Collett, who after serving as President was elected to the Council of IASP and then served as Hon Treasurer to IASP, as well as Hon Secretary of the European Federation of IASP Chapters (EFIC). Dr Collett actively campaigned for raising the profile of Pain Medicine in the UK Parliament through the Chronic Pain Policy Coalition (CPPC) and was awarded the OBE in 2015 for her services to Pain Medicine.

My earliest memory of Dr William Campbell is at the ASM with his ever-smiling presence, camera in hand taking a zillion pictures of the event. I was elected to the BPS Council during the Presidency of Dr Campbell, and he has been generous with his advice and encouragement. Dr Campbell has been the longest serving office-bearer of the BPS Council for nearly 20 years and he is the only person who has held all the high offices of the BPS Executive. Interestingly, Dr Campbell's first application to join the Society was rejected. He had initially applied to join the Society in 1978 before reaching the Consultant level, but he was contacted Personally by Dr Keith Budd (President 1986–1989) and informed that his application was declined. However, 2 years later, he reapplied and was successfully accepted into the fold after paying a significant fee (understood to be £2)!

I would also like to take this opportunity to thank some of my senior colleagues on behalf of the BPS Membership for their contributions to the Society and Pain Medicine. Dr Doug

Justins, Prof David Rowbotham, Dr Kate Grady and Dr Karen Simpson deserve special mention for their contributions to the development of the Faculty of Pain Medicine and providing a curriculum for pain training in the United Kingdom. However, the main strength of the BPS lies in its eminent multidisciplinary members. Prof Chris Main and Prof Stephen Morely have been leading lights in researching into the psychological aspects of pain and have been awarded the Honorary Membership of IASP in Yokohama in 2016. Prof Chris Eccleston was the Chair of the Scientific Committee for the BPS and also for the EFIC ASMs, and Dr Amanda de C de Williams continues to contribute to research in pain in torture survivors among other things. Prof Maria Fitzgerald has been a co-opted member of the council and had been on the Scientific Committee for several years, and Prof Tony Dickenson never ceases to amaze me by simplifying complex neurophysiological principles in his unique style. Prof Henry McQuay, Prof Andrew Moore and Prof Chris Eccleston have been setting the benchmark for evidence-base in Pain Medicine.

The Interventional Medicine of the BPS grew in stature under the stewardship of Dr John Wedley, Dr Charles Gauci, Dr Jon Richardson and Dr Ron Cooper, while the Pain Management Programmes SIG is another large group with Dr Chris Spanswick, Prof Chris Main, Prof Paul Watson, Prof Stephen Morely and Dr Paul Wilkinson leading the way. The United Kingdom has been on the forefront of neuromodulation for managing pain, thanks to Dr Simon Thomson (served two terms as President of the International Neuromodulation Society and founder of NSUKI), Prof Sam Eldabe (Past President of NSUKI and chair of the Neuromodulation SIG of IASP), Prof Jon Raphael, Dr Teo Goroszenuik and Dr Adnan Al-Kaisy.

Prof Sam Ahmedzai and Prof Michael Bennett have brought a wealth of experience in the management of pain in cancer patients and have strived to work in collaboration with the Association of Palliative Medicine. Prof Andrew Rice had been the Chair of NeupSIG and continues to act as IASP liaison to the BPS Council. Dr Stephen Ward, who was one of the former Editors of Pain News, chaired the Guideline Development Group (GDG) for National Institute for Health and Care Excellence (NICE) back-pain guidance which was well received and he is currently also the Chair of Rheumatoid Arthritis GDG for NICE.

Other eminent figures from the field of nursing and academia are Prof Eloise Carr, Prof Patricia Schofield, Prof Nick Allcock and more recently Dr Ann Taylor. Felicia Cox, who was the co-editor of 'Reviews in Pain', along with Dr Michael Platt, worked hard to establish the *British Journal of Pain* and serves as the Chief Editor, along with Prof Roger Knaggs. *Pain News* has improved in style and substance under the editorship of Dr Thanthulu Vasu and Dr Arasu Rayen. The Physiotherapy Pain Association was initially represented by Ms Heather Muncie and was taken over by Prof Paul Watson, and Dr Heather Cameron and Dr Paul Cameron are carrying the good work forward. Dr Raj Munglani and Dr John Goddard had contributed to increasing the online presence of pain medicine, the former through creating a Google Group discussion forum and the latter setting up the platform for the BPS website during his tenure as Hon Treasurer and then Vice-President. Dr Martin Johnson has been influential in promoting pain via the CPPC, as well

as his connections with the Royal College of General Practitioners (RCGP), and he is currently serving as Vice-President after being Hon Secretary. Dr Ollie Hart and Dr Chris Barker had also been active in promoting Pain Management in a primary care setting.

Dr Chris Wells has been actively involved with EFIC serving as Hon Secretary, and he is the current President of the European Pain Federation. He, along with his colleagues from Liverpool, Mr John Miles, Dr David Bowsher and Mr Paul Elridge continued to carry on the legacy of Dr Sam Lipton. Dr Stephen Ward and Dr Cathy Price were responsible for the National Pain Audit and along with Prof Richard Langford and Dr Andrew Baranowski led the way to put pain on Map of Medicine. Other important personalities who made important contributions were Dr Cathy Stannard, Dr William McCrae, Dr Peter Evans, Dr Barbara Hoggart, Dr Margaret Bone and Prof Joanna Zakreweska.

The above list would not be complete without mentioning the importance of the Patient Liaison Committee (PLC) and the BPS Secretariat. Mrs Jean Gaffin, Mrs Heather Wallace, Mr Neil Betteridge and Mr Peter Moore have made sterling contributions to the BPS, and the excellent work of the PLC is now being carried forward by Mr Antony Chuter. The heartbeat of the BPS is at its Secretariat based at Churchill House. Our special thanks go to Jenny Nicholas, Dina Almuli, Rikke Sussgard-Vigon and Ken Obbard, who spare no effort in ensuring the smooth running of the BPS.

In the following sections, the former Presidents of the BPS will provide you a first-hand account of their times with the

Society and share their thoughts and feelings.

Dr Stephen Humble

*Co-author*

Dr Asako Shida, Specialist Registrar in Anaesthesia

Dr Alice Costello, Specialist Registrar in Anaesthesia

*Research and contributing authors*

### Acknowledgements

Notes and documents were obtained from Dr Tim Nash on the early days of the Pain Society. Dr William Campbell was thanked for his advice and continuing support, and Dr Arasu Rayen, Jenny Nicholas and Dina Almuli were thanked for their valuable support and assistance.<sup>1</sup>

The Communications Committee and the Editorial Board of Pain News proposed to bring out a special edition of Pain News commemorating the 50th Anniversary of the British Pain Society (BPS), which was welcomed by the Council and supported by the Executives. It was also decided that as part of raising the profile of the Society, a Wikipedia page should be created and the story so far of the BPS should be kept updated for the benefit of the public as well as the newer members who are joining the Society. This project is currently underway, and I would like to appeal to all members past and present to contact the BPS Secretariat or Dr Stephen Humble at [srhumble@doctors.org.uk](mailto:srhumble@doctors.org.uk) or me via email on [akbhaskar@btinternet.com](mailto:akbhaskar@btinternet.com) with contributions including anecdotes, key milestones and anything that would help promote the BPS.

For more information, please visit the following link: [https://en.wikipedia.org/wiki/British\\_Pain\\_Society](https://en.wikipedia.org/wiki/British_Pain_Society)

### Reference

1. Mehta M. The history of the Intractable Pain Society of Great Britain and Ireland. *Pain* 1980; 8: 121-2.

# A personal account of the development of the British Pain Society

Tim 'Needles' Nash



Tim Nash

Pain Society:	Council Member, 15 of 16 years
Assistant Secretary:	1982–1985 (Founding Editor of IPS Forum)
Secretary:	1985–1988
Council Member:	1989–1992
President Elect:	1992–1994
President:	1994–1997
Immediate Past President:	1997–1998

After qualifying in 1969, I developed apparent sciatica as a house physician, which persisted throughout my career until receiving hip replacements 1 year before retiring in 2006. After my surgical house job, I worked in casualty and orthopaedics, then obstetrics and gynaecology and then turned to anaesthetics. During my training, I did a dedicated intensive care job and at this time learnt that pain clinics existed. I was fortunate to attend some of the

multidisciplinary pain sessions while at UCH and then as a senior registrar in East Anglia attended Mark Mehta's clinic in Norwich.

Appointed in 1976 to Basingstoke District Hospital as a Consultant with special interests in obstetric anaesthesia, ITU and pain treatment, I was released for my first 3 months to spend 2 months at Alder Hey Children's Hospital, Liverpool (to develop a paediatric interest as well!), during which time I was able to spend 2 weeks visiting Sam Lipton and Mark Swerdlow while covering the hospital at night. I then visited other pain clinics and hospices including John Lloyd in Abingdon, James Burn in Southampton, Robert Twycross at Michael Sobell House, and Dame Cicely Saunders at St. Christopher's Hospice, London.

I joined the Intractable Pain Society in 1976. Two new members were admitted at the Annual General Meeting, Jenny Burton and myself. One of us was the 100th member of the Society. I was reckoned to be the first consultant appointed with designated pain sessions in my job description, having been allowed one session every 2 weeks. Before I started, I had negotiated clinic time for one session per week, doing the extra half session in my own time.

Eighteen years at Basingstoke saw the clinic grow to 6.5 sessions per week, shared with a colleague. My 4.5 sessions included a regular theatre session, serviced by four in-patient beds, two clinics a week in Basingstoke, one a fortnight in Alton and an outpatient x-ray session alternating with minor

procedures performed on the ward. Attempts to set up a pain management programme failed, despite running an in-patient programme for four patients using psychology and physiotherapy colleagues. Interventions included radiofrequency percutaneous cordotomy, dorsal root ganglion lesioning and facet denervation, and spinal cord stimulation. To enable the clinic to develop, initially I fitted the extra work in displaying the need, and at that time in the hospital, my colleagues, in particular, supported the recognition of this need, and time was built in to my work plan. Alongside developing the pain service, I was intimately involved in developing the service for the care of the dying using Macmillan nurses as an educational resource to promulgate our aim to enable all staff to care for the dying with sufficient educational and emotional support to do it well, rather than taking over the care. I also ran the intensive care unit for several years and took my turn at running the anaesthetic department, achieving complete upgrade of anaesthetic monitoring to Association of Anaesthetists recommendations. I was also the undergraduate clinical tutor, Faculty/College of Anaesthetics tutor and vice chair of the medical executive committee. These were generally very satisfying years.

The Intractable Pain Society was a small Society when I joined and prided itself in being a friendly Society, and the first professional Society in the world devoted to Pain. Families were welcome at the annual meetings with a full social programme for them while the meeting





The Society's first newsletter from the Intractable Pain Society of Great Britain and Ireland (IPS).

was in progress. At the meeting in Bath, I walked out of my caravan to find several other caravaners who were also heading off to the meeting. We relied on anecdote and case series; there was little good evidence available, although a few were trying to perform randomised controlled trials. The Society was a Doctors (Consultants)-only Society, and in the late 1970s, it was suggested we become a chapter of IASP (the International Association for the Study of Pain);

however, it was decided that we should continue to be exclusively for doctors. We did eventually expand our membership to all health and research disciplines in 1987, paving the way to a merger with the existing British Chapter of IASP and becoming the Pain Society, the British Chapter of IASP. As the Society grew and the Annual Scientific Meetings (ASMs) became busier, catering for all health care groups and with an increased emphasis on evidence-

based practice, many felt that the old, friendly supportive aspect of the Society was being lost. The Society encouraged the development of regional pain groups and Special Interest Groups (or 'SIGs') to increase the professional support for the membership.

I was elected as the Assistant Secretary in 1982, with the prime purpose of initiating and editing a newsletter for the Society. I served the Council for 15 of the next 16 years, becoming Secretary, and ultimately President. Hugh Raftery was the President. I expected to do a simple newsletter typed up by my Pain Clinic Secretary, but Keith Budd, who followed Hugh as President, had contacts with Reckitt and Colman, who produced buprenorphine, and Mike Ridley of Reckitt and Colman took on the supervision of the publishing of a tabloid-style newsletter within Reckitt and Colman which we called 'IPS Forum' (the Forum of the Intractable Pain Society), the forerunner of today's *Pain News*.

In 1985, I became the Secretary with Keith as the President. We were entering a time of great change. The majority of members were anaesthetists, and our council meetings, which until then had happened at the annual meetings, had begun to be quarterly, briefly at the Association of Anaesthetists suite of rooms in BMA House. The Association then moved to its own premises in Bedford Square, which became our new venue. Simultaneously, the Faculty of Anaesthetists was negotiating to become independent of the Royal College of Surgeons of England and initially moved in with the Association, before moving into their own premises in Russel Square. Both bodies have now moved to their present accommodation, the Association in Langford Place, and the now Royal College of Anaesthetists to Red Lion Square, where we now lodge, alongside the Faculty of Pain Medicine.



## The history of the IPS – Part 1

# The sense of 'working in isolation' that brought us together

IN THE MID-SIXTIES pain relief clinics were relatively few and far between and many of us in this type of practice had a certain sense of working in isolation. Having felt for some time the need for discussion with others I wrote in the Spring of 1967 to all the pain relief colleagues that I could discover, suggesting a meeting to exchange experiences and ideas.

The response was very encouraging and as a result a meeting was organised at the University of Salford on the 10th of November, 1967 and was attended by the following: Dr. J. Anderson – Edgeware; Dr. A. S. Brown – Edinburgh; Dr. J. M. Burn – Southampton; Dr. J. H. Challenger – Bath; Dr. Anne Laughland – Glasgow; Dr. R. M. Maher – Rochdale; Dr. M. Mehta – Norwich; Dr. H. Raftery – Dublin; Dr. R. N. Sinclair – Glasgow; Dr. G. C. Steele – London; Dr. J. H. Stevens – Cambridge; Dr. M. Swerdlow – Manchester; Dr. E. Thomas – Birmingham; Dr. T. C. Thorne – Rochford; Dr. J. A. Thornton – Sheffield; Dr. R. P. Wise – London; Dr. M. D. Vickers – Birmingham.

There was no formal programme; the day's discussion was divided into four parts dealing with:-

1. The organisation of a pain clinic;
2. Pain patients, pain conditions and pain problems;
3. Nerve blocks and other methods of treatment;
4. Evaluation of results and complications.

At the end of the day's work it was unanimously agreed that further similar meetings should be held annually.

### Bristol

The second meeting of the embryo I.P.S. took place in October, 1968 in Cambridge with Dr. J. H. Stevens as host. Most of the 'founder members' attended together with a few new ones and a number of visitors. Once again, the one-day meeting took the form of a general discussion without formal presentations.

The following year Dr. J. H. Challenger hosted the meeting in Bristol. In addition to general discussion, individual members spoke on 'the neurolytic effect of phenol', 'the collection of information', 'phantom limb pain' and 'the multidisciplinary approach to pain relief'. An attempt was made at this meeting to initiate a joint study of the results of pain relief treatment in patients with a) cancer, b) post-herpetic neuralgia, c) phantom limb.

Following the meeting a question-

by  
**Mark Swerdlow,**  
M.D., M.Sc., FFARCS



Mark Swerdlow

naire was compiled and circulated to members for completion.

The results were reported at the 1970 meeting. In fact only 100 completed forms were returned. Eighty referred to cancer patients and provided some useful information regarding the results of treatment; the other two subjects of study yielded insufficient data to be of value.

The 1970 annual meeting of the Pain Group was held at the Royal Marsden Hospital, London with Dr. D. S. Robbie as host. At this meeting notekeeping was discussed in depth and members gave papers on 'the relation between pain and personality in patients with advanced cancer', 'thermography in the diagnosis of sympathetic dystrophy' and 'experiences with percutaneous cordotomy'.

The Pain Group was now firmly established and steadily growing; its activities were being regularly reported in "Anaesthesia". However, the pattern of its activities, although basically attractive and enjoyable, was giving the organisers some food for thought. It was felt that the lack of structure of the meetings tended to result in repetitiveness of discussion and that the invitation of guest speakers on topics of special interest

would add to the value of the meetings. It was also considered that too much time was being spent on administrative matters and that some definition of criteria for membership should be agreed on.

The time had clearly come to formalise the organisation of the Group by the appointment of a small executive. Accordingly, at the 1971 annual meeting in Birmingham, with (the late) Dr. Eugene Thomas as host, the members decided to constitute the Group into The Intractable Pain Society of Great Britain and Ireland and elected the following for a 3 year term of office:-

Dr. M. Swerdlow, chairman; Dr. J. H. Challenger, hon. treasurer; and Dr. M. D. Churcher, hon. secretary.

It was decided that membership should be confined to medical practitioners who were actively engaged in the treatment of patients with intractable pain. An annual subscription of £1 was agreed to cover expenses.

At the meeting in Cardiff in 1972 organised by Prof. W. W. Mushin, the new pattern of proceedings was set. There were 40 members as well as a large number of visitors and guests. Eight papers were given, two being by invited guest speakers. A 'business' meeting, for members only, was held at the end of the scientific sessions.

### Venues

The venues of the subsequent meetings of the Society with the name(s) of the organiser(s) have been as follows: 1973 Oxford (Dr. J. Lloyd); 1974 Liverpool (Dr. S. Lipton); 1975 Brighton (Dr. G. Gerson); 1976 Norwich (Dr. M. Mehta); 1977 Bradford (Dr. K. Budd); 1978 Bangor (Dr. T. K. Hardy); 1979 Dublin (Dr. H. Raftery); 1980 Oxford (Dr. J.



Lloyd); 1981 Bath (Drs. L. Redman and Hughes-Davies); 1982 Sheffield (Drs. R. E. Atkinson and G. G. Taylor); 1983 Plymouth (Drs. Churcher and Hodgson).

The formalisation and growth of the I.P.S. was now starting to be accompanied by an involvement in a wider range of medical affairs, an involvement which is continuing today.

In May 1973, representatives of the Society were invited to a one-day meeting at the Department of Health and Social Security in London. Those present were: Prof. W. W. Mushin (chairman); Drs. R. M. Maher, M. Mehta, D. S. Robbie, M. C. Smith, M. Swerdlow and Prof. D. W. Vere, together with six senior members of the D.H.S.S. staff.

The discussion covered three main areas:-

1. The pain relief arrangements current at that time, the magnitude of the problems of chronic pain and the organisation of its treatment.
2. The therapies being used in pain relief clinics, particularly the non-drug methods.
3. Recommendations for the future organisation of the emerging subspecialty.

### Society Officers

**President:** Emeritus Professor W. W. Mushin (Cardiff)

**Vice-Presidents:** Dr. S. Lipton (Liverpool)  
Dr. R. Maher (Chorley)  
Dr. M. Swerdlow (Manchester)

**Chairman:** Dr. J. W. Lloyd (Oxford)

**Hon. Treasurer:** Dr. R. E. Atkinson (Chesterfield)

**Hon. Secretary:** Dr. G. Taylor (Derby)

**Hon. Asst. Sec.:** Dr. T. Nash (Basingstoke)

History of IPS. Image from the Intractable Pain Society of Great Britain and Ireland (IPS).



## A personal account of the development of the Pain Society

We also had aspirations at that time, and while the Faculty of Anaesthetists was negotiating its independence and evolution into a stand-alone college, we were negotiating with them to be a sub-specialty within Anaesthesia and striving to formulate formalised training. We also wished to obtain our own 'Korner Specialty Code' for data returns to the Department of Health to enable recognised activity data and the possibility of increased resources, something we could only be granted as a recognised specialty or sub-specialty. The recognition as a Specialty within Anaesthesia took a little while, as this had to be agreed with the Conference of Medical Royal Colleges and their faculties, and the Faculty of Anaesthetists had had a particularly difficult time attempting the same for intensive care. Our submission in 1987 to the Faculty of Anaesthetists outlined our proposed training programme. Its substance was very similar to that recommended by the new Faculty of Pain Medicine 21 years later. As part of developing training and education standards, we assessed and

recommended three courses as being a good basis for education at that time, the PANG (Pain and Nociception Group) organised at St Thomas' Hospital, London, and representing mainly basic sciences; the Oxford Course, which combined academia and clinical practice; and the Liverpool Course based at the Pain Relief Foundation and the Walton Centre for Neurology and Neurosurgery in Liverpool which focused primarily on clinical practice. We now of course have the Fellowship of the Faculty of Pain Medicine with its exam. It was a very proud moment for me to be invited to become a founding Fellow of the Faculty of Pain Medicine. Recognition as a Specialty within Anaesthesia came when I was the President in 1994, and I initially represented the Pain Society on the newly formed Standing Committee of the Royal College of Anaesthetists to oversee the sub-specialty. The granting of a Korner code for central returns was granted in 1997. The Society had presented to the All Parties Disabilities Group at Westminster in 1991, thus

raising political awareness about pain and the lack of pain services and resources.

During my time as Secretary, the Council met with representatives of the Department of Health, including Bob Hangartner, who had no activity data on pain at all. I did my best to rectify this by sending the activity data that I collected for my own clinic to Bob Hangartner on a regular basis. He also made it clear that we could not make claims about our efficacy without hard evidence, and I remember discussing with him the need for funding for research into pain and its treatment. Later, as President, I received regular communications from the NHS R&D National Coordinating Centre for Health Technology Assessment to participate in identifying HTA (Health Technology Assessment) priorities. Many of our suggested areas for prioritisation were taken up and calls sent out for submissions of interest to research these areas. We also submitted our R&D Priority Listing to the Royal College of Anaesthetists for their support.



### IPS Diary

25th and 26th March – Intractable Pain Society of Great Britain and Ireland – Plymouth Meeting.

11th April – “Opioids: Past, Present and Future” – at Churchill College, Cambridge. To celebrate the 80th birthday of Hans W. Kosterlitz FRS.

15th-21st May – I.A.S.P. European Chapters Meeting, Venice.

June – Combined meeting of Hospice Movement and Intractable Pain Society, somewhere near Keith Budd, Bradford.

June 6th – 10th – “The Problem of Terminal Care” at Scargill House, Kettlewell, North Yorkshire. Contact Dr. P. M. Brown, Bradford Royal Infirmary.

### Fine Hosts

The Dutch Intractable Pain Society again excelled themselves as hosts at the combined meeting of our societies in Breda last October. They are to be congratulated for organising such an interesting meeting, with the superb hospitality that we are learning to expect from them!

It was felt by the clinical members present that as a result of the meeting, the D.H.S.S. was more aware of the nature and value of organised pain relief facilities.

The University of Salford, site of the inaugural meeting of the group from which the Intractable Pain Society was to develop.

to the society.

The 'business' session at the 1975 annual meeting was a very full one

the increasing occurrence of regional pain meetings, a single meeting of I.P.S. per year was adequate.

History of IPS. Image from the Intractable Pain Society of Great Britain and Ireland (IPS).

I spent many hours representing the Pain Society on the Clinical Terms Project (Read Codes) of the NHS IM&T Strategy, chairing the Pain Terms Working Party and participating in other working parties such as the HRG (Healthcare Resource Groups) Working Party. Cathy Stannard joined me in Basingstoke for 6 months as my research registrar, funded by the Clinical Terms Project, and successfully published the Pain Chapter of the Read Codes version 3. Although the NHS Executive expected that our local hospitals would support us in this work, they failed to make this explicit to hospital trusts. This lack of support was directly responsible for me moving from Basingstoke to the Walton Centre for Neurology and Neurosurgery in Liverpool during my first year as President. The dream of an NHS electronic patient record has cost millions, and has not yet,

or probably ever will, be achieved. The Clinical Information Special Interest developed a Pain Administration System that used the agreed terms for their own coding, and this has been used to produce audit data from various units using the system.

The Society changed its name from the Intractable Pain Society to the Pain Society in 1988 when it became incorporated for the first time. It was a matter of some surprise when this was reversed by Council 1 year later, to be reincorporated about a decade later! We became a Chapter of the IASP in 1989, and the European Federation of Chapters of IASP was formed soon after. We now needed to become a truly interdisciplinary Society, and so during my Presidential term, the Council focused on attracting all the professions allied to medicine involved in pain

treatment to join the Society. With Pain Society members on Council of the Association of Anaesthetists and also on the Board of the Royal College of Anaesthetics, we began to develop a higher profile, with various pain topics on the short list for continuing consideration by the Department of Health, and also further topics in their long list for future consideration. I also found myself chairing the Education and Training Task Force of EFIC.

The work of the Society increased to the extent that we needed an office and Secretariat. The Council was by this time very busy, with the Scientific Sub-Committee organising the ASMs, the Education and Standards Sub-Committee developing standards for education and training, and the Audit and Quality of Practice Sub-Committee producing publications such as

## The history of the IPS – Part 2

# Progress continues and a constitution is drawn up

**THE FIRST PART** of this history of the IPS ended with an account of the annual meeting in 1975 which involved a number of items of great importance to the developing Society. The content of subsequent meetings and the increasing participation of the IPS in wider medical affairs have continued to reflect the growing maturity of the Society and the committed involvement of its members.

The 1976 annual meeting was held at Norwich and had a very full scientific programme covering two days. In addition to papers by members there were contributions by Drs. Carlsson and Finer of Sweden and by Dr. Ventafridda of Italy. At the business meeting Dr. Mark Churcher retired as Hon. Secretary and Dr. Keith Budd was elected to succeed him.

by Mark Swerdlow  
M.D., M.Sc., FFARCS

These data were much more satisfactory than the results of a similar, but informal, inquiry which had been made a few years previously. However, it was clear that many members still did their pain relief work with a minimum of help and facilities and often in their own free time and without remuneration. It would be interesting to see the results of a similar inquiry today.

In 1977 too, the Association of Anaesthetists set up a sub-committee on intractable pain to discuss and make recommendations concerning the manpower requirements of anaesthetists undertaking pain relief

pose. Those present were: Prof. W. W. Mushin (Chairman), Dr. K. Budd, Dr. J. H. Burn, Dr. S. Lipton, Dr. M. Mehta and Dr. M. Swerdlow. See below for the constitution they drew up.

The annual meeting of 1977 was held at the University of Bradford. The programme included a symposium on low back pain and a number of papers on sympathetic block and on post-herpetic neuralgia. A large number of overseas guests attended.

In 1977 in addition to the Annual IPS Meeting, the Society met for the first time with the members of the Dutch Society for the Study of Pain. The joint meeting was held in Leiden on May 13 in conjunction with the

History of IPS. Image from the Intractable Pain Society of Great Britain and Ireland (IPS).



'Information for Patients' and 'Desirable Characteristics of Pain Management Programmes'. The 'Patient Cancer Pain Booklet' was also produced. In the earlier days, including my time as Secretary, members would apply to organise the ASM. There was no support from Council, and any surplus funds might be donated to the Society after the meeting. As Secretary, I organised a joint meeting with the British Medical Acupuncture Society, and I believe this was the first meeting that returned a statement of accounts relating to the meeting. The second meeting to formally submit a statement of accounts was the meeting I hosted and organised in Basingstoke in 1988. Thereafter, accounts were expected after each meeting.

A working party of the Clinical Standards Advisory Group was set up to look at pain in its entirety following a submission from the Royal College of

Anaesthetists, and the Audit Commission started to look at the role of anaesthetists outside of the operating theatre, and to help to highlight service needs. The Standing Medical Advisory Committee, who advise the Chief Medical Officer, asked for submissions relating to changes in medical practice. Out of a long list of 96 topics identified, we were in the short list (for detailed investigation) with 'increasing spread of proven chronic pain management technologies to acute hospitals from specialised centres, necessitating resources to train clinicians and set up and run services'. MIMS and the British Formulary both reworked their introductory paragraphs on analgesia to include comment on non-analgesic drugs, making it clear that anti-depressants, anticoagulants and other drugs can be helpful for pain management.

At Liverpool, I was able to develop Special Study Modules in Pain for Medical

Students and set up one of the first training posts in Pain Medicine within Anaesthetic training. I joined the Mersey Anaesthetic Training Committee, which became the Mersey School of Anaesthesia, as the representative for Pain, and ultimately became the first Mersey Regional Adviser in Pain Medicine of the Faculty of Pain Medicine, as formal assessments of training were being developed.

It is a source of considerable pride to see the British Pain Society moving ever faster forward. My pride in the Society is overshadowed by the pride I feel to be an Honorary Member of the British Pain Society and to be awarded the FFPMRCA as a founding member of the Faculty. The FFPMRCA to me is the culmination of work that started way back before the 1980s, back to the pioneers and the founding of the Pain Society in 1966.

I wish you all the very best of futures.

## The history of the IPS – Part 3

# 1980s bring growing interest in the treatment of pain

by Mark Swerdlow,  
M.D., M.Sc., FFARCS

IN THE SECOND part of our history of the IPS we looked at the development of the constitution and further meetings that were held until the end of the 1970s.

This final part looks at what the 1980s have brought and the growing interest throughout the country in the treatment of pain.

It was now evident that the Society was having a greater involvement in medical affairs. One indication of this wider activity was the fact that the IPS was now to be represented on the Medical Research Council (by the Chairman) and on the Back Pain Association (by Dr. Mehta who continues to give his services for this valuable purpose). It is gratifying to note that the activities of the Society were also resulting in an increasing number of advertisements for consultant anaesthetist posts which included official pain sessions. Senior registrars in anaesthesia are now being given the option of rotation to the pain relief centre as part of their advanced training. Furthermore there are now questions on pain relief therapy in the FFA examination.

The 1981 Meeting featured a number of papers on various aspects of acupuncture and several papers on joint pain. The meeting finished with a memorable civic reception at the Roman Baths and dinner in the Pump Room at Bath.

In 1982, the Annual General Meeting was, as usual, a busy one and included a number of important items. It was agreed that members should be circularised regarding their willingness and ability to accept suitable qualified and registered visitors for theoretical and practical instruction in Pain Relief work. It was decided also that a clinic location list should be compiled and included in the next members' information handbook. (This has now been received and is an excellent production.) Last but by no means least, the

programme were arthritic pain and psychological treatment of pain. However, a wide range of other subjects were discussed including an erudite and amusing contribution by Prof. E. Wilkes. A unique item in the social programme was a delightful performance at the Triangle Puppet Theatre. Again the hospitality of our Dutch colleagues was warm and plentiful and unmarred even by the torrential rain.

Looking back over the years, the Society has tried to satisfy the need to keep up to date with progress in the field of intractable pain relevant to the various medical disciplines of its members. However IPS also has an important role in trying to ensure that pain relief services in Great Britain develop in a sound and practical way. The Society can fulfil a useful function both as a receiver and disseminator of information. Furthermore by collating information regarding the training facilities available at the various pain relief centres

participation is important. The number of non-anaesthetist members has certainly increased but their proportion of the total membership is still very small. There can be little doubt that the Society's value would be increased by input from a wider based clinical membership.

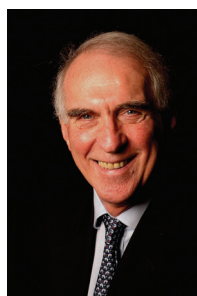
As well as being an enjoyable club, the IPS has an important role to play both in the clinical investigation and management of the relief of chronic pain and in a wide area of administration, education and information dissemination. There can be little doubt that the IPS is capable of fulfilling these obligations in the future, and that it will continue to grow both in quality and in usefulness.

This history ends in April, 1983 with the publication of the Society's own journal – *IPS Forum* – sponsored by Messrs Reckitt & Colman and edited by Dr. T. Nash.

History of IPS. Image from the Intractable Pain Society of Great Britain and Ireland (IPS).

# The birth of the British Pain Society

Prof. Sir Michael Bond



In 1967, I attended a meeting at the Christie Hospital in Manchester where a small group of anaesthetists invited there by Dr Mark Swerdlaw discussed problems of chronic pain therapy. It was

decided to hold further meetings annually and to restrict membership to doctor's activity engaged in pain relief. A formal constitution was adopted at the fifth meeting of the Society in Birmingham in 1971 and Dr Swerdlaw became the first chairman and Dr Professor William Mushin of Cardiff as first President.

The next four Presidents, Dr Lipton (1975–1977), Dr Mehta (1978–1980), Dr Lloyd (1981–1983) and Dr Raftery (1984–1986) were at the original meeting of the founding group in 1967. I was the only non-anaesthetist and the only non-consultant at that meeting but when the business of the formation of a Society concluded, I was asked, out of the blue, to give a talk on my research into the relationship between pain and two aspects of personality – extroversion and introversion. As I had just given the talk elsewhere I had slides in my bag!

When the Pain Society was established at first, membership was confined to consultants. A year or two later, senior registrars were admitted but it was not until the foundation of the multi-professional International Society for the Study of Pain in 1974 that membership was opened to non-medical

clinicians, for example, psychologists, nurses and physiotherapists.

The Society was founded at a time when the understanding of pain and its treatment entered a period of great expansion. It is worth reflecting on that era because it reveals the context in which it emerged.

What was pain treatment like 50 years ago? With one notable exception, the foundation of the inter-disciplinary pain clinic in Seattle by John Bonica in 1947, it was almost solely physical and generally for the painful condition rather than the person in pain. The powerful analgesics, morphine and pethidine, were in frequent use as was codeine, paracetamol and aspirin. The full range of non-steroidal analgesics we use today had not been developed. Migraine was treated with simple analgesics or ergotamine and rheumatoid arthritis with aspirin or at times gold injections. Neurosurgeons carried out injections of the trigeminal ganglion or its ablation for relief of the pain trigeminal neurogia and they performed anterolateral cordotomy surgery for cancer pain relief.

Anaesthetists were at the forefront of the development of techniques for pain relief and one notable example was the use of percutaneous cervical cordotomy pioneered in the United Kingdom by Dr Sam Lipton, an early President of the Society. Prior to the 1960s, little research was done on psychological and social aspects of pain – an area of significant growth in knowledge and practice since those times. Much of the work now is carried out by clinical psychologists who,

until about 1964, did not have formal clinical status within the British National Health Service.

The very important developments in the understanding and treatment of pain in three distinct areas took place in the 1960s and 1970s and involved individuals who were members of the Society.

First, in contrast to the limited improvements in pain management, prior to the 1960s other than in Seattle, research into the neurophysiological basis for pain had been in progress for many years. In 1965, a major advance occurred with the publication by Melzack and Wall of the 'Gate Theory of Pain'. That led to an increase in interest worldwide in pain mechanisms in the spinal cord and brain. Wall and many other distinguished neuroscientists carried the work forward with the generation of vast amounts of detailed information. Patrick Wall was a member of our Society and for many years Editor of the International Association for the Study of Pain's (IASP) journal *Pain*.

Next, turning to psychological and psychiatric aspects of pain, in the Department of Psychiatry in Sheffield, early work on the relationship between pain and emotions was developed. Harold Merskey and his coworkers published papers on pain and depression. Issy Pilowsky investigated the relationship between hypochondriasis and pain, a line of enquiring which led him to become a world authority on the concept of illness behaviour in pain patients. In doing so, he complemented

## The birth of the British Pain Society

the work of Wilbert Fordyce in Canada who introduced the psychological technique of operant conditioning as pain therapy – before the development of cognitive behaviour therapy.

Michael Bond, also in Sheffield, showed an association between aspects of personality pain experience and complaint behaviour. He and Pilowsky published the first recorded use of the analogue scale for pain measurement in 1966.

The 'Sheffield Group' of members of the Society went on to further significant developments under the auspices of IASP. Merskey chaired a group, including Bond, which developed the standard

definition of pain now used worldwide. It has played a major part in embedding the concept of the biopsychosocial model of pain. With Merskey as chairman of an IASP Committee on Taxonomy, the first classification of chronic pains was published in 1986.

Returning to the 1960s, a further major advance was pioneered in Britain by Dame Cecily Saunders who initiated the Hospice Movement with the Foundation of St Christopher's Hospice in London. She and her colleagues played a major part in standardising the use of analgesics in cancer pain.

It is clear that the drive to establish a Society devoted to the best possible

means of relieving acute and chronic pain was part of a surge in interest in pain relief which was picked up by a group of senior anaesthetists in the mid-1960s. The Society began as the Intractable Pain Society – a reflection of the types of pain the group expected to treat, The Intractable Pain Society of Great Britain and Ireland (later a separate Irish Society was formed) followed and now we have the Pain Society.

I have been fortunate in being a member of the Society since its foundation, the President in 1999–2001 and, at the time of stresses in the Society, its Interim President in 2009–2010.

## Up for a challenge? – Get on your bike!

Could you cycle from London to Birmingham? Of course you can! As part of the British Pain Society (BPS) initiative to promote awareness, we are looking to get a group of intrepid souls together to ride from Red Lion Square to the 50th Annual Scientific Meeting (ASM) in Birmingham this year. The meeting starts on 3 May, so we would probably be looking to start on 1 May staying overnight on the way and arriving on the evening of 2 May. Though we would also be happy to explore doing the ride in a day for the cycling enthusiasts!

We aim to publicise the ride via a variety of available media routes along the way with an event at the finish. It will also hopefully act as the start of a cycling-based fundraising campaign over the month of May – more details soon.

We would really like to get as many of you involved as possible. If you are interested please contact us at [jennynicholas@britishpainsociety.org](mailto:jennynicholas@britishpainsociety.org)



Credit: Sean\_Gao



# IPS -PANG - Pain Society - BPS - FPM

Dr Douglas Justins



I was involved with the British Pain Society (BPS) in various capacities for 20 years from 1986 starting as a Committee

member of the Intractable Pain Society (IPS) through to 2006 when I was a co-opted member as Chairman of the Pain Management Committee of the Royal College of Anaesthetists. The multi-professional inter-disciplinary BPS that we have now evolved from the IPS whose membership was limited to consultants only. Medical trainees and professionals from other disciplines including scientists could not join the IPS. A great leap forward came when the Society opened membership to all doctors and healthcare professionals involved in the pain management. Also, welcomed were scientists researching in the field of pain who were members of IASP. At that time many distinguished scientists were working in the United Kingdom including people such as Patrick Wall, Clifford Woolf and Steve McMahon. The Society became an official chapter of the International Association for the Study of Pain.

The IPS of Great Britain and Ireland was registered as a charity on 29 November 1979. In 1988 when the membership became multidisciplinary, the name was changed to The Pain Society. During my tenure as President, in August 2004, the society was renamed The British Pain Society.

Initially the IPS was a small Society for consultants in pain management and the members were predominately anaesthetists whose main therapeutic armamentarium was needle-based interventions. It was a time when opioid usage was relatively restricted and few other drugs were available to manage pain. Dame Cicely Saunders was pioneering the hospice movement and emphasising the importance of pain relief and palliative care for patients with pain due to cancer. Psychological approaches to pain management were not very well known at that time. IPS members such as Dr Ed Charlton (Newcastle) went to Seattle and saw the broader, multidisciplinary approach that was practised there under the supervision of Dr John Bonica. A number of influential pain doctors from around the world did some or all of their initial training in Seattle including John Loeser, Bob Boas and Michael Cousins. Eventually psychological approaches were popularised in the United Kingdom by people such as Prof. Sir Michael Bond and Prof. Chris Main.

In the early days of the IPS, evidence-based medicine had not been invented; there was only a relatively sketchy understanding of the neurophysiology of pain and no rigorous scientific evaluation of treatments. At the IPS meetings, colleagues shared case reports, clinical experiences and discussed new interventions. There was a pioneering spirit and great camaraderie at these meetings. Some of the prominent people in the pain management at this time were Dr Sam Lipton (Liverpool), Dr Mark Churcher (Plymouth), Dr Mark Swerdlow

(Salford), Dr Mark Mehta (Norwich) and Dr John Lloyd (Abingdon). These pioneers in the pain management trained the next generation of pain specialists in the United Kingdom. For example, Dr John Lloyd started the Oxford Pain Unit, which nurtured Prof. Henry McQuay, Prof. Andrew Moore, Dr Peter Evans and Dr Chris Glynn. Other prominent figures who led the way in the 1980s and 1990s included Dr Ed Charlton (Newcastle), Dr Andrew Diamond (Bristol), Dr Keith Budd (Bradford) and Dr Tim Nash (Basingstoke and Liverpool). All went on to become Presidents of the Pain Society. There were a few non-anaesthetist members of the IPS including highly influential figures such as Sir Michael Bond (Psychiatry, Glasgow), Mr John Miles (Neurosurgeon, Liverpool), Dr David Bowsher (Neurologist, Liverpool) and Dr Peter Nathan (Neurologist, Queens Square).

PANG (Pain and Nociception Group) was another formative influence in the 1980s and 1990s. PANG was formed in London by Dr Peter Evans (Charing Cross Hospital), Dr Joe Chamberlain (Palliative Care, Guys Hospital) and myself (St Thomas Hospital). PANG organised meetings, courses and lectures in acute pain, chronic pain and regional anaesthesia. The speakers were research scientists and clinicians who were making advances in understanding and managing pain. They came from the United Kingdom and abroad. The first PANG meeting in September 1983 was memorable for various reasons but especially because Australia won the America's Cup while Prof. Patrick Wall was delivering the inaugural lecture. PANG



meetings raised the height of the bar and set the benchmark for multidisciplinary sessions at future Pain Society ASMs.

In 1986, I became Assistant Honorary Treasurer of the Pain Society and was also the Chair of the Scientific Sub-Committee (Research and Education) for 6 years from 1987. During this time we attempted to enhance the scientific content of the meetings with contributions from basic scientists, pharmacologists, psychologists, nurses, clinicians and so on. This was the beginning of the age of evidence-based medicine and pain management was a major leader in this revolution because of Prof. Henry McQuay and Prof. Andrew Moore from Oxford. The application of evidence-based medicine in the pain management began to move the focus away from needle-based interventions and paved the way for multidisciplinary teams and a biopsychosocial approach to the pain management.

I was the Honorary Treasurer of the Pain Society from 1990 to 1993 and was President from 2001 to 2003. In 1995, I was fortunate to be elected to the Council of the Royal College of Anaesthetists. This led to 8 years as Chairman of the College's Pain Management Committee and eventually to me becoming the first Dean of the

Faculty of Pain Medicine. Being President of the BPS while on College Council lent strength to the arguments for the importance of pain management and the desire to have a Faculty of Pain Medicine. Even at that time there were still anaesthetists who did not see an important role for anaesthetists in chronic pain management. There had been exciting developments in basic science and clinical management during the preceding decade, but there was residual inertia in the system. Palliative Medicine had developed as a separate specialty and the Royal College of Anaesthetists helped launch that Faculty. Ultimately, the efforts bore fruit and the Faculty of Pain Medicine of the Royal College of Anaesthetists was formed in 2007.

The creation of the Faculty of Pain Medicine was an important step for the pain management because it established a separate qualification for medical specialists in pain medicine. The BPS continued as a multidisciplinary organisation encompassing all aspects of pain management. The Faculty of Pain Medicine was aimed specifically at medically qualified pain specialists. The Faculty was not an intercollegiate faculty as in Australia or as subsequently

happened with Intensive Care in the United Kingdom. It was considered that involving the numerous medical colleges in the United Kingdom might have delayed the development of the Faculty although approval was sought from all the relevant colleges and none expressed any concerns. There are a number of non-anaesthetists (e.g. neurologists, neurosurgeons, orofacial medicine specialists and palliative care physicians) who are interested in pain medicine, but the vast majority of practicing pain physicians trained as anaesthetists. Non-anaesthetists can join the Faculty. It is heartening to note that the membership of the Faculty of Pain Medicine has increased in the past 10 years, and that the Faculty now has a secure future. The BPS and the FPM have worked together closely on many successful projects in the past and will continue to do so in the future.

Over the last 50 years, the BPS in its various manifestations has made a significant contribution to improving the understanding of pain for professionals and the public. It has launched many successful educational initiatives and has encouraged research into the mechanisms and management of pain. All this has helped to improve the lot of patients with acute and chronic pain.

# Cinderella specialty to Chronic Pain Policy Coalition

Dr Beverly Collett



I first joined the Intractable Pain Society when I was a senior registrar at Kings College Hospital, London, and my membership number is 47. I was encouraged by Dr Charles James, Consultant at Kings who was a senior member of the society. At that time, it was a doctors only society with pioneering figures like Dr Samson Lipton (Liverpool), Dr John Lloyd (Oxford), Dr Mark Mehta (Norwich), Dr Ed Charlton (Newcastle), Dr Dick Atkinson (Chesterfield) and Dr Tim Nash (Basingstoke). The other influential figures who later went on to become President of the British Pain Society (BPS) were Dr Ken Hardy (Wales), Dr Andrew Diamond (Bristol), Dr Keith Budd (Bradford) and Professor Sir Michael Bond (Glasgow). Dr Chris Glynn, Prof. Henry McQuay (Oxford) and Dr Chris Wells (Liverpool) were then fledgling members, Prof. Chris Main was instrumental in stressing the

importance of psychological factors in pain management, and I remember his role in bringing in Prof. Dennis Turk for a UK meeting where he presented his 'Turkshop'. A young Australian doctor called Doug Justins (St Thomas') arrived at England after sailing around the world. He and Dr Peter Evans (Charing Cross) started Pain and Nociception Group (PANG) where researchers and clinicians would meet for regular educational events. Prof. Pat Wall and his young researcher Prof. Tony Dickenson were regular educators, giving us young clinicians the benefit of their scientific rigour to our clinical practice.

In those days, pain clinicians had a lot more involvement in palliative care and the department at Kings College had excellent relationship with St Christopher's Hospice where Dame Cicely Saunders was making groundbreaking achievements with the hospice movement. I had the opportunity to provide pain management through interventions like coeliac plexus blocks and intrathecal barbotage for relieving pain in cancer patients; we were doing these procedures in the hospice side-rooms without access to imaging facilities. In fact, X-ray control was only in its infancy in the early 1970s. On a Friday afternoon, Dr James and I would visit the wards to perform lumbar sympathetic blocks for peripheral vascular disease on elderly patients in their beds – leaning forward over their bed tables, I would keep the phenol in glycerol warm in my pocket so that it was easier to inject.

I was elected as Hon. Assistant Secretary when Dr Andrew Diamond was President and continued as Hon.

Secretary when Prof. Sir Michael Bond was President. I served as President from 2003 to 2006 after Dr Doug Justins.

In my role as President, my aim was to raise the profile of pain medicine, which was always considered as a poor relation, a Cinderella specialty. Some years ago, along with Dr Charles Pither and an ex-patient from the advertising agency Bartle, Doyle and Hegarty, a pain charity called 'Campain' was launched. Even these creative professionals found that it was not easy to raise public awareness regarding pain and to encapsulate the importance of pain and its associated problems. The charity closed after a couple of years!

So, as President, I felt that it was really important to get the BPS to be the pre-eminent body for information on the management of pain in the Department of Heath, in the media, in parliament and for other national organisations. I also felt that it was vital to bring together the various specialists in pain medicine, the colleagues who were interventionalists and those who focussed on the psychological aspects on pain medicine. My aim was also to encourage patients to develop good collaboration with the BPS, as I felt that patients are our greatest allies in spreading our message.

As President, I was proud to encourage the BPS to be the vibrant multidisciplinary society as we see it now incorporating clinicians, scientists and researchers, nurses, physiotherapists, psychologists and expert patients.

With regard to ASM meetings of BPS, I well remember the Exeter meeting where I delivered a talk on the management of pelvic pain. The society

comprised predominantly male colleagues. This meeting was the first at which there was to be dancing after the annual dinner. I recollect some of the senior members complaining that they would have brought their wives so that they could actively take part in the dancing at the social event, if they had known of this change of format, as they were worried there would not be enough women to dance with!

I was first an IASP member in 1988 and involved in the Task Force on pain problems related to women in 1993. In 2007, I Chaired the Global Year against Pain in Women in 2007. I was elected to the Council of IASP in 2005 and elected Treasurer in 2008. Being on the IASP Executive was a huge honour and privilege. It gave me a very interesting insight into the global perspective where perceptions of pain and pain behaviour varied from country to country and the provisions for providing pain relief also had wide variations. There are such huge disparities among the worldwide IASP chapters with each country working hard to improve pain management in their individual settings with their own issues and major problems.

I was also elected as Hon. Secretary of European Federation of IASP Chapters (EFIC) and served from 2005 to 2008. I was involved with Prof. Harald Breivik

and colleagues in looking at the prevalence of pain in Europe. A further high-profile study was with Dr Nathan Cherny and colleagues where the EPIC survey looked at the incidence and prevalence of pain in cancer patients in Europe. One of the highlights during this time was to deal with colleagues from various other European countries and it was a privilege to know so many people who were involved in the pain management. It was also an eye-opener to note that unlike in the United Kingdom, in some of our European countries, nurses were not considered as important as doctors in the hierarchy of healthcare professionals.

One of my proudest achievements in raising the profile of Pain Medicine and awareness of the problem of chronic pain was to be involved with Chronic Pain Policy Coalition. While Prof. Sir Michael Bond was President and I was Hon. Secretary of the BPS, the Patient Liaison Group was established with Mrs Jean Gaffin OBE, as chair. Jean was wonderfully connected politically, being well acquainted with Mr Barry Sheerman, the Right Hon. MP for Huddersfield, and Dame Margaret Hodge, the Right Hon MP for Barking. Using her connections, in 2005, the BPS was permitted to hold its first reception in the House of Commons, celebrating

the IASP Global Year 'Pain in Children' supported by the first Children's Commissioner, Prof. Sir Al Aynsley Green. That event was a great success, and it led ultimately to the establishment of a formal organisation, the Chronic Pain Policy Coalition to highlight to parliamentarians the problem of chronic pain and to suggest solutions to its better management.

Baroness Rennie Fritchie, who is also the Chancellor of the University of Gloucestershire, is the President of the CPPC and along with Parliamentary champions Mr John Cryer, the Right Hon MP for Leyton, and Wanstead and Lord Richard Luce KG GCVO PC DL a crossbench peer, continue to raise issues relating to pain in both Houses of Parliament.

I was awarded the Order of the British Empire (OBE) in the Queens Honours List in 2015 for my contributions to Pain Medicine. Prince Charles presented this award to me at Buckingham Palace and remarked how important it is to optimally manage pain in surgery, trauma, in cancer and in chronic conditions and how until one had been in severe pain, one never realised how important this was. At the time, I had just broken my arm, which was in a sling, so we jointly empathised on painful trauma!

# Memories of being President of the British Pain Society, April 2006–April 2009

Dr Joan Hester



The British Pain Society (BPS) moved in 2006 from the Association of Anaesthetists in Portland Place into Churchill House, home of the Royal

College of Anaesthetists. Much discussion about the pros and cons of the move had taken place, initiated by my predecessor, Beverly Collett. The Association had provided a happy base for the Society for many years and we were sorry to leave. The Faculty was at the stage of the Foundation Board under the direction of Dr Doug Justins. The educational facilities at the College were outstanding with a 150-seater auditorium and several rooms for smaller sessions. We wished to work alongside the Faculty, stressing the importance of the Society's unique multidisciplinary membership.

There were winds of change in the wider National Health Service (NHS), with several Pain services under threat of closure, but we felt confident that pain management was playing an increasingly important role in the management of chronic conditions, as well as in the management of acute pain in hospitals. The Department of Health (DH) was including pain input into the creation of its white papers: 'Our Health, Our Care, Our Say', the 18-week referral to treatment pathway and the Musculoskeletal Services Framework. There were 939 attendees at the Annual Scientific Meeting (ASM) in Harrogate, a

slight reduction on previous years, but not a cause for concern. The core objectives of the Society were education and research; the 'Learning in Pain' Series of seminars initiated under the guidance of Dr Kate Grady provided teaching in small tutorials of 8–10 people, as well as lectures. The seminars were based on topics from the International Association for the Study of Pain (IASP) core curriculum and were very well received. The Society also initiated an educational day for general practitioners (GPs) in March 2007, the first of its kind, and there was much discussion about GPs 'with a special interest in pain'. I planned to set up a Research Trust Fund to fund good-quality research on an annual basis. Several publications were initiated, the Patient Liaison Committee under the guidance of Nia Taylor was very active and a new cancer pain committee was formed. One of my first tasks as President was to deal with a fraudulent employee; these unpleasant episodes can disrupt the smooth running of an office, cause a great deal of emotional upset and take an extraordinary amount of time away from core business. Sandra Upali was the Secretariat Manager at the time, and she coped admirably with the difficult situation, which was eventually resolved, and new staffs were appointed.

In September 2006, there were cold winds of change afoot, consultants felt undervalued, skilled nurses were losing their posts, doctors had been asked to accept a reduction in pay, there was

unemployment among young doctors and consultant posts not being replaced. The General Medical Council (GMC) described the changes in medical registration that would affect all doctors, US business leaders and gurus were called in to reform services, some services were moved into primary care and Independent Sector Treatment centres were the flavour of the month, often staffed by doctors from abroad who had not been integrated into the wider NHS. The Expert Patient Programme (EPP) was thought to be an effective way of providing simple pain management. The BPS quietly published its Guidelines for Pain Management Programmes for Adults under the chairmanship of Dr Amanda C de C. Williams and advised that there should be evidence of effectiveness and caution before rolling out a new service. Where is the EPP now? Were our fears of change unfounded?

The ASM in Glasgow in April 2007 was a great success with a well-evaluated scientific programme devised by Dr Paul Watson, which included Maria Fitzgerald on the 'science of pain in infants and children', a lecture I shall never forget, and the legendary Professor Henry McQuay. He has been proved right about so many things.

2007 saw the appointment of Jenny Duncan to the Secretariat, who started by organising the ASM, but who was swiftly promoted to Secretariat Manager when Sandra Upali left on maternity leave. She had a swift learning curve, but



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what a tower of strength and support to all the Society's business she has proved to be! We would not have a Society without her dedication and hard work.

We launched the publication 'Pain in the Older person' jointly with the British Geriatric Society, and Professor Jon Raphael initiated and edited a new educational supplement to the newsletter. This was the beginning of what has now become the *British Journal of Pain*. Such is the timescale of evolution.

The NHS was majoring on the 18-week commissioning pathways, and we spent a lot of time at meetings writing the pathways for chronic pain conditions. Cathy Price was instrumental in this work, and some good work was completed; the pathways, if followed, could have improved management of back pain, hip and knee pain, could have helped to prevent inadvisable surgery, but the scheme, like so many others before and since, was never properly implemented and was soon supplanted by something else, pathways were reinvented, and 'experts' called in to 'reform' services yet again. What a waste of effort and expertise. But the sense of team working and collaboration at the time was fantastic, interdisciplinary, multidisciplinary, a real buzz and feeling of driving forward. I remember a meeting at a plush central London venue of DH where the 18-week team had called in an orthopaedic surgeon from New York to explain how they managed to complete so many joint replacements in a single operating session. The surprising new discovery was that if the surgeon was made the focus of attention and was allowed to get on with his job efficiently and without interruption, the turnover was much quicker and outcomes improved! This was considered revelatory, but nothing seems to have changed.

Later in the year, the National Institute for Health and Care Excellence (NICE) low back pain guidelines for primary care

were convened, chaired by a Primary Care Professor, with Prof. Paul Watson as physiotherapy representative, several alternative medicine practitioners and the unusual choice of a rheumatologist representing the BPS. The rest is history, as they say, the recently published revised guidelines tell a rather different story!

During my Presidency, the pain interventionalists were a powerful section of the membership who expressed their views clearly. It was, and is, necessary to reconcile interventional and non-interventional pain medicine, with mutual respect. We have come a long way from thinking that injections alone can cure long-term pain problems. The new Low Back Pain guidance has managed to produce a balanced perspective.

The 2008 ASM was held in Liverpool at the brand new conference centre which was not quite finished. However, the city of Liverpool was revealed in all its glory, regenerated and magnificent. I will not forget walking along the Mersey imaging the big ships coming in from abroad, what a vibrant place it once was, and is again, now. Liverpool hosted the final annual dinner of the ASM. This is a great relief for the President who has to give an after-dinner speech, a daunting task, but there have been many memorable dinners, from Eastbourne in 1995 when the President's head (Dr Tim Nash) was removed in a rotating box and a conjuror sent paper darts to stick onto the high ceiling, through occasions when not a word could be heard and no-one listened anyhow, to my feeble last efforts in Liverpool. Perhaps, it is just as well that we have moved on.

The scientific programme featured our much loved Professor Tony Dickenson, the only scientist who has an unfailing ability to make the science of pain totally fascinating and understandable to a non-scientific audience, a lecture about the genetics of pain, and insights into visceral pain; both topics that have grown so much in importance over the

past few years. BPS was at the cutting edge, thanks to the insight of Chris Ecclestone and his committee.

The ASM has always featured two or three illustrious people who have made a big contribution to pain management from different perspectives, who receive Honorary Membership of the Society. It is a ritual but an important occasion that aims to give people the recognition that they deserve.

Liverpool saw the first Fun Run of 5 km around the harbour, which seemed to be over very quickly; it proved popular, and it was great fun, for both competitors and spectators.

I would like to commend the individuals who worked on publications during my Presidency, Ruth Day, Cathy Stannard and Eloise Carr. They did a brilliant job as there were 12 publications during my time as President, each one an important statement. The publication on the safe and effective use of opioids has been widely read and had a great impact on clinical practice throughout the world.

2008 also saw the World Congress on Pain, run by the IASP, in Glasgow, the BPS acting as local hosts. This involved many meetings and more work, but we met many people from the United States and other countries and it was exciting to be a part of it all.

The Society continued to be buoyant through 2008, running four educational seminars a year; working on publications; supporting the Special Interest Groups (SIGs); liaising with pain services in Scotland, Wales and Northern Ireland; rolling out the 18-week commissioning pathway; and trying to support pain services in difficulty. Jenny Duncan became Jenny Nicholas and continued to run the Society with great enthusiasm.

In winter 2008, doom and gloom was the order of the day after collapse of the financial markets, and life became more difficult for us all. Costs began to rise and the number of attendees at the BPS seminars began to fall. The Faculty was

getting into full swing and starting to run its own educational programme for doctors. *Pain News* had an outstanding number of contributions; warnings about harm from prescribed opioids for chronic pain started to emerge. A coroner wrote to the Society voicing his concern about a young man with sleep apnoea, also taking opioids, who had died in the night. This was the first warning shot that made a real impact. It changed my practice, and I suspect that many of you followed suit when the truth about mortality and prescribed opioids emerged. An audit of pain services in England was commissioned, after much background work by Dr Cathy Price.

Among the economic gloom of early 2009 came the news that the G20 summit meeting was to be held at the Excel Centre in London precisely at the time we had booked the venue for the 2009 ASM. We made the decision to move the meeting and found an alternative venue at Sandown Park in Surrey, combined with the Palliative Care Association. The move was seamless and the venue turned out to be very relaxed; the Fun Run took place around the racecourse. I initiated an art exhibition which was curated by the Patient Liaison Committee. There was a wonderful drinks reception at Hampton Court Palace. The scientific content was outstanding and included many illustrious

speakers on cancer pain. Joint guidelines on the management of cancer pain were launched. Prof. Paul Watson took over as President of the Society.

And that was it, an extremely busy 3 years, but very rewarding. Times are harder now. During the years 2006–2009, the Society was riding on the crest of a wave, there was a lot of financial support from industry, an enthusiastic membership, mostly good NHS support for pain services, the Society was the name for Pain Management, external organisations and the media came to the BPS for advice and information, finances were in order and the Society was at the top of its game. It was a privilege and honour to be President during this time.

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# Evolving MDT in BPS

Prof Paul Watson



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Dr Joan Hester handing over Presidency of the BPS to Professor Paul Watson in London 2009.

I was trained in Manchester and was based at the Salford Pain Centre along with Dr Chris Spanswick (Anaesthesia & Pain Medicine) and Prof Chris Main (Psychology). The three of us used to travel wide promoting the multidisciplinary approach to Pain Management from a medical, psychological and physiotherapy perspective. I was privileged to be associated with some of the eminent personalities in the field of Pain Management in the United Kingdom like Prof Sir Michael Bond, Dr Doug Justins, Dr Ed Charlton and Dr Chris Wells.

My first Pain Society meeting was probably in 1993, which was held in Edinburgh as a joint meeting with the Swedish Pain Society. I found that the Society was very welcoming towards me and other new members. The Society at that time had two distinct groups, one very much supportive of Interventional Pain Medicine and the other championing the psychosocial model of pain. Over the years things have evolved and it is refreshing to note that the Society is now a truly multidisciplinary one.

I took over as Chair of the Scientific Committee from Prof David Rowbotham in 1999–2000. During a meeting in March

1998, Dr Chris Wells and others had advocated that it was time to say no to the parochial society and stressed the importance of raising the quality of the scientific contents to the highest international standards. Till that time, most of the Society meetings were organised by a local organising committee and the speakers were well-known figures nationally. During the meeting at Leicester, the meeting organisation was done centrally through an organising committee with the able support of the British Pain Society (BPS) Secretariat under Ms Sandra Schia. The Society meetings became known as the Annual Scientific Meeting (ASM) and started attracting over 1200 delegates from home and abroad as the meeting faculty comprised eminent clinicians and scientists from all over the world. Prof Christopher Eccleston took over as Chair of the ASM, but with hardly any new drug developments for pain management, over the next few years, there was dwindling support from the pharmaceutical industry.

I was the first non-medical professional to be part of the Pain Society Council when I was co-opted in 1997 while I was the Chair of the Physiotherapy Pain Association. I also served as Chair of the Education Committee and also was the Chair of the Scientific Committee. I was in the Council from 1997 to 2009 when I became the President of the BPS. It was a great honour and I was also the first non-medical President of the BPS. The events that took place following the publication of the NICE (National Institute for Health and Care Excellence) guidance for the management of non-specific low back pain in 2009 of which I was a member of the guidelines development group culminated in an extraordinary general meeting on 21 July 2009. The membership who attended

and voted at that meeting had a majority and I tendered my resignation from the office of President of the BPS.

## Author's note

The incumbent President, Professor Paul Watson was asked to step down following the controversy surrounding the disputed NICE guidelines for low back pain. A petition was gathered in order to generate an extra-ordinary general meeting regarding a perceived presidential conflict of interest between the Society and NICE as he was a member of the Guidelines Development Group. A vote of no confidence was carried out and a narrow majority voted against Prof Paul Watson remaining as President (the vote was 186 against Prof Watson with 179 for him to continue; the total membership of the BPS at that time was over 1600). Following the resignation of Prof Watson, the BPS went through a period of trial and tribulations challenging the very fabric of the multidisciplinary society. Dr Heather Cameron, current Hon Treasurer of the BPS, was 'shocked and deeply disappointed' and commented on behalf of the Physiotherapy Pain Association that 'Paul has behaved in exactly the manner that has and will continue to make him an excellent ambassador for both physiotherapy and the field of pain medicine'. Sir Michael Bond, who stood in as Interim President, issued the following statement on behalf of the BPS Council – 'We deplore the blogs which vilified Paul and which were offensive to your Society and the profession of physiotherapy'. The dignity and grace shown by Prof Watson in accepting the outcome of the vote is best summed up in his resignation letter – Prof Watson wrote, *'If there is anything that I can help the Society with, please don't be afraid to contact me'* (as retold by Dr William Campbell, then Hon Secretary of the BPS).

# Turbulent tides

Prof Richard Langford



I had been a Council Member and also Chair of the Science Committee, before being elected as the President of the British Pain Society from 2010-2013, and then continuing on Council as Immediate

Past President. Due to the unfortunate sequence of events in 2009 that led to the resignation of the then President, Prof Paul Watson in relation to the controversy surrounding the disputed NICE guidelines for low back pain, former President, Prof Sir Michael Bond stepped in as Interim President in order to maintain stability until my election by membership as President in 2010. My initial challenge was to reunite a Society on the verge of division.

The year 2010 also saw changes in UK government with David Cameron elected as Prime Minister after more than ten years of Labour rule. A rather controversial reorganisation of the health service by Andrew Lansley followed soon, placing a greater emphasis on primary care rather than the pre-existing secondary care providers, through the setting up of new Clinical Commissioning Groups. These reforms posed significant threats to some of the services delivering Pain Medicine. As President, I initiated and worked alongside Dr Cathy Price, Dr Martin Johnson and Dr Andrew Baranowski as well as over seventy other colleagues to develop Pain Management Pathways for the 'Maps of Medicine' and review publications in the British Journal of Anaesthesia. The spinal pain pathways served to address the issues surrounding

NICE low back pain guidelines (the latter seen by many Pain Specialists as being significantly flawed). This has provided the template for new NICE and other guidelines. NICE has since accepted the arguments, and under the chairmanship of Dr Stephen Ward, a new NICE low back pain guideline was developed and published.

During the years that followed, along with Dr Beverly Collett, the then Chair of CPPC and Dr Martin Johnson, we had a series of productive conversations with the government on the importance of pain services. With Dr Collett, I had a pivotal meeting with Sir Bruce Keogh, Medical Director of the NHS England, and National Medical Director of the NHS Commissioning Board.

During my term, the BPS partnered with Dr Foster Intelligence, in the HQIP funded National Pain Audit, with major contributions by Dr Cathy Price, Dr Stephen Ward and Dr Amanda C de C Williams. The report discussed the impact of pain and drew on data related to around 10,000 new attendees at pain clinics nationally, and the accessibility to multidisciplinary care.

A highlight of this period for the BPS, was the Pain Summit in Westminster, organised jointly by the BPS, the RCoA Faculty of Pain Medicine, the RCGP and the Chronic Pain Policy Coalition. This meeting was very well attended with several high profile delegates from the CCG, Regional Health Directors and Managers. The speakers included Dame Carol Black and Professor Liam Donaldson. The BPS worked in partnership with the Chronic Pain Policy Coalition to devise questions for this snapshot survey of the nation's health on

behalf of Health Survey England and commissioned by the Department of Health. Pain related questions were included in the Health Survey for England (HSE) for the first time. This gave an authoritative understanding of the incidence, prevalence and nature of pain in England. Fourteen million people reported having daily pain, many mild to moderate, with 22% of men and 21% of women aged 16-34 reporting a disabling 'high interference pain grade', rising to 39% of men and 44% of women aged 75 and over.

Having been on the Editorial Board of the original BPS journal, 'Reviews in Pain', I was keen to support the progression to 'The British Journal of Pain' (BJP) under the editorship of Ms Felicia Cox. The BJP publishes original pain-related research in addition to reviews and educational pieces, under the auspices of a professional publishing house.

With stability restored to the BPS, it has continued as the multi-disciplinary Society for all healthcare professionals and scientists involved in the study, education and management of pain medicine. The Patient Liaison Committee has been an important component of the BPS, and with Council's support it continues to flourish under the leadership of Mr Antony Chuter.

Meanwhile, the recently convened Faculty of Pain Medicine established its place overseeing medical training, as under the umbrella of the statutory body, the Royal College of Anaesthetists. Closer working was fostered between the two organisations, an example of which was the Department of Health funded e-learning package, 'ePain',



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## Turbulent tides

developed jointly during 2010-11, under the leadership of Dr Douglas Justins and Prof David Rowbotham (the first two Faculty Deans) and myself and Dr William Campbell (my successor).

Three very successful BPS Annual Scientific Meetings (ASM) included a combined meeting with the Canadian Pain Society. In 2010, the ASM narrowly missed major problems, when an Icelandic volcanic ash cloud caused a shutdown of UK air space from the second day! Fortunately everyone had managed to travel to the ASM, however, a couple of invited international speakers found it

significantly challenging to return home!

I also introduced the 'Medal of Distinction', for occasional award to individuals who have done outstanding work for the BPS and the field of Pain Medicine. The first recipient was Prof Sir Michael Bond, the second medal was awarded to Dr Douglas Justins, and the third to Dr Beverly Collett.

I will always remain indebted to Prof Sir Michael Bond for his advice and also, on behalf of the Society, for his willingness to step in at a difficult time. I was also very well supported by Dr Beverly Collett (CPPC) and Prof David

Rowbotham (FPM). Along with Dr Martin Johnson, we secured educational days and the support of the Royal College of General Practitioners for pain initiatives. During my tenure (2010-13), I am also deeply grateful to the BPS executive officers, Dr William Campbell (the Society's first Vice President), Dr Pat Schofield and Dr Martin Johnson (Honorary Secretaries) and Dr John Goddard (Honorary Treasurer) and the outstanding Council and Secretariat, whose support and dedication enabled the BPS to reunite and flourish.

# A look back at 35 years interest in pain

William Campbell, President (2013–2016)

## My interest in pain and overview of the Society

Shortly after qualifying in medicine, I became interested in acute and later chronic pain. With a specific interest in the latter as an anaesthetic registrar, I tried to join the Intractable Pain Society of Great Britain and Ireland in 1980, only to be told that this organisation was only for medical consultants. During the following year I took up a 1-year clinical attachment at the Norfolk and Norwich Hospital, under the supervision of Dr Mark Metha since he had pioneered many interventions in the management of cancer and chronic pain. Just after starting this attachment, Mark asked me if I was a member of the Intractable Pain Society. After explaining my trainee position, he asked me for £2 and told me that I was now a member. He said that he could do this as one of the 16 founding members and past President of the Intractable Pain Society. I have been a member since.

Apart from the superb educational material that the Intractable Pain Society produced at their Annual Scientific Meetings (ASMs), it was a great opportunity to meet colleagues from various regions within the British Isles and further afield. These contacts were most valuable not only for social and educational reasons but also in discussing problems which may occur during the year between ASMs – including concerns relating to difficult cases and commissioning treats – little has changed in some respects! In the early years, there were joint meetings on



Dr William Campbell presenting Prof Sir Michael Bond with the BPS Lecture Medal, at the 2014 ASM held in Manchester.

alternate years between the Dutch Pain Society and the Intractable Pain Society, but these dwindled over the 1980s.

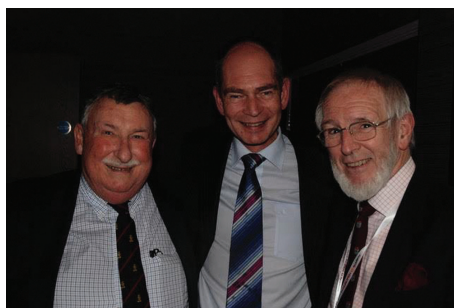
As recommended by the International Association for the Study of Pain, their British Isles Chapter, the Intractable Pain Society of Great Britain and Ireland, had then to open membership to all disciplines dealing with pain from a research, teaching and management point of view. Shortly after this, we became the Pain Society. However, at the turn of this century, the Republic of Ireland representative on Council stated that they wished to form an independent Irish Pain Society, since they had the requisite number of members within the International Society for the Study of Pain to form their own chapter. So, it was

from this point that we became the British Pain Society (BPS).

## My terms on Council (1999–2017)

In 1999, I started one of several terms on the BPS Council, initially as Honorary Assistant Treasurer, becoming Honorary Treasurer. Later Honorary Assistant Secretary becoming Honorary Secretary, and so on. Over the past 17 years, there have been dramatic changes in Secretariat staffing and their workload. In 1999, we had one half-time Secretariat based on the top floor of the Association of Anaesthetists premises in Bedford Square and then moved with the Association of Anaesthetists (with several Secretariat)

## A look back at 35 years interest in pain



Dr Ed Charlton, Dr William Campbell & Dr Keith Budd at the 2008 ASM held in Liverpool.

to Portland Place. The Association was always very accommodating and helpful but about a decade ago, we relocated to our current office within Churchill House.

When I started on Council, we could get through two committee meetings in the morning and a Council meeting in the afternoon. Everything now seems to take so long, despite emails and teleconferences. We receive communications from so many likeminded organisations, media, the public and government departments, in addition to communications with our membership. It is now 10 years since the Faculty of Pain Medicine of the Royal College of Anaesthetists started, so there is a considerable degree of communication with them, especially to avoid overlapping in activities.

### During my term as President

Although I had been President Elect during the preceding year, and Vice President during the year before that, I wasn't aware of the amount of queries and emails that would be forwarded to me! Previously receiving a 100 or so per week, but when I started as President, I received 500 per week! Our Chief Executive Officer must receive considerably more than this.

Between the enthusiasm of the Council and the dedication of the Secretariat, we, as a team, oversaw the

completion of many of my predecessors' activities:

- Roadshows for the five Pain Pathways and associated Map of Medicine, for which Professor Richard Langford had already acquired a very considerable degree of external funding.
- Clinical Review Groups' Specialised Pain Service representation, together with commissioning advice were arranged by the Society's publications and website.
- National Institute for Clinical Excellence's (NICE) liaisons were established. Professor Mark Baker met annually with BPS Executives, permitting us to express our mutual concerns. We carried on with the BPS recommendations on 'A Shadow framework for pain', led by Professor Richard Langford. This was showcased within *Pain News* as well as on the Society's website.
- The BPS's National Pain Audit, 3rd led by Dr Cathy Price, was completed. This highlighted the devastating effect that persistent, poorly managed chronic pain had on the health of the nation. A launch of the document was held at a private function within the House of Lords in autumn 2013, facilitated by the Chronic Pain Policy Coalition (CPPC).
- The BPS website was due for updating. Dr Raj Munglani initially led this task and the work finalised early in 2015 by Dr John Goddard.
- The new site is much more interactive and permits members to register for meetings as well as providing much more information, including news and the Society's publications.
- We continued to run an Annual Patient Seminar Day, organised by the Patient Liaison Committee, Chaired by Mr Antony Chuter. The events are attended by both

patients living with pain, as well as healthcare professionals and are recognised for continuing professional development purposes. During 2015, the Patient Liaison Committee launched their new publication 'Understanding and Managing Long-term Pain'.

As I started my 3-year term as President, our Honorary Treasurer Dr Andrew Baranowski expressed his concerns about dwindling annual income, mainly from trade support. Over the previous decade, we had become dependent on this income to carry out many activities that were over and above that which a membership subscription alone could offer. (The membership subscriptions only cover part of the office costs, together with quarterly copies of *Pain News* and the *British Journal of Pain*.) Surplus from ASMs seeds additional educational meetings and some office costs.

Over the following years, measures were taken to address expenditure, as well as more recently income. We are aware that trade support for medical events has fallen internationally, so now we need to function from subscriptions alone until other sources of income can be identified to help with some of the extended activities that took place in the past. Our new President Dr Andrew Baranowski started work on a National Awareness Campaign within his year as President Elect. This campaign became active in January 2017 and has a second function of hopefully drawing income from various non-medical sources, as well as through events to be run in the near future.

### Recent and future ASMs

From 2013, we obtained feedback from the 500–600 ASM delegates each year, as well as from the Special Interest Group (SIG) Chairs, and used this to rearrange

the format of the ASM to a 2-night/3-day event, with party activity introduced.

During the last few years, we reduced face-to-face meetings where possible, used teleconferencing and email more frequently, but attempted to reduce the 'reply to all'! However, as the balance sheets continued to be of concern, we started a trading arm – BPS Pain Business Ltd – through which more VATable activity would run. Personally, I always found the ASMs a great networking as well as educational event although during the past 5 years, I haven't taken as many photographs during the previous three decades!

### Liaisons with other professional bodies

We started regular Faculty of Pain Medicine (FPM) contact to prevent overlap in activities; this later developed into the Pain Consortium, with the additional input from the CPPC and the Royal College of General Practitioners (RCGP) lead. The Pain Consortium meetings were held just prior to our BPS Council meetings (as many individuals who attended the consortium also sat on Council). The Pain Consortium reviewed the work recommendations from the Pain Summit held during 2011 (The British Pain Society's task being to investigate current data sources on pain, terminology use in clinical practice and the evaluation of appropriate recorded

health measures for pain.). In addition, we also found that the Pain Consortium was in a strong position to 'voice' its concerns from a combined point of view, when letters on such issues were considered necessary to key bodies.

During 2014, we contributed towards meetings at the House of Lords on the progress of Pain Summit challenges, and in 2016, at the House of Commons 'a Pain Charter'. The CPPC facilitated these.

### Joint BPS and FPM activities

*e-Learning Pain* – this was a combined FPM and BPS project funded by the Department of Health e-Learning Programme. It covers a huge selection of interactive, online modules for non-specialist healthcare professionals. This was led by 13 module leaders mentioned within the summer 2013 edition of *Pain News*, and the website became active in 2014.

*Pathfinder project on low back pain* – during 2009, the NICE published CG88, low back pain guidance. Much of this was not considered fit for purpose, so Professor Charles Greenough – National Clinical Director for spinal disorders – was tasked with chairing a working group to develop suitable guidance for commissioners within the United Kingdom until such times as new NICE guidance became available. A large multidisciplinary group was convened and the work on a flowchart for low back pain management was agreed by late

2013 and sanctioned by commissioners by December 2014. Despite the new NICE guidance for low back pain NG59 being available late 2016, the Pathfinder advice on low back pain is still valued and used.

*Meeting with the General Medical Council (GMC) regards undergraduate education in pain management* – representation was made to the GMC by the BPS and the FPM in 2014, illustrating the problem of pain management by the results of the National Pain Audit and the potential for improvement by suitable undergraduate medical education via a poster presentation courtesy of Dr Emma Briggs. It was agreed that after a pilot study of Essential Pain Management given as half days training (EPM Lite) in a dozen medical schools, the matter would be re-evaluated by GMC.

### The future of the BPS as I see it

The BPS will always have challenges ahead. Not just financial but also competition with other specialist organisations when they put on study days, and so on.

Despite this, the BPS is truly a multidisciplinary organisation, and we all gain from the communication both across disciplines and regions, regarding problems and solutions of all sorts within our professions, which is always to put the patient first.



# “Looking back over the years...”



Dr Cathy Price receiving Honorary BPS Membership from Dr William Campbell, following a citation delivered by Dr Joan Hester at the 2014 ASM held in Manchester.



Dr John Goddard, Dr Beverly Collett, Prof Andrew Rice & Dr Peter Evans. ASM 2010 Manchester.



Prof Sir Michael Bond and Dr Beverly Collett, 2000 ASM.



Dr Joan Hester with Prof Paul Watson at the Glasgow ASM 2007.



Prof Chris Main, Dr Joan Hester, Prof Sir Michael Bond, Dr Beverly Collett & Dr Tim Nash at the Manchester ASM 2010.



Dr Joan Hester with Prof Antony Dickenson, who delivered the Patrick Wall lecture at the 2008 ASM, held in Liverpool.



Two of the key founders of the Intractable Pain Society. Dr Sam Lipton and Dr Mark Swerdlow - IPS (Intractable Pain Society) Meeting around 1985.



Dr Andrew Diamond and wife at 1992 ASM, Cirencester.

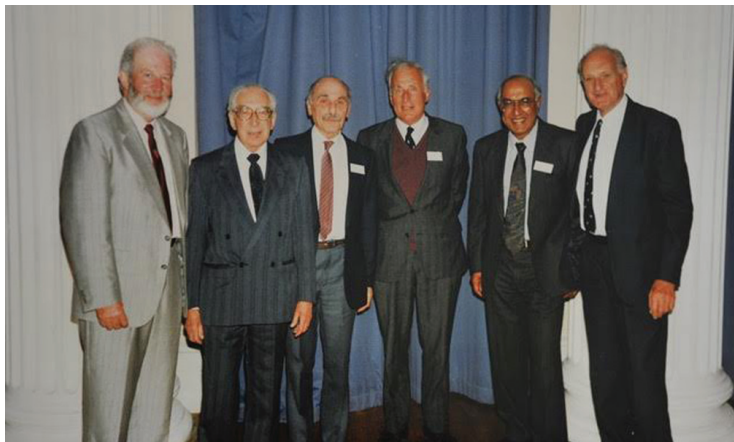


Prof Rolf-Detlef Treede receiving the BPS medal from Dr William Campbell, following the 2014 Pat Wall Lecture in Manchester.

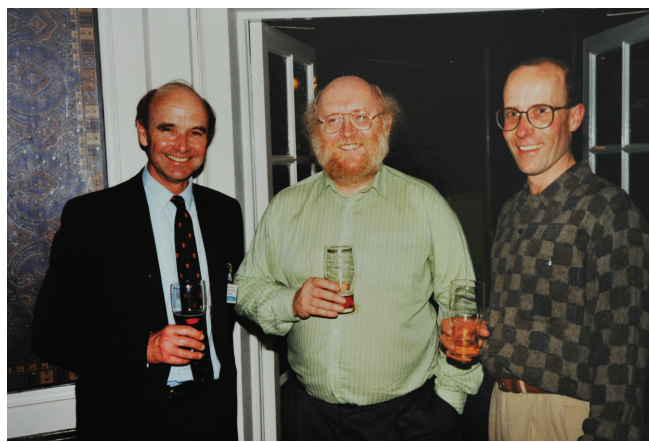


Prof Richard Langford, Dr Beverly Collett, Prof Sir Michael Bond and Dr William Campbell at the 2014 ASM, Manchester.





Some founding members of the IPS. Dr H Raftery, Dr S Lipton, Dr M Swerdlow, Dr Mark Churcher, Dr Mark Mehta & Dr J Birkhahn at the Cirencester ASM 1992.



Dr Douglas Justins, Prof Chris Main and Prof Paul Watson.



Prof Richard Langford presenting the BPS Honorary Medal of Distinction to Dr Doug Justins at the Bournemouth ASM 2013.



Prof John Wood receiving Honorary BPS Membership 2014 Manchester, following the delivery of a citation by Prof Maria Fitzgerald. Dr William Campbell, President to extreme right.



Dr Andrew Diamond at Intractable Pain Society ASM, Exeter 1990.



Prof Chris Main, Dr Beverly Collet (President 2003-6) & Dr Dick Atkinson.



Dr Joan Hester presenting Honorary Membership of the BPS in London, 2009.



Dr Amanda C de C Williams & Prof Chris Eccleston at the presentation of Honorary BPS Membership to Prof Stephen Morley at the 2012 ASM held in Liverpool.



Dr Beverly Collett with Dr Joan Hester at the Glasgow ASM in 2007.



Henry VIII with BPS delegates, in Hampton Court Palace 2009 ASM.



Dr Joan Hester presenting Honorary BPS Membership on Prof Antony Dickenson at the ASM 2009.



# Intractable Pain Society of Great Britain and Ireland

Chris Wells *President, EFIC*



The Society was started in that most exciting of decades, the 1960s, during which I was fortunate to spend my teens. Potential members met for the first time

in Salford in November, 1967, at the invitation of Dr. Mark Swerdlow (Manchester), to discuss problems of chronic pain therapy. It was decided to hold further meetings annually and to restrict membership to doctors actively engaged in the practice of pain relief. The initial group consisted of 17 enthusiasts (Mehta, Pain 8, 1980: 121–122).

A formal constitution was adopted at the fifth meeting in 1971 when Swerdlow became Chairman, William Mushin President, Mark Churcher Secretary and John Challenger Treasurer. Sam Lipton took over as chair in 1976 and by 1980, the society had 200 members.

I qualified from Liverpool University when the Intractable Pain Society (IPS) was only 3 years old, and emigrated to Canada in the days when a 100-hour week was rewarded with £1,200/year. I returned to England after a stint as a General Practitioner (GP) Anaesthetist, determined to follow my chosen specialty in the premier environment of the Liverpool School of Anaesthesia, with colossi such as Cecil Grey and Jackson Reese. Routine anaesthesia soon lost its sparkle and other colossi, such as Sam

Lipton, Norton Williams and J E (Dinge) Riding lured me into the fantastic world of Pain Medicine.

I worked first at the Liverpool Royal where 'Dinge', Editor of the *British Journal of Anaesthesia* (BJA) for many years until 1973 and Dean of the College of Anaesthesia (no Royal Warrant then) from 1976 to 1979, dispensed nerve blocks with psychological advice gleaned from his knowledgeable wife Joyce, a Consultant Psychiatrist. I loved it, and so secured a rotation to the Neurosciences Centre at Walton Hospital to work with the UK pain hero Sam Lipton – a man who was doggedly determined to build the best pain service, the best clinical research institute and to leave no pain unblocked. On arriving at Walton, I expressed my interest and delight at being rostered there. Sam asked if I had done any pain work and, hearing that I had, said with delight 'Excellent, you will be able to run the service whilst I am away in Lubbock for 6 weeks, doing a locum for Gabor Racz' (Gabor had in his youth read Medicine at Liverpool University).

Luckily I could learn blocks (including trigeminal radiofrequency ablation) from Norton Williams and everything else from David Bowsher (Reader in Anatomy and an Honorary Neurologist), John Miles (a Neurosurgeon and a pioneer in SCS and interventional pain relief neurosurgery) and Eric Ghadiali (a Clinical Neuropsychologist). Sam was around for part of the time and my first experience of cordotomies was on a Friday morning. 'Did you understand?' Sam

probed, after I'd watched the first one, and when I said 'Yes', I was given the next to do, while he read for his Open University maths degree. After success, I was told I was teaching the technique on the next Tuesday to an overseas visitor, and 3 months later gave a lecture on the subject in Edinburgh, filling in for Sam with slides borrowed from him ('But I've only done 12!', I protested; 'Well that's 12 more than them', he retorted).

During this period, I attended my first IPS annual meeting in 1981, at the Glasgow Holiday Inn underneath the railway bridges (plenty of evidence of addiction outside). I remember more anecdote than science and a brilliant paper by Ernie Allen from Christie's in Manchester, on 'My first 100 Cordotomies'. However, things were slowly changing as one Michael Bond was there – the first non-Anaesthetist to become a member – and he was a huge influence in convincing IPS members of the importance of the brain and mind in chronic pain. Prior to that, for the first 10 years of its life, the IPS gave a great chance for Consultant Anaesthetists – interested in interventions to relieve pain – to get together and discuss options, rather like Raj Munglani's Google group does over the Internet today.

Juniors were just being admitted as associate members (£2 please) when I started, and then later were allowed to join as full members, but no other non-medical health care professionals could join, and the British chapter of the International Association for the Study of Pain (IASP), the original British Pain



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Society (BPS), was largely run by David Bowsher and Vince Moloney, a Veterinary researcher from Edinburgh, and meetings were mainly directed at basic science research papers.

With a burgeoning interest in psychology, and having started, with Eric, the first continuously running Pain Management Programme in Europe at Walton in 1983, I formed (with Chris Main and Annabelle Broome) the Psychology Interest (in pain) Group (PIG) and this group soon had over 100 members. Bill Fordyce spoke at our first meeting at the Adelphi in 1983. After several years of often-heated discussion, the IPS eventually allowed a merger with the BPS and PIG to form a truly multidisciplinary Pain Society in 1987.

Originally, it was known as the Pain Society – historically having members from Ireland and at one time an Irish President, Hugh Raftery, and in celebration of it originating 6 years before the IASP in May 1973 in Issaquah (Sam Lipton and David Bowsher were both Founders and later Honorary Members). This was a bit like ‘the Open’ in golf as opposed to the US Open for its later origin, but there were changes back and forth, before eventually the Irish appropriately left to form their own IASP Chapter and we became again as we are today, the BPS.

I have been delighted to have been a council member, chair of the Scientific Programme committee for the annual meeting from 1997–1999 and also act

as Secretary from 1996 (assistant Secretary the first 3 years) to 2002, the Presidents in those years being Ed Charlton and Sir Michael Bond, before becoming Secretary of the European Pain Federation in 2002 (at that time EFIC). We grew the BPS Annual Scientific Meeting attendance from less than 300 in Llandudno in 1996 to nearly 1000 in 1998 and 1999 by bringing in plenarists from abroad and expanding the size of the meeting to cover all interests. It was a huge privilege to give the BPS lecture in 2008 in my own city of Liverpool and to be made an honorary member at that time. I have enjoyed meetings from 1981 onwards and look forward to attending and speaking at the 50th one in May this year.



# Pain Management Programme (PMP) SIG

Dr Lars Williams

2017 will see the 50th anniversary of what we now know as the British Pain Society (BPS). When the Society was first registered as a charity on 29 November 1979 (as the Intractable Pain Society of Great Britain and Ireland), membership was limited primarily to anaesthetists working in pain clinics, with a predominately biomedical focus. Over time, the membership of the Society became increasingly multidisciplinary, reflecting a growing emphasis on a biopsychosocial approach to the management of chronic pain. The first formal Pain Management Programme (PMP) in the United Kingdom was developed in 1983 at the Walton Centre, and many more PMPs have been established since then throughout the United Kingdom, estimated over 100 at the time of writing. Clinicians working in PMPs are represented by an active Special Interest Group (SIG) on the BPS council.

2017 will also see the 16th Biennial National Conference of the PMP SIG, which will be held in Glasgow on Thursday 14th and Friday 15th September 2017. The Glasgow PMP is a relative youngster, established less than 10 years ago, in 2008. Even younger is the newly established Scottish National Residential PMP, which opened last year in the grounds of the city's Gartnavel Hospital (a stone's throw away from the site of Professor Sir Michael Bond's pioneering work on pain management in the early 1980s). Clinicians from both the Glasgow and the Scottish National PMPs are involved in organising the conference, under the theme of 'Fear'. Plenary speakers include Johan Vlaeyen and



Glasgow City Chambers.  
Credit: People Make Glasgow.

Amanda Williams, and we will be running workshops including 'fear of patient involvement', ACT in teams, compassion-focused therapy and many more. The conference provides an ideal opportunity for networking, and we will facilitate this by organising unidisciplinary meetings on the first day. Delegates will be invited to contribute to the agenda for these meetings prior to the conference.

In addition to the excellent conference line up, you can also expect a warm welcome to Glasgow. Glasgow is famed for its culture, architecture, music scene and humour. On arrival on Wednesday, you will have the opportunity to take in

some of Glasgow's finest Victorian architecture in a drinks reception at the City Chambers, hosted by Glasgow's Lord Provost. The main social event will take place on Thursday at the National Piping Centre where you will have the chance to take part in either Scottish gin or craft beer tasting, as well as the opportunity to show off your bagpipe-playing skills! Those wishing to make the most of their visit might consider extending their stay into the weekend. Glasgow is fortunate in being under an hour away from the southern shores of Loch Lomond and the beautiful Loch Lomond and the Trossachs National

Park, stunning at this time of year. And of course, Edinburgh is less than an hour east by train, with a frequent service.

We recognise that tomorrow's grandees of pain management are today's clinical trainees and research neophytes. To celebrate the BPS' 50th Anniversary, and the relatively recent establishment of Glasgow's PMPs, we

are offering five bursaries for young researchers or clinicians who are just establishing their careers in pain management, to attend the PMP SIG National Conference in September 2017.

Prospective candidates can apply by email to [lars.williams@ggc.scot.nhs.uk](mailto:lars.williams@ggc.scot.nhs.uk) for further details.

Registration for the 16th Biennial National Conference of the PMP SIG is now open through the BPS website: <https://www.britishpainsociety.org/mediacentre/events/pmp-sig-bi-annual-meeting/>

Follow our Twitter feed for further updates:



#PMPSIG17



Credit: People Make Glasgow.



Finnieston crane, SECC and SSE Hydro.  
Credit: People Make Glasgow.



Glasgow Cathedral.  
Credit: People Make Glasgow.

# Re-launch of the Pain in Older People Special Interest Group: We need your help

Margaret M Dunham *Sheffield Hallam University*

There are some 117 members currently signed up to the Older People Special Interest Group (SIG). At the Annual Scientific Meeting (ASM) in Birmingham, we will re-launch the SIG, so we need your enthusiasm, expertise, ideas and most importantly, a little of your time.

Here is a summary of why I think this SIG is so important.

The population is ageing. The global population is growing exponentially. Out of this growing population, in the industrialised world, birth rates have declined and people are generally living longer. In the United Kingdom, the Office for National Statistics (ONS)<sup>1</sup> projection suggests that the proportion of people aged above 65 years will massively increase over the next 10 years. Public Health England (PHE)<sup>2</sup> has noted this increased life expectancy but considers that not all these older people will enjoy good health. Given the current state of the National Health Service (NHS) financial woes and concerns about lack of capacity, in both in-patient and out-patient services, this should be of concern to the whole population, and not just the health professions and the aged.

Older people's health and social care needs are under-funded. The needs of older people are growing with the increase in population, yet the funds do not appear to grow correspondingly. The Kings Fund<sup>3</sup> has formally assessed what we all know anecdotally that health and social care providers are struggling to meet many of the needs of their local ageing

populations. Access to care is largely based on what people can afford; by becoming aged, the care which is needed appears to be no longer free at the point of delivery. There is currently an anomaly where some care, and social needs support, is means-tested for the old unwaged yet free for younger adults. One in seven pensioners is currently in poverty yet,<sup>4</sup> the next generation of pensioners, appears to be less well-placed financially than their predecessors did at the same age.

Whether older people experience more or less pain than their younger counterparts is debatable. It is questionable whether older people have a different experience of pain from younger adults which justifies any under-treatment of their pain. The physiological basis for experiencing pain in an aged nervous system could suggest that older people might have a lower sensitivity to pain and thus have a higher pain threshold.<sup>5</sup> Indeed, some researchers suggest that older people's general experience of pain is less than that of younger adults with similar disease progression.<sup>6,7</sup> Decreased sensitivity to external stimuli, which has also been associated with increasing cognitive impairment due to common vascular and neurological diseases of the brain, is frequently associated with ageing.<sup>8</sup> However, such gross generalisations are questionable when all potential confounding factors are taken into consideration.

Pain in old age is not 'normal', yet it is widely reported. Indeed, pain is very common in older people, with almost 5 million people aged 65 years and older experiencing pain or discomfort in the United Kingdom.<sup>9</sup> Pain in older people is an acknowledged physical and therapeutic problem. Furthermore, there is some evidence that sensory ability may decline increasingly with advancing age.<sup>10</sup> However, it is not established whether this changing sensory ability may result in a predisposition to either increased or decreased pain sensitivity, as much of the neurological data are modelled on animal studies. Thus, there is no clear biological rationale for the changing pain experience with increasing age. Similarly, the biopsychosocial changes are not fully understood.<sup>11,12</sup>

Pain can limit mobility and contribute to loss of independence. The under-treatment of pain in older people, or any group of people, is unethical and unacceptable. In particular, pain in older people may have a deleterious effect on their mobility and independence. Inadequately managed pain is known to have detrimental effects on quality of life and activities of daily living.<sup>13–15</sup> For many older people, the loss of independence is a massive worry.<sup>16</sup> Independence should also be a goal for the many rather than the few if the available public pot of money to support their care remains so limited.<sup>17</sup>

Pharmacological and other treatment options may be reduced because of risks



associated with declining renal function, drug interactions and other contraindications. Older people may be subjected to restrictions on the types and amounts of analgesia which can be provided.<sup>18</sup> This constraint is usually justified by disease processes, which are more frequent in, but not common to, all older people, such as reduced renal function.<sup>19</sup> The susceptibility to increased effect and chronic toxicity is associated with decreasing renal function which is associated with ageing, but not exclusive to older people. Thus, the increasing health and longevity of the ageing population, in the industrialised world, has led to a separation between physiological and chronological age with associated stratified or restricted analgesia regimens.

Comorbidities of ageing make things more complicated; we don't have equivocal data for this population because of the confounding factors limiting research. By the age of 65 years, most people will have at least one long-term condition and by 75 years, many will have two or more.<sup>20</sup> Older people may experience many comorbidities which render them more likely to experience pain, and psychosocial distress, than younger people.<sup>21–24</sup>

Expert consensus remains the primary source of guidance for pain assessment in older people in the United Kingdom and Europe. Knowledge of age-related pain differences is informed by limited primary research and mostly expert consensus.<sup>25–28</sup> Pain assessment should always be based on the individual's own description of their pain experience or 'self report'. However, in the clinical environment, the assessment is usually based on a combination of the 'self report', the observed physiological process or event which has caused the pain, and the observed behavioural response of the individual. Therefore, empathy and understanding visual and non-verbal cues of suffering are all important to assess pain.<sup>29,30</sup>

This is a quick, but by no means, exhaustive summary of the topic, and I am sure many of you know much more about older people's pain, pain assessment and management from your experiences. Since most of the in-patient population is over 60, this SIG is important for you and the older people you look after, manage the care of or research about.

What is very clear is that we need more research about pain in the older population. We need to establish the known and best practice. There has to be more, and better education, of all health professionals in the appropriate assessment and management of older people's pain. We, in the British Pain Society (BPS), need to be a voice of good practice, best evidence and person-centred holistic care for older people in pain.

Please watch out for regular communications and surveys over the next few months. We want this to be a vibrant and lively debating and supportive group which grows and evolves in response to our needs and the needs of the ageing population. We will need committee members and active members to keep the committee informed.

Finally, we're all going to be old one day (hopefully); so if we can get this right, our future pain services will benefit all of us.

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## Re-launch of the pain in Older People Special Interest Group: We need your help

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# The enigma of the Placebo effect

**Sandeep Kapur** *Consultant in Pain Medicine & Anaesthesia,  
University Hospital Birmingham, UK*



Sandeep Kapur

called 'Placebos', from the Latin for 'I will please'. Placebos have always evoked mixed feelings among clinicians; Thomas Jefferson termed them a 'pious fraud'.<sup>1</sup>

Henry Beecher (an eminent American anaesthesiologist and medical ethicist), in 1955, published a paper titled 'The powerful placebo', in which he wrote, 'placebos have a high degree of therapeutic effectiveness in treating subjective responses'. This paper, in which he noted that placebos are effective 30% of the time, has been cited over a thousand times and had a profound effect on clinical research.<sup>1</sup>

In a seminal paper in 1978, Levine, Gordon and Fields investigated the role of endorphins within the placebo effect. Following a dental procedure, patients were randomised to receive either morphine (treatment) or saline (placebo) injection. Patients from the placebo arm of the study were then separated into placebo-responders and non-responders. Both groups were then administered i.v naloxone. The placebo-responders reported increased pain following the naloxone injection, whereas the placebo

In medieval times, mourners were hired to attend funerals, but because their emotions were considered insincere, they were

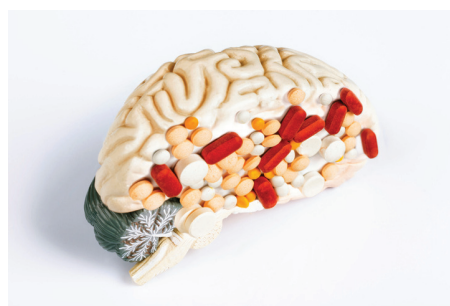
non-responders showed no change in their pain scores, hence proving that endogenous endorphin production was the likely cause for the positive placebo effect in the group that initially responded to the saline injection.<sup>2</sup> More recently, the endocannabinoid and serotonergic systems have also been implicated in placebo analgesia.<sup>3</sup>

In December 2016, Prof Ted Kaptchuk (Director of the Program in Placebo Studies at Harvard Medical School) co-authored a paper in the journal 'Pain' titled 'Open-label placebo treatment in chronic low back pain: a randomized controlled trial'. Open label placebo (OLP) is an interesting idea that breaks from the received wisdom that clinical administration of a placebo requires deception (or double-blind conditions) to be effective: several studies have directly tested the effect of an OLP prescription, and all indicated that patients reported benefits after taking pills presented honestly as placebos. This study is the first to demonstrate potential clinically significant benefits of OLP treatment in chronic low back pain (cLBP); it found

that adding OLP to Treatment as Usual (TAU) resulted in significantly greater reductions in cLBP and pain-related disability than TAU alone. The amount of additional pain reduction produced by OLP was approximately 30% of baseline pain and disability ratings.<sup>4</sup>

The question then arises how a treatment openly labelled as placebo actually produces benefit without 'fooling' the mind, as randomised controlled trials (RCTs) do. The authors postulate that 'engendering hope when participants feel hopeless about their condition can be therapeutic'. Another possible explanation is the Hawthorne (or Observer) effect: a person who is aware of being studied/observed often feels better, even if nothing has actually changed: this is also why patients say they feel better when their attending doctor or nurse is attentive and has a good bedside manner.<sup>1,4</sup>

This may also help partly explain an intriguing phenomenon noted recently by Tuttle et al., and published in 'Pain': 'Increasing placebo responses in US clinical trials of neuropathic pain'. Surprisingly, Tuttle and co-authors noted that placebo responses are rising only in the United States. In 1996, patients in clinical trials reported that drugs relieved their pain by 27% more than a placebo. By 2013, that gap had slipped to just 9%. The phenomenon is driven by 35 US trials; among trials in Europe, Asia and elsewhere, there was no significant change in placebo responses. One possible explanation is that direct-to-consumer drug advertising is allowed in



Credit: Nastasic.

## The enigma of the Placebo effect

the United States and this has increased people's expectations of the benefits of drugs, creating stronger placebo effects. Moreover, big, well-funded US trials, and the glamour and gloss of their presentation might indirectly enhance patients' expectations, leading to an increase in the placebo response. This, however, creates a problem: pharmaceutical companies are finding it ever harder to get painkillers through clinical trials. Over the past 10 years, more than 90% of potential drugs for treatment of neuropathic and cancer pain have failed at advanced phases of clinical trials.<sup>5,6</sup>

Yet another exciting recent development is the study of genomic effects on placebo response, termed the 'placebome'. The analgesic effects of placebo have been shown to be mediated

through activation of endogenous opioid as well dopaminergic and serotonergic mechanisms. However, genetic polymorphism in the expressing of these mechanisms may mean that placebo responses vary by genotype. In general, the placebo arm is considered to be an adequate control for outcomes in the active treatment arm of RCTs. However, if the placebo response does, indeed, vary by genotype, we might expect challenges with confounding, potential gene–drug–placebo effect modification and disease-specific effects.<sup>3</sup>

As our understanding of placebo evolves, it is worth bearing in mind the advice by the American Institute of Medicine: 'placebo (can) conceivably be a form of treatment of pain, especially in light of the shortcoming of other

modalities or benefits they bring in their right'.<sup>7</sup>

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The British Pain Society is nothing without you, its members, and we appreciate your continuing involvement and support. We recognise that, for many members, in recent years, the decision to pay the membership fee for a non-compulsory professional society has been more challenging so we will continue to look closely at our fees and we will take care to limit any increases. We hope that you will continue to encourage your colleagues to join us.

May we also remind you that The British Pain Society is a registered charity and we welcome funds received from legacies and through sponsorship. As we know from the numbers who have joined fun runs at previous ASMs, many of our members are actively engaged in sporting activities. So, if you are signing up for any marathons, half-marathons, triathlons, swims or tiddlywinks contests, please consider nominating The Society as your chosen charity.

**Thank you for supporting the BPS!**



# Creativity and the use of metaphor in Primary Care

Maureen Tilford

This article is a transcript from the Philosophy & Ethics SIG meeting from 2016

Metaphors may be as necessary to illness as they are to literature, as comforting as a bathrobe and slippers Broyard (1992)

I started using hypnosis with my patients in about 1992. I was very nervous when I first started. I suspect my colleagues thought I had lost my reason, but the patients were keen to try it. My initial reason to do the training was to find some way to teach relaxation to the many highly stressed cases presenting into Primary Care but soon found there were many applications, including pain and skin disorders.

It became clear to me that given the opportunity and minimal encouragement, people are able to harness their imagination, instantly finding personal metaphors to enable them to deal with illness and suffering.

We constantly think and speak in metaphors: patients will emphasise and illustrate their symptoms using phrases such as 'It's like an electrical shock going down my leg' or 'my heart is broken' or 'Pain, like a vice around my head'. They are using symbolic language to impress on you the true nature of their pain.

With hypnosis, you can create a relaxed space where the patient is free to turn off the critical, rational mind and enable the imaginative, creative mind to focus entirely on whatever presents as the issue. Using their personal imagery, such as the vice like headache, you can then suggest that they consider how it might feel if the vice were loosening. I will often ascertain, before the hypnosis

begins, as many characteristics of the pain as possible, such as its colour, texture, temperature, size, position and how it would have to transform (such as red to blue). Then in trance, I suggest the slow change of these characteristics.

The benefits of these suggestions is much enhanced if the person is relaxed, so asking what place they would choose to be their personal perfect place and suggesting they go there in their imagination and become comfortable sets the scene for change.

## Case histories

One of my patients had phantom hand pain following an accident with an apple sorting machine when her right thumb and index finger were severed. She had to give up her original career as a professional knitter and was much troubled by pain despite the standard medication. Her metaphor in the hypnosis sessions for easing the pain was a profuse flow of blue liquid pouring out from the crown of her head, spilling down over her whole body including the painful hand bringing sensations of 'soothing, cooling and healing'. After several sessions, the pain was under control and she went on to train as a psychological therapist.

I once saw a young man with psoriasis who had experienced a very stressful time in his life when there was fighting in his family over who should have ownership of his grandmother's ashes of which he had charge. He had severe psoriasis all over his torso for about 2

years with no relief from creams, and was really fed up. So I suggested hypnosis. I asked him to close his eyes and think of his own wonderfully peaceful place. His was lying on wooden decking looking out over a lake surrounded by mountains and blue sky. I asked him, 'what would your immune system look like if it was going to heal your skin for you?' His was a blue fleecy dressing-gown coming down from the sky, which would magically go on him and would be soothing, smoothing and warming. I did five or six sessions with him, and the skin cleared. Of course in general practice you have people for many years. He came back with a cough about 2 or 3 years later, and he pulled up his shirt and did a little dance around the room.

Health anxiety is a common problem. One lady – a paediatric nurse – was very embarrassed about always coming back complaining of various symptoms. She had seen all three partners with abdominal pain and other symptoms that 'might be cancer ...' Her imagery was a beach, so while she was lying on the couch in a hypnotic trance I gave her a post-hypnotic suggestion by saying: 'put your hands on your tummy and feel a nice warm sensation – soothing and relaxing, and your tummy is comfortable ...' – a very simple approach. She got better after a few sessions and stopped coming back, so that seemed like a success, but about 2 years later, she came in for a sick note. The discharge letter from the hospital revealed that she had had an appendectomy, having sat on her appendicitis for 2 or 3 days! She

thought it was just her neurotic abdominal pain and had been using the techniques I had taught her until her appendix was gangrenous – so sometimes you have to tune it down a bit!

I had another patient with an inoperable tumour of his gallbladder who had been given about 6 months to live. His imagery was standing on a beach on the Indian Ocean looking at the surf breaking over the reef, and using the power of the ocean for healing. His image of his immune system was of millions of green 'Pac-men' whizzing around his blood-stream, and that of his tumour was a big brown hard rock under his diaphragm. Every week during hypnosis we would set the little men off and they would nibble away at his tumour like little fish. In the middle of his six or seven sessions he went back to his home island in the Indian Ocean where he dreamt about his grandmother. In the dream, she asked what was wrong with him, and when he told her that he had a tumour she put her hand in his abdomen, pulled something out and threw it away. Later he went into the mountains and picked a herb that the grannies had always used when children were ill and drank the herbal tea. He came back for a few

more sessions, and on the last day he got off the couch and said, 'I've got the last bit today'. His next scan showed that the tumour had gone away. About 6 months later he was still alive and he thought maybe I should get it checked out by somebody, so I sent him to an eminent professor of gastroenterology in Cambridge. He looked at the scan and opined that it had been the wrong diagnosis, and discharged him. A couple of years later he was still alive; it was then suggested by the specialist that the first people had looked at the wrong slide, but they proved it was his by checking the DNA. He lived for another 8 years. I think his immune system was just holding this thing; I don't believe it had completely gone away. His daughter was in a very difficult relationship with a very violent young man while the patient was a very benign easy going person. Anyway, all this furore came into his life, and he was dead within a month. Of course, it is impossible to claim it was the hypnosis that had the effect (could have been the tea!) but interesting all the same.

Enabling people to tap into their own resources can be very rewarding. But the word 'resources' is rather colourless, and they often find the concept difficult. As part of a Neurolinguistic Programming

technique called the 'Score Dance' described by Robert Dilts, the patient is asked to stand up, close their eyes and consider what their personal source of power would be like: maybe it is the power of the sun, nuclear power, hurricane force, earth energy and so on. Once chosen, it is suggested that they draw in this energy, feeling it coursing around their body, energising and enabling them to be stronger and empowered.

It would seem that allowing patients to have personal and bespoke influence over their conditions makes them hugely important partners in managing their problems rather than being passive receivers of whatever the system bestows:

In the midst of winter  
I finally learned  
There was in me  
An invincible summer  
Albert Camus

Training in clinical hypnosis for health professionals is provided by the British Society for Clinical and Academic Hypnosis and you can start to use hypnosis for your patients after the foundation course consisting of only 3 weekends.

# Hypnotherapy for migraine: a pilot project

Patrick Browning *Clinical Hypnotherapist*

This article is a transcript from the Philosophy and Ethics SIG meeting from 2016.

I started to train as a clinical hypnotherapist 12 years ago after a career in law and finance. I consider myself very fortunate to have found such a rewarding and satisfying occupation in working with people in a way that helps them to change.

I undertook a pilot project on hypnotherapy in migraine after an Institute of Clinical Hypnosis teaching session on pain management, when I was looking for someone with a pain problem that I could use to help me to demonstrate an appropriate technique and it so happened that there was someone there with migraine – in fact they had a migraine at that moment. He was already well practised at going into a trance so I used glove anaesthesia which involved inducing numbness, or at least reduced sensation, in his hand, and invited him to put his hand on his head and spread the numbness to it. His pain was considerably diminished and remained diminished for the rest of the day.

A little after that, I was at a meeting of the Royal Society of Medicine where Dr Giles Elrlington, the medical director of the National Migraine Centre in Charterhouse Square, was giving a talk. I asked him if he had thought of using hypnosis for treating headache and migraine. He hadn't and we agreed to meet so I could tell him about it. He was initially sceptical but I was able to show him several articles on the subject (including the Review of the Efficacy of Clinical Hypnosis with Headaches and

Migraines by D Corydon Hammond (2007)) and he agreed that we could do a pilot project. There was no funding (they are a charity) but I was prepared to do it unfunded.

Migraine is more common than diabetes, epilepsy and asthma combined, so it is a big problem for the individual and for society. It has been estimated that there is a cost to the United Kingdom of £3 or £4 billion due to lost days at work or school. Once I started working with people with migraine, I discovered just how painful and awful it could be and how devastated they could be for quite long periods.

While the causes of migraine are still argued about by specialists, there are certain triggers which seem to be significant in setting off the neurovascular event that causes so much distress. We have usually found that a combination of triggers is more likely to bring on a migraine than a single one. These may include hormonal factors, especially in women, missed meals, lack of sleep and work stress. There is a potential for doing something about triggers using hypnosis.

## **The National Migraine Centre Study**

I wanted to compare working with groups and working with individuals in terms of outcome. So, we agreed that I would see three people one-to-one and have three groups of eight people whom I would treat essentially the same way,

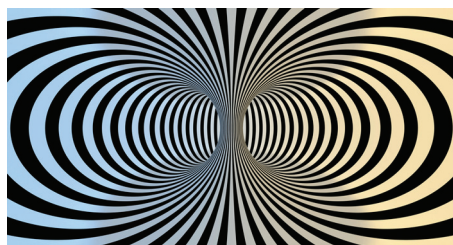
but in groups. They all had chronic migraine and were taking medication. One person dropped out, so there were 26 patients in all.

I was expecting to find that I would get more or less the same outcome in groups as I was doing already with individuals, as the techniques would be helpful for pain management generally and so applicable to all types of migraine. Treating people in groups was obviously much more cost-effective and there was a hope that someone in the National Health Service (NHS) would take some notice and treating migraine in groups would reduce the load on the economy.

I ran five 1-hour sessions at weekly intervals. The attendance rate was 88%. The participants were all given CDs to practise with and notes, and the intention was to teach them self-help techniques. I know that when I am working with clients, whatever I do, people are always going to feel better at the end of the session. But of course that is not enough. What we need is for the person with migraine to be able to take something away that they can use for themselves.

There is plenty of evidence that hypnosis can be helpful in pain management, so I knew I could help people diminish or manage their pain. I knew I couldn't cure or eliminate people's migraine, but I was hoping to reduce the frequency or the severity of their attacks, or perhaps a bit of both. I knew that hypnosis would help them with





Credit: Bonerok.

relaxation, so that was one of the first skills I was going to teach. It would help not only with stress reduction but also with motivation to better manage their lives, so the triggers were less likely to coincide and trigger a migraine.

I knew from previous experience that interaction between the members of the group would be helpful. Some people would come thinking, 'I'm not very comfortable in a group and I think I'll just sit very quietly and not say anything', but probably by the second session, they would be more open to the idea of joining in. So, in the first session, all I asked them to do was to say a little bit about their condition. What I wanted to get from them was first a sense that they were all sharing a common problem, and that what I was offering was a series of solutions, one or more of which was bound to fit them, perhaps in different ways. They said a bit about their migraine and how bad it was. There was one woman who had such severe nausea and vomiting that she was beginning to get dangerously underweight. There were others for whom migraine had become a daily occurrence. There were some who didn't seem to be helped by their medication. The triptans that are prescribed for migraine have only about a 50% success rate.

I would then talk a bit about hypnosis. Most of them had never experienced hypnosis and required explanation, reassurance and encouragement. Then, I would give them some experience of it using a group relaxation approach.

I asked them to keep a migraine diary and measure how bad things were on a

0–10 scale. In the second and subsequent sessions, I would go round the room and ask them what had happened since the previous session so we were getting some kind of progress report. Then, I would teach them one or more self-help techniques. I was hoping that at least one person would say, 'I've tried what you suggested and haven't had a migraine since!' – so someone who hadn't had any benefit might think, 'well, it helped her so maybe if I give it another go it will help me'. So, the group effect was to encourage people to put a bit of effort into the self-help techniques. And that went well. The one-to-one sessions also went well, and there was no significant difference in outcome between the two groups.

### Self-help techniques

First, self-hypnosis, which I teach to practically every client I see. I know they are going to find it useful: if they don't use it indefinitely they are bound to find it helpful in the short term even if it only gives them 10 minutes of relaxation they wouldn't otherwise have. I gave them a CD which would make it easier for them and when they first tried self-hypnosis all by themselves they could be sure they were doing it right, and that it was working; they could recognise the sort of state they went into during the session. They might not be able to go very deeply into hypnosis but that would come with practice.

In subsequent sessions, I would teach them dissociation for pain management. The principle of this is to enable the person to think of their body being 'here' and their mind being 'there'. The pain message just becomes less relevant. They don't feel 'here I am suffering' as they are 'somewhere else', separate, different: close enough as necessary but far enough away that they don't have to pay so much attention to the pain. I suggest that they should have a cue word which they can use to get into that

dissociated state without to elaborate a preamble, and then float away from their body. But that needs quite a lot of practice.

Master control room imagery is something we use a lot in hypnosis. We imagine a master control room in the brain where we control everything that is going on in our body. You go and visit it and see screens and dials and a technician or two in white coats, and you discuss with them what little changes could be made so that whatever it is could be less significant.

Symptom imagery can be very helpful: you imagine what your symptom could look like or feel like, and then have a dialogue with it, perhaps becoming your symptom and looking back at yourself. This can provide a new perspective on what is going on, and whether changes in your lifestyle could help you to relieve the symptom. Is the symptom telling you something? – perhaps that you are working too long hours or whatever? We can often help people to avoid triggers. For example, people often get migraines at weekends; the reason sometimes is that their sleeping patterns are different: they lie in and change the pattern of their day. So avoidance of triggers using self-hypnosis can motivate you to do whatever you have to do differently.

### Stress reduction

I taught three techniques for stress reduction: with worry time you make a note of your worries and set a time, perhaps 5 o'clock, when you are going to deal with the worry. If you forget about it when the time comes, that's fine because it's no longer a worry, but if you do need to deal with it, you can save the rest of the day from being dominated by worrisome thoughts.

Internal voice tempo change is a very interesting technique. You know how an anxious thought can go round and round in your brain? If you ask someone if that is at the speed of a normal conversation



Credit: Paula Connelly.

or faster, the answer is always faster. So you get them to say their anxious thought slower and slower and notice how it feels different. So then they can gain control of that thought, because they have established that it's not so powerful and they can simply feel different about it.

Bilateral stimulation is based on EMDR (Eye Movement Desensitisation and Reprocessing) and is a very simple technique to teach people to deal with emotional overload. I use it in at least half my clients and it's helpful 19 times out of 20.

## Outcome

The Medical Director of the National Migraine Centre wanted me to use HIT-6 (Headache Impact Test) to measure outcomes. This is a series of six questions to which you answer never, rarely, sometimes, very often or always. The questions are as follows:

- When you have headaches, how often is the pain severe?
- How often do headaches limit your ability to do usual daily activities including household work, work, school or social activities?
- When you have a headache, how often do you wish you could lie down?

- In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?
- In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?
- In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

The problem with the first three questions as I saw it, and as was proved by the answers we were getting, was that if you answer this questionnaire before you start, after you finish the course, and three and six months later, not having the preamble 'in the past 4 weeks' seems to suggest that these question could mean 'in my entire life experience.'

The following are the outcome scores for the pilot project:

HIT-6	Before	After	3months	6months
$\Delta$	66.4	62.6	61.1	62.7
		3.7	5.2	3.7

The range of scores for HIT-6 is 36–78, so as you can see from the 'before' score, this was a group that was seriously affected by migraine. At the end of the 5-week course, it went down by 3.7 with a further fall at 3 months and a small rise at 6 months. So, we had a notable improvement. Although these may not look like very big changes, they are statistically significant. Other measures we used were MYMOP (Measure Yourself Medical Outcome Profile) and EQ5D (EuroQol five dimensions questionnaire). What I wanted to use was the migraine days and peak severity score. We did measure that and got improvement at the end of

the course and at 3 months but it was not sustained at 6 months. If I was doing this project again, I might suggest monthly follow-up sessions to keep people on the straight and narrow, as I suspect some people were no longer using the techniques.

I also asked them for qualitative comments and these were very revealing. One of the questions we asked was 'Would you recommend hypnotherapy to other people with migraine?' Out of 26 people 25 said, 'Yes' (regardless of how well they had done).

Sadly we haven't been able to raise funding to do a proper RCT, but I am using the same techniques with other migraine sufferers. I didn't include glove anaesthesia in the group treatment because I thought it would be difficult in that setting, but I did use it in two out of the three one-to-one people and they rated that intervention very highly.

There is a lot of variation in what people call a headache or a migraine, but as far as I am concerned, this is a person in pain and with other problems, and I am offering self-help techniques which can be just as helpful with tension headaches as migraine. Giles Elrington and I hoped that this approach would be ideal for people with medication overuse headache as they could come off all their medication for a period and use self-help techniques to fill the gap. But we haven't yet been able to put this into effect.

For more information, please visit the following links:

- <http://www.nationalmigrainecentre.org.uk>;
- <http://www.browning-hypnosis.co.uk>;
- To learn self-hypnosis, go to the Apple App Store and search on Patrick Browning.

# Designing and delivering an intensive Pain Management Programme

Diana Dubash *Psychology Placement Student, BSc Psychology, Brunel University London*

Sarah Sherwood *Psychologist*

Rebecca Pardoe *Physiotherapist*

Lynne Harrison *Nurse Specialist*

Dr Atika Kabeer *Consultant in Pain Management*

*City Hospital Pain Management Service, Sandwell and West Birmingham Hospitals NHS Trust*

The Pain Management team at City Hospital, Birmingham, deploys a multidisciplinary approach to the management of chronic pain. One of their main interventions is a Pain Management Programme (PMP). The PMP is designed to help enhance a patient's quality of life by encouraging the return to normal daily activities. This may include a focus on self-care, increasing mobility, a reduction of analgesia and the health care services. It draws upon the cognitive-behavioural model, aiming to educate patients and consequently produce a behavioural change.

City Hospital's usual PMPs have a 10-week duration, with the group attending for 2.5 hours per week. During these 10 weeks, they cover a variety of psychological, medical and physical topics related to chronic pain. Some of these include the medical reasons for experiencing chronic pain, as well as the impacts of your psychological well-being on persistent pain. Sleep hygiene and medication are discussed, and the patients visit the gym with the physiotherapists in order to learn new exercises to manage their pain. This year, the team at City Hospital has successfully acquired charitable funds in order to run a new intensive Pain Management Programme (iPMP), in a bid

to make the service available to those patients who require an iPMP. At present, there are no ongoing iPMPs in the West Midlands, and residential programmes, located in Bath, Wales, Liverpool and London, are inaccessible for many of our patients. Therefore, it is hoped that this iPMP will succeed in filling a niche in the market and will benefit many patients living in the West Midlands area.

There is strong research support for the use of iPMPs; Angst et al.<sup>1</sup> and Artnet et al.<sup>2</sup> found that iPMPs have significant improvements in short-term results, pain intensity and functionality when compared to a standard PMP. Oslund et al.<sup>3</sup> found that iPMPs are effective when you use a multidisciplinary approach; by incorporating a variety of strategies, you can improve the overall outcomes of an iPMP compared to a normal PMP. The age of the patient can affect the clinical effectiveness of iPMPs. People attending iPMPs tend to be younger than those attending a normal PMP and consequently are more likely to be affected by psychological problems. As a result, it is essential that iPMPs have continued psychological input in order to maintain low levels of emotional distress.<sup>1</sup> The average age of a patient attending a PMP falls between 50 and

55 years; however, the average age of patients attending the iPMP was 43 years; and 50% of patients attending were below 35 years. This is one of the reasons why there is a stronger psychological emphasis placed on the iPMP than the regular PMP; cognitive therapy was present in almost every session delivered, and it therefore became a core component of the iPMP.

The team who organised and executed this new iPMP included Dr Atika Kabeer, Consultant Anaesthetist; Dr Sarah Sherwood, Health Psychologist; Dr Anna Everatt, Clinical Psychologist; Rebecca Pardoe, Lead Physiotherapist; Paul Rees, Senior Physiotherapist; Lynne Harrison, Lead Nurse; and Sarah Benham, Senior Sister.

The main aims of the iPMP were increasing the number of contact hours, gaining an increase in intensity. Providing vocational rehabilitation for the patients as returning to work is a key element to an increase in quality of life, and finally, gaining a decrease in reliance on the medical model. These aims come in addition those set out by the British Pain Society: improving physical, emotional and social health of chronic pain patients; improving participation in daily activities; and pain reduction through behavioural changes.<sup>4</sup>

The team decided to hold the programme every Monday, Wednesday and Friday from 10 a.m. to 3 p.m. (including 1-hour lunch and two 15-minute breaks). The programme was delivered mainly at the Park Inn Hotel, West Bromwich; however, three of the Wednesday sessions were held at Portway, 'a centre of excellence for people with disabilities' in Oldbury.

### Measurements

In order to produce some quantitative data, the patients were asked to complete some measurements. These were divided into two categories: physical and non-physical. Physical measurements included four basic exercises set by the physiotherapists: sit-to-stand, arm elevations, step-ups and a timed 10-m walk. These allow the team to see how mobile patients were prior to attending the programme, and also to see whether the patient's mobility had improved during the programme and whether the techniques being taught were being put to use. The non-physical measurements used by the team came in the form of questionnaires. The GAD-7 (Generalised Anxiety Disorder – 7 Questionnaire) and PHQ-9 (Patient Health Questionnaire – 9) were used to measure levels of anxiety and depression, respectively. The CPAQ-8 (8-item Chronic Pain Acceptance Questionnaire) measured patient's levels of pain acceptance, and the PSEQ (Pain Self-Efficacy Questionnaire) measured levels of self-efficacy.

### Week 1

Week 1 of the programme was held exclusively at Park Inn. The first day was spent introducing the team members and patients, and setting some ground rules for the programme. Measurements were taken, and the difference between chronic and acute pain was explained. An explanation as to why people can suffer with chronic pain was also given.

The next 2 days were spent looking at accepting your pain, the benefits of exercise and any anxieties surrounding physical movement. Medication management was another important component of this week, and patients showed a great deal of interest in this topic. The patients were introduced to Tai Chi by an external instructor and Mindfulness by one of the psychologists, Dr Anna Everatt. At the end of the week, an 'expert patient' came to talk to the patients about her experiences with pain. Estelle Greenwood, a fibromyalgia sufferer, delivered an excellent and informative talk. She is a living example of a successful woman and mother who suffers with chronic pain and this was very useful for patients.

### Week 2

Week 2 began with an introduction to pacing; perhaps, the most commonly used word among professionals working within a chronic pain ward. Patients seemed ambivalent about the idea of pacing at first, but towards the end of the programme, many had begun to put its teachings into practice. There was a heavy psychological focus placed on week 2 of the programme, with talks being delivered regarding barriers to pacing and cognitive distortion, stress management, thoughts and feelings, and sleep and relaxation. Grasping the basic components of psychology proved harder for some patients, as they had regimented medical ideation surrounding their pain. However, towards the end of the week, these patients began to show signs of a deeper understanding that chronic pain is not purely a medical issue, and it in fact has a variety of psycho-social stressors. Goal setting was another important element, and patients responded well to the idea of SMARTY goals. SMARTY goals are Simple, Measurable, Achievable, Realistic, Timed and Yours. With a little encouragement from the team, patients

were able to produce individual goals which served as something positive to aim towards after the programme had ended.

### Week 3

Week 3 saw the start of the vocational rehabilitation element of the programme. External visitor's occupational therapists from Wolverhampton, Ian Connell and Kay Millinchip, came in and talked to the group about any obstacles to getting employment and helped work through some individual problems patients had. This topic continued for the whole day. Later on in the week, Rebecca Pardoe, physiotherapist, delivered a talk on the anatomy, pathology and posture. With the help of diagrams and medical models, she was able to explain a plethora of conditions and why they are caused. Patients were very keen on asking about their own pain, and they made full use of this opportunity. On Friday, the team held a 'Friends and Family' day. Here, patients attended with a family member or friend, and the psychologists led the activities on this day. They aimed to highlight the difficulties of living with a chronic pain sufferer to the patients and the difficulties of living with chronic pain to the carers. Towards the end of the day, Dr Sarah Sherwood took the family members aside and held a brainstorming activity regarding being a carer for a chronic pain sufferer. Dr Anna Everatt stayed with the patients and led a talk about pain behaviours. The final activity was an 'expert panel' where the patients and their family members could ask the team members questions regarding chronic pain. All team members attended this session, and having access to professionals from different backgrounds in one setting proved very helpful for the patients.

### Week 4

The final week of the programme started with another vocational rehabilitation day. The occupational therapists, Ian



Connell and Kay Millinchip, returned and led the morning session. In the afternoon, the team was joined by three organisations: Remploy, Sandwell College and the NHS volunteering services. A small 'market-place' was set up by Paul Rees, physiotherapist, which enabled patients to talk to each organisation individually. Many patients found this extremely useful and have continued to liaise with the organisations in order to make efforts to return to work. The final day was spent recapping the events of the previous weeks and ensuring an understanding of the key messages of the programme by all patients. Measurements were taken again, and the day drew to an end with a discussion of the future. Telephone reviews were to be held with the patients a few weeks after the end of the iPMP, and the group was set to meet again for the final time for a formal review session. This review will be held in January, and here we can see whether the patients were able to self-manage their pain as effectively as they were doing while attending the group.

### Portway sessions

Portway Lifestyle Centre, Oldbury, is a leisure centre that can offer expert help to clients with specific health problems. The physiotherapists, Paul Rees and Rebecca Pardoe, decided to use the facilities at Portway, as they would be able to introduce the patients to a variety of interventions to help reduce the fear associated with physical strategies and to help manage their pain. During the three Wednesday sessions at Portway, the patients were introduced to Hydrotherapy, using the gym equipment effectively, and Tai Chi. Patients were encouraged to try every activity, and many patients attended Hydrotherapy more than once.

While a few patients were conducting some sort of physical activity, the remainder of the patients were able to attend either a Medication or Psychology review. During the medication reviews, either Sarah Benham or Lynne Harrison would speak to the patient individually about their current medication. Here, the patient could report any side effects or concerns they had with their current analgesia and request a change in medication. In a few cases, patients began to reduce dependency on certain analgesia.

The psychology reviews gave Dr Sarah Sherwood and Dr Anna Everatt a chance to explore the effects of the group on patients individually. Here, patients were able to express their views about the group and raise any concerns. Patients were asked whether they were struggling with anything during the group, and many had external problems that were negatively impacting their performance on the group. Having time away from the rest of the group was very important for some patients, as it gave them the opportunity to explore possible psychosocial stressors negatively impacting their pain with confidence. Research conducted by Oslund et al.<sup>3</sup> shows that psychological intervention is needed in order to maintain low levels of emotional distress in patients attending a PMP and during review sessions.

### The results

There was an overall increase in the physical measurements. A 69.2% increase was present in the sit-to-stand, a 76.9% increase in arm elevations and an 84.6% increase in step-ups. Also, 61.5% of patients had a decrease in the time it took them to walk 10m.

The results of the questionnaires before and after the programme were also positive. With regard to the GAD-7

and PHQ-9, there was a 53.8% and 69.2% decrease in anxiety and depression scores, respectively. Self-Efficacy had increased by 84.6%, and Pain Acceptance had a 69.2% increase.

This pilot has proved that the iPMP was successful in improving patient's immediate functionality and mobility; however, with further research, it will become clearer whether an iPMP has any long-term benefits which outweigh those produced by a normal PMP. Following evaluation of the project, and its success, the plan is to disseminate results to commissioners in order to secure permanent funding, rather than using charitable funds. Until funding has been decided, members of the Pain Management team will reflect upon the way to incorporate elements from the iPMP into the standard PMP, with the hopes to encourage many more patients to get back into work.

The team thoroughly enjoyed delivering this iPMP and will welcome another chance to run it in the future. They found that it has not only enhanced their knowledge of more iPMPs but also enriched their professional careers and given them an excellent opportunity to develop invaluable skills.

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**SAGE**

# New members ratified since December 2016

Name	Current post	Place of work
Dr Rhona McGurk	Clinical Psychologist	St Mary's Hospital, Portsmouth
Mr Nicholas Attaway	Clinical Nurse Specialist, Pain Management	Princess Royal Hospital, Brighton
Dr Rob O'Donnell	Specialty Registrar	Glasgow Royal Infirmary
Dr Andrew Whelan	Anaesthetic Trainee	Bradford Royal Infirmary
Dr Sara Wasson	Lecturer, English and Creative Writing	Lancaster University
Dr Polly Ashworth	Clinical Psychologist	Gloucestershire Royal Hospital
Ms Monika Halicka	PhD Research Programme	University of Bath
Mr Ziheng Liew	Band 5 Physiotherapy	University Hospital Coventry
Dr Sangram Patil	ST5	Ysbyty Gwynedd
Mrs Jennifer Wright	Acting Senior Nurse	Harefield Hospital