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PAIN NEWS

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Andreas Achenbach: Clearing Up, Coast of Sicily 1847. Public Domain

Patients and patience in the time of Corona

Curing and Healing

Is cannabis useful for pain?

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Encountering a history of child abuse in a Pain Clinic

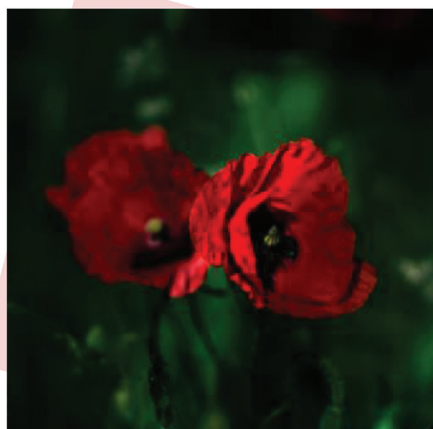
How do we manage suicidal patients?

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Remembrance and loss in the time of corona

Rajesh Munglani



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Salus populi esto suprema lex

Let the health of the people be the supreme law **Cicero**¹

Christmas 2019 almost seems a lifetime away. Very few of us indeed would have had any inkling of what would then subsequently envelop our world. On 12 December 2019, health officials started seeing an unusual viral pneumonia in Wuhan City, the capital city of Hubei province in China.² Wuhan is considered the political, economic, financial, commercial, cultural and educational centre of Central China. Wuhan is a major transportation hub, with dozens of railways, roads and expressways passing through the city and connecting to other major cities. Because of its key role in domestic transportation, Wuhan is sometimes referred to as the 'Chicago' of China.

The common feature reported among those patients with the viral pneumonia was that they had all visited Huanan and the seafood wholesale market which is close by the Virology institute.³ On 30 December, Dr Li Wenliang, an ophthalmologist, alerted his fellow doctors to a new disease which bore similarities to SARS and he advised his colleagues to wear protective equipment. He was initially severely admonished by the Wuhan police on 3 January 2020 'for making false comments on the Internet' but subsequently his

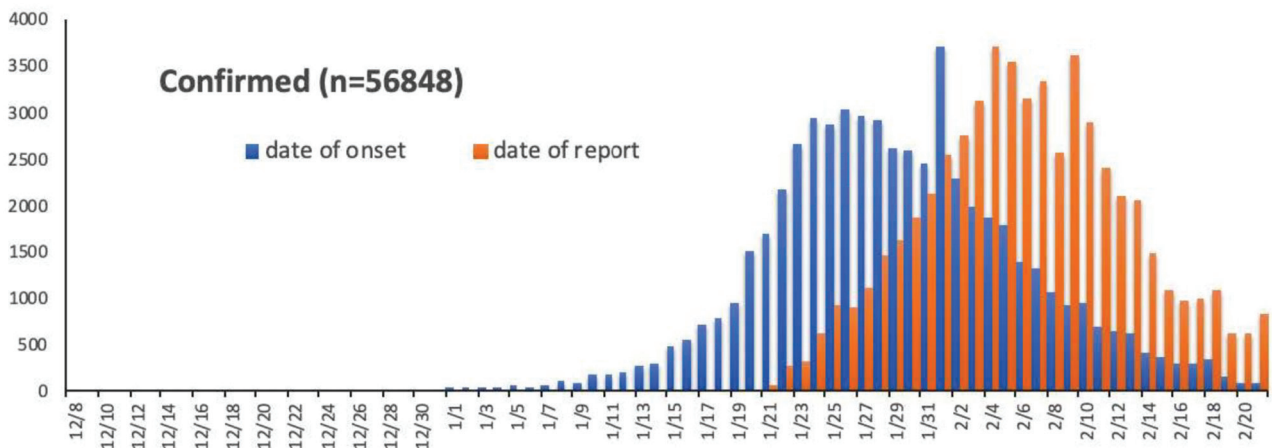
concerns proved fatally correct. He died on 7 February 2020, at the age of 33 from the new disease that he had tried to warn his colleagues about.⁴ Posthumously, he was given a solemn apology by the Government of the People's Republic of China.⁵

On 18 January 2020, Imai et al published a paper entitled 'Estimating the potential total number of novel Coronavirus cases in Wuhan City, China'.⁶ Imai and his colleagues estimated that by 12 January 2020 there were approximately 1,723 cases in Wuhan city. Zhu et al published their paper on 24 January 2020 in the *New England Journal of Medicine* (NEJM) identifying a novel Coronavirus, different from both MERS-CoV and SARS-CoV, two other previously known deadly coronavirus types.⁷ On 16–24 January, the report of the World Health Organization (WHO)-China Joint Mission on Coronavirus Disease 2019 (COVID-19) was published, indicating that based on 55,924 laboratory confirmed cases, the typical signs and symptoms of this novel Coronavirus included fever (90%), dry cough (70%), fatigue (40%), sputum production (33%), shortness of breath (20%), sore throat (15%), headache (15%), myalgia or arthralgia (15%), chills (10%), nausea or vomiting (5.0%), nasal congestion (5%), diarrhoea (5%), hemoptysis (1%) and conjunctival congestion (1%).⁸ Since then, Giacomelli et al.⁹ noted the loss of taste and smell in one third of infected patients.

Subsequently, by 25 January 2020, the Chinese government imposed travel restrictions on 56 million people in the surrounding region. By 30 January 2020, 170 deaths were reported and the WHO declared coronavirus a global emergency. On 11 February, the WHO named the disease COVID-19. Between 8 and 10 March 2020, a lockdown of Lombardy in Italy was extended throughout Italy. However, it took until 11 March 2020 for the WHO to declare the Coronavirus outbreak as a pandemic. On that day Madrid, Spain closed all educational establishments and on 12 March 2020 Italy closed all shops. France followed suit on 16 March 2020. On 12 March 2020, the UK Prime Minister warned the people of the United Kingdom that 'many more people will lose loved ones to Coronavirus'.¹⁰

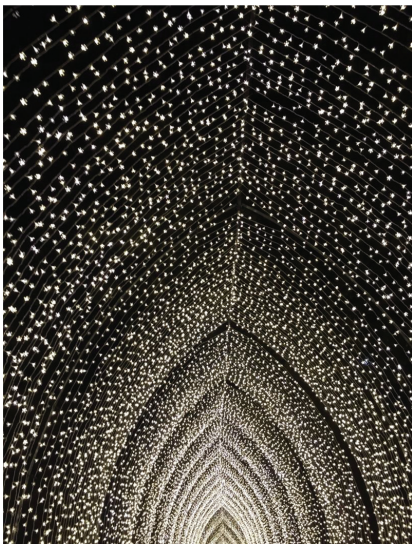
On 13 March 2020, Sir Patrick Vallance, Chief Scientific Advisor to the Government, mentioned the benefits of

Figure 1. Epidemic curves of laboratory-confirmed cases, by symptom onset and separately by date of report, at 20 February 2020. The epidemic rapidly grew from 10 to 22 January, reported cases peaked and plateaued between 23 and 27 January, and have been steadily declining since then, apart from the spike that was reported on 1 February (note: at a major hospital in Wuhan, fever clinic patients fell from a peak of 500/day in late January to average 50/day since mid-February). From previous studies⁷. Copyright free from the WHO.



creating 'herd immunity'. By 16 March 2020, Ferguson et al from Imperial publish their paper on the likely death rates in the United Kingdom and the United States, suggesting 500,000 deaths in the United Kingdom and 2,200,000 deaths in the United States if suppression and mitigation strategies were not introduced.¹¹ By 23 March 2020, the United Kingdom introduced containment measures.

It is not the purpose of this writer to scrutinise or indeed to excoriate the decisions and their timings made by various



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governments throughout the world in trying to deal with this novel epidemic. No doubt there will be much soul searching and investigation at some point of future reflection, but for now, at this time we will continue to remember Dr Li Wenliang and all of humanity who have been so affected by and died from this terrible disease, and here and now in the United

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Kingdom we will especially honour those National Health Services (NHS), care home and other key workers, our brothers and sisters, our friends and colleagues who put themselves in harm's way to help others. **We will remember them**

'When you go home, tell them of us and say,

For your tomorrow, we gave our today'

The inscription on the Kohima Memorial, made of Naga stone to commemorate the Allied dead. John Maxwell Edmonds (1875–1958)¹²

Do not hurry

as you walk with grief

It does not help the journey.

Walk slowly, pausing often.

Do not hurry

as you walk with grief.

Be not disturbed

by memories

that come unbidden.

Be gentle with yourself.

Walk slowly, pausing often.

Take time.

Be gentle as you walk

with grief.

Adapted from 'Walking with grief' Celtic Daily Prayers and Reading from the Northumbria Community New York: HarperOne, 2002.

The effect of this Coronavirus on routine NHS patient services has been catastrophic as the NHS braced itself for the pandemic. Previously already overstretched routine clinical services have been simply shut down as resources and staff were diverted to prepare for the feared approaching tsunami of patients who would be suffering from respiratory failure and who would therefore require intensive care.

Pain Services have also been significantly affected as many of the healthcare professionals involved in the

treatment of pain are also routinely trained in Anaesthetics and Intensive Care and therefore were highly sought after in the current pandemic. This diversion of skilled personnel and resources from existing Pain Services, stretched at the best of times, has meant such 'elective' Pain Services have effectively been mothballed as resources and staff have been diverted to dealing with those patients severely affected by Coronavirus.

Ironically on 6 February 2020, before the United Kingdom felt the impact of the now named SARS-Cov2 virus and the clinical syndrome of COVID-19, Dawn Connelly writing in the Pharmaceutical Journal described the delays that patients were already having in accessing specialist pain services.¹³ She noted that the previous International Association for the Study of Pain (IASP) task force recommendations of 2009 were simply not being met. The 2009 IASP recommendations suggested a maximum wait of 8 weeks for persistent long-term pain without significant clinical progression, while urgent and semi-urgent patients in pain should be seen within 1 week to 1 month.¹⁴ Using a statutory Freedom of Information request, she established that some patients in the United Kingdom waited years to receive treatment, see Figure 2.

In her article, Connelly quotes Dr Lorraine de Grey, a Pain Consultant at Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust in Norfolk and current Vice Dean of the Faculty of Pain Medicine at the Royal College of Anaesthetists, who said: *My experience of seeing patients in the Pain Clinic is that it has been a long, long time before they actually get there. And a lot of them have lost faith in the medical profession by the time they do.*

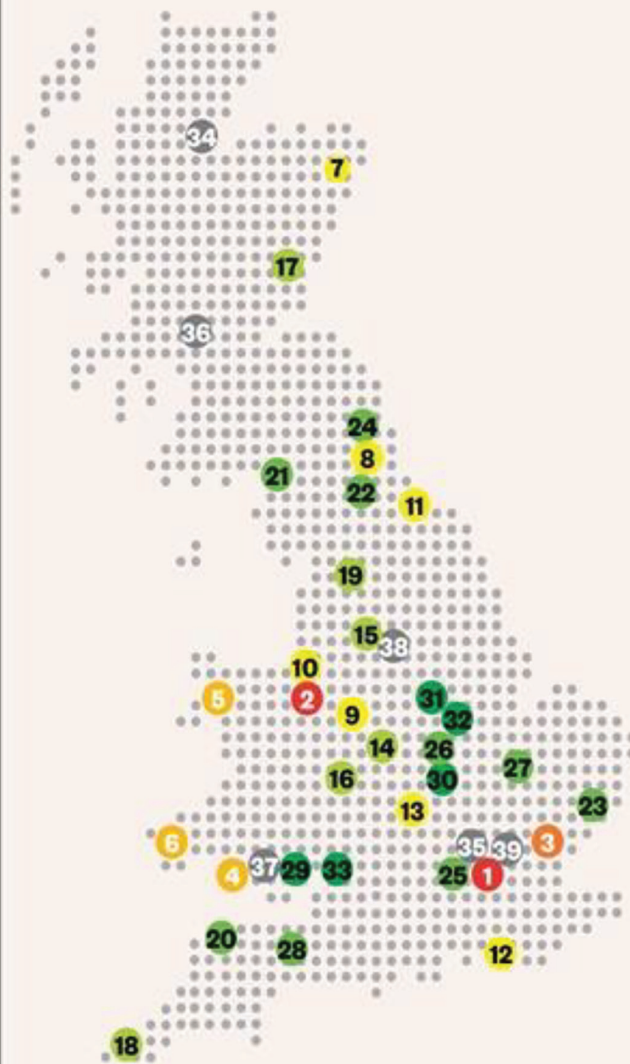
Indeed, the literature supports the Vice Dean's view. Lynch 2008 et al found that waits of over 6 months from the time of referral to treatment for chronic pain are associated with deterioration in health related quality of life (HRQOL) and a reduction in psychological well-being with an increase in depression scores. They concluded that wait-times for chronic pain treatment of 6 months or longer are medically unacceptable, but that they were unable to determine at what stage the deterioration began from the onset of pain to eventual treatment, and they were also unable to assess the impact of waiting on treatment outcomes.¹⁵ While studies of pain and disability outcomes as a function of time to treatment of the pain still remain to be determined, the clinical experience of many is that the longer one waits, the more entrenched and despondent patients become and their pain becomes more resistant to treatment, and are associated with poor functional outcomes and increased disability.^{16,17} In 1994, Cherny and Portenoy were quoting studies that 40%–50% of cancer patients were resistant to

Figure 2. Waiting times for Chronic Pain Services from GP referral to treatment in 39 centres across the United Kingdom 87% of those Pain Services who responded have waiting times greater than 8 weeks. NHS Highland waiting times were reported to be 40–112 weeks. Obtained under a FOI request from the Royal Pharmaceutical Society. By kind permission of Dawn Connelly, Snr Editor *Pharmaceutical Journal*.

Figure

Large variation in waiting times for chronic pain services across Great Britain

The majority of pain services (85%) that responded to a Freedom of Information request had an average waiting time of greater than the 8 weeks recommended by the International Association for the Study of Pain. Patients in England and Scotland have a right to start consultant-led treatment within 18 weeks of GP referral, whereas in Wales 95% of patients should be seen within 26 weeks and all patients within 36 weeks.



Source: Freedom of Information request sent by The Pharmaceutical Journal in November 2019.
* These trusts provided a range for the average waiting time

Pain management service	Weeks
1 Royal Free London NHS Foundation Trust	37
2 Countess of Chester NHS Foundation Trust	35
3 Mid and South Essex University Hospitals Group	27
4 Swansea Bay University Health Board	24
5 Betsi Cadwaladr University Health Board	22
6 Hywel Dda University Health Board	21
7 NHS Grampian	20
8 The Newcastle upon Tyne Hospitals NHS Foundation Trust	20
9 University Hospitals of North Midlands NHS Trust	19
10 The Walton Centre NHS Foundation Trust	17
11 University Hospital of North Tees	17
12 Brighton and Sussex University Hospitals NHS Trust	17
13 Oxford University Hospitals NHS Foundation Trust	17
14 University Hospitals of Derby and Burton NHS Foundation Trust	16
15 Calderdale and Huddersfield NHS Foundation Trust	15
16 Worcestershire Acute Hospitals NHS Trust	15
17 NHS Tayside	14
18 Royal Cornwall Hospitals NHS Trust	13
19 East Lancashire Hospitals NHS Trust	13
20 Northern Devon Healthcare NHS Trust	12
21 North Cumbria Integrated Care NHS Foundation Trust	12
22 County Durham and Darlington NHS Foundation Trust	12
23 East Suffolk and North Essex NHS Foundation Trust	12
24 Northumbria Healthcare NHS Foundation Trust	12
25 Ashford and St Peters' Hospitals NHS Foundation Trust	12
26 University Hospitals of Leicester NHS Trust	11
27 Cambridge University Hospitals NHS Foundation Trust	9
28 Taunton and Somerset NHS Foundation Trust	9
29 Aneurin Bevan University Health Board	8
30 Northampton General Hospital NHS Trust	8
31 Nottingham University Hospitals NHS Trust	8
32 Kettering General Hospital NHS Foundation Trust	7
33 University Hospitals Bristol NHS Foundation Trust	6
34 NHS Highland*	40-112
35 Whittington Health NHS Trust*	32-60
36 NHS Greater Glasgow and Clyde*	19-36
37 Cardiff and Vale University Health Board*	22-24
38 Sheffield Teaching Hospital NHS Foundation Trust*	14-22
39 Lewisham and Greenwich NHS Trust*	10-24

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treatment,¹⁸ a similar figure to the 40% quoted by Whitten in 2005, but now seemingly applied to all types of chronic pain.¹⁹ As a comparison, it is clear from other studies, for example, that survival rates in cancer are linked to HRQOL, that is HRQOL is predictive of outcome.²⁰ Such studies into the treatment of severe and intrusive chronic pain continue to be urgent, and importantly whether they change long-term outcome, in the mean time we note that prevalence of chronic pain in the general population is not reducing.

The diversion of the NHS resources to the wave of SARS-CoV-2 positive patients with Covid-19 disease has had a knock-on effect leading to, for example, the failure to diagnose early, and so effectively treat many unrelated healthcare conditions including cancers, where early diagnosis and treatment is closely associated with a good outcome. The current NHS laser-like focus on Corona to the exclusion of all else is something that will need to be assessed in the coming years. According to Drs Bakshi and Payling, there is evidence that non-Covid mortality may be rising, and in particular the failure to promptly diagnose and treat cancer symptoms may worsen the prognosis in the future.²¹

The future mental health consequences, both for patients and for health workers of the current crisis remain to be

determined, but this is considered to be a timebomb which will need to be assessed in due course. Jessica Gold, writing an editorial in the *British Medical Journal* (BMJ), stated that data from previous pandemics, particularly after quarantine, suggest that healthcare workers might develop symptoms of post-traumatic stress disorder, depression and substance use disorders. Preliminary data revealed that 50% of healthcare workers in China reported depression and anxiety, and insomnia developed in one third of cases. This is in addition to the high rates of pre-existing mental health and substance use disorders in health care workers, with doctors having the highest rates of suicide among any profession. Gold goes on to say that although evidence-based effective interventions and treatments for these conditions are available, barriers such as stigma and lack of time limit their uptake, even in normal times. Even less is known about interventions for the mental health of healthcare workers during pandemics.^{22,23}

The overall societal impact of Corona²⁴ is not only being felt and written about, but it does beg the question of what is important. If we don't treat most pain that is referred to specialist pain services during the time of Corona, do we need to treat it all? Here, we are not talking about cancer-related pain or acute sickle-cell crisis or trigeminal neuralgia



Danse Macabre of Basel, watercolour copy by Johann Rudolf Feyerabend, 1806 Historisches Museum of Basel. Public Domain.

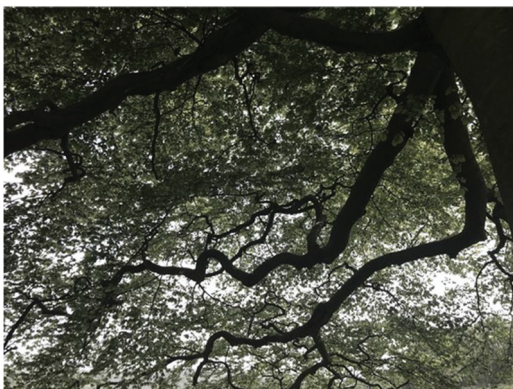
and acute complex regional pain syndrome (CRPS), but the burden of chronic musculoskeletal pain and chronic widespread pain that affects about 55% of the United States population at any one time²⁵. Fayaz et al.²⁶ came up with similar figures of up to 51% of the United Kingdom affected by chronic pain, with only 10%–15% of the population having severe pain. Nahin reported that 23% of the population suffer from pain in category 1, which is the least severe. But the rest, that is approximately one third of the population, suffer from category 2,3 and 4 level pain that are the more severe forms which are associated with increasing disability and physical impairment, and an increasing requirement to visit the general practitioner and specialist healthcare services. Feldman et al.²⁷ revealed that 12% of the US population attended medical services and 40% of them were prescribed analgesic medication, 20% were prescribed opioids and between 10% and 15% were prescribed physical therapy, counselling and non-pharmacological treatment.

There will always be an argument that some of these patients perhaps in the less severe categories could self-manage, but if categories 2, 3 and 4 represent one third of the population in a western world country, of which, say, half need a prescription or other active intervention, then the failure to effectively treat early 15% of the population might represent a significant increase in the ongoing suffering in people who cannot access such care and treatment.

What of the future?

‘Despite all our medical advances, the mortality rate has remained constant – one per person’²⁸

The presence of death creates a time of uncertainty, and in our insulated Western lives an untreatable pandemic causes us to question ourselves and our purpose. Warren Ward in his



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paper²⁸ stated that Aristotle saw all of existence, including human beings, as things we could classify and analyse so to increase our understanding of the world. In contrast Heidegger, in his book ‘Being and Time’ (1927)²⁹ argued that we should first ask the question: ‘*Who or what is doing all this questioning?*’ The Beings that are asking the questions are qualitatively different to the rest of existence: the flora and the fauna. His word for this ‘Being’ that asks, looks and cares, he named ‘*Dasein*’, which means ‘*being there*’. Heidegger hoped the use of this novel term would restore our sense of wonder about our own self-awareness.

Ward goes on to describe how, when he was studying medicine, his friend studied philosophy, and stated that the best thing we could do to appreciate life was to keep the inevitability of our death always at the forefront of our minds.

Ward then goes on to describe the top five regrets of the dying, published in 2011 by Bronnie Ware, a palliative care nurse.³⁰ These are given below, but rephrased for the current time as a question that we as ‘*Dasein*’ can ask ourselves and encourage our patients to ask themselves, as we may face an uncertain future:

- **Have I the courage to live a life true to myself, not the life others expected of me?**
- **Am I working too hard?**
- **Have I the courage to express my feelings?**
- **Am I staying in touch with my friends?**
- **Can I let myself be happier?**

Midway upon the journey of our life

I found myself within a forest dark,

For the straightforward pathway

had been lost.

Ah me! how hard a thing it is to say

What was this forest savage,

Rough and stern,

Which in the very thought

renews the fear.

Inferno, Canto 1 Dante Alighieri (1265-1321)

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Jenny Nicholas



This is the second issue of the new look *Pain News* and we'd love to know your thoughts on the changes we've made. Don't be shy! Feel free to drop us an email and let us know your thoughts, after all this is your newsletter!

This issue is filled to the brim with a range of articles across a real breadth of topics, from practical guidance in **'Managing a patient in pain clinic with suicidal ideation'** to philosophical questions in

'God and suffering: does a religious belief alleviate pain and suffering?' and professional perspectives.

- We have two articles this issue looking at medicinal cannabis and pain. The first by Mary Biles looks at **'Medical Cannabis – A Missed Opportunity for Managing Pain'** while Michael Barnes talks to us about **'Cannabis and Analgesia'**.
- **'Group Interventions for Chronic Pain: What Are the Active Ingredients? A Reflection on Change**

Processes' by Charlotte Langton discusses what is the effective factor in therapeutic interventions in relation to group-based interventions in chronic pain.

- Pain Concern talk to us about their project to develop and evaluate an intervention to overcome barriers to people with chronic pain getting support with self-management from primary care in their article **'A Pilot Evaluation of the Self-Management Navigator Tool to Enhance Communication in Primary Care Consultations About Chronic Pain'**.

However, first, we wish to take the time to remember a dear friend and colleague, Dr T K Hardy, former President of the Society who sadly past away recently at the grand age of 93 as we take a look at what was happening in the Society at the time of his Presidency.

Finally, these are unprecedented times for us all, and as such, we hope that you have had the opportunity to visit the COVID-19 resource page that we have introduced on the British Pain Society website: <https://www.britishpainsociety.org/COVID-19-Resources/>.

The September issue of *Pain News* will feature more articles relating to COVID-19; however, for now we'd love to know which articles have inspired you or helped your practice in this issue?

President's message

Arun Bhaskar



Dear Friends

We live in challenging times for Society and for our specialty. Words such as COVID-19/Corona virus/Lockdown/Social distancing were not part of my vocabulary when I was writing my last message here. Most of us have been involved in the battle to contain the spread of the pandemic by flattening the curve and reducing the R-numbers, but it involved being redeployed and moving away from our

commitment to pain medicine to take up roles as clinicians in anaesthesia, intensive care, A&E, medical wards and indeed the Nightingale centres. I would like to thank each and every one of you on behalf of The British Pain Society for stepping forward to take up the mantle to lead and support the COVID-19 relief efforts within the United Kingdom and beyond. I hope you have all returned or will return soon to your respective departments. We should feel pride in the support we have given our patients, our colleagues and the National Health Service (NHS) in managing the thousands of often severely ill patients in these challenging times.

It was been a difficult decision to defer holding the Annual Scientific Meeting (ASM) in March this year as planned, but with the wisdom of hindsight it has proven to be the correct one. However, the ASM and the membership fees are the two main income generating sources for the Society, and this has significantly impacted on our financial reserves. Our Hon. Treasurer, Dr Ashish Gulve, and other Council members had worked so hard in 2019 and their efforts had borne fruit to a point that we were on course to turn things around financially this year. We will start this process again of achieving financial stability. You will have noticed by now that most international meetings scheduled for this year had been postponed or cancelled and most of our study days and regional meetings have also been cancelled due to

social distancing guidance. The Education Committee under Prof. Sam Ahmedzai is looking at organising webinars and other online platforms and you shall be hearing soon about them. We had discussed about holding an ASM in November or December, but this was not deemed as suitable for a variety of operational reasons. The aim would be to use the same venue at a suitable date in 2021, and once we have confirmation, we shall be disseminating the information to you.

The British Pain Society wants to formally acknowledge the contributions made by our members and the wider fraternity involved in pain management, and to this end, we are discussing holding a meeting over 2 days sometime later in the year. The primary aim is to have a meeting to share our experiences of managing the COVID-19 crisis as well as a 'wind down' session from the stresses of this year and look at planning how to get things back on track. Since we are not having an ASM, it is also important to hold an Annual General Meeting (AGM) to take things forward into the next year as the proposed meeting would be covering that as well. Hopefully with appropriate support from you and industry partners, we should be able to have a good turnout. Like the rest of society business and health care, we are going to be increasingly reliant on digital technology for future meetings, some of which are certainly going to be 'virtual'; the Society is also exploring avenues to facilitate this for the benefit of its membership.

I had mentioned in my previous message here that my priorities for the year 2020–2021 is about the three Ps – Patients, Partnerships and Politics. I had the pleasure of sitting in a couple of virtual meetings as well as several other discussions with the Patient Liaison Committee, who are a group of patients who have vast amount of experience and have already started looking at projects that would enable our Society to have a wider reach among patients, carers and professionals. It was decided that the committee would be henceforth known as the Patient Voice, and indeed, it is a voice we as professionals should listen and have meaningful conversations to work together and take the Society forward into a better future. Mrs Stephanie Stevens as Chair of the committee has suggested a few

initiatives to consider and though understandably COVID-19 is the hot topic at the moment, the aim is to have a broader remit when developing their strategies. The Council and the Executives are fully supportive in having this engagement and you shall be hearing some local initiatives in the not too distant future.

The British Pain Society has been working closely with the Faculty of Pain Medicine in bringing out joint guidance relating to pain management during the COVID outbreak as well as guidance on pain interventions, use of steroids and re-starting of multidisciplinary services. We, along with the Faculty of Pain Medicine and Clinical Reference Groups for Pain Medicine are closely monitoring the plans from NHS England regarding the delivery of MSK services as well as having collaborative guidance for the use of steroids for pain interventions along with BASS (British Association of Spinal Surgeons). Both the much-awaited guidance for neuromodulation for pain management as well as the document on cancer pain management had been delayed due to the COVID-19 situation, and the aim is to get them back on track as soon as possible. It is also expected that the National Institute for Health and Clinical Excellence (NICE) guidance on chronic pain may be published later in the year. The scope of the guidance is all settings where NHS and local authority commissioned care is being provided and is about biopsychosocial assessment and management including pharmacological and non-pharmacological interventions for chronic primary pain (when pain management is not addressed by existing NICE guidance). This new NICE document will cover the management of chronic pain if not already covered by existing NICE guidance, for example, in managing chronic pain in headaches, low back pain and sciatica, neuropathic pain, rheumatoid arthritis, osteoarthritis, spondyloarthritis, endometriosis, irritable bowel syndrome and in pain associated with palliative care, and so, these conditions will not be covered by this new document.

The past few weeks have been difficult for many due to the changes we had to make to accommodate, abide by and to adapt to, to ensure that the pandemic doesn't get out of control. We lost three colleagues who were known to us recently who represented three generations of pain specialists. Dr Ken Hardy who was based in Bangor, North Wales was one of the founding members of the Intractable Pain Society, which later evolved into The British Pain Society and Dr Hardy was a former President of the Society. Dr Peter Toomey recently lost his battle to cancer, Peter was someone who always made an impression when you met him; I have several memories that show-cased Peter's multi-faceted talents. Dr Rajesh Gupta was starting his career as a consultant and had been performing COVID duties for his trust. He was tragically found dead and so we lost a colleague who had a very bright future ahead of him. People who knew them closely have already written obituaries – Dr Chris Wells (Dr Hardy), Dr Peter Hall (Dr Toomey) and Dr Mohjir Baloch (Dr Gupta). May the souls of the departed rest in peace. We remember them and those they leave behind.

This summer will be a period of some uncertainty as the shadow of the pandemic is yet to pass; the economic impact of the lockdowns, the political and social unrest in the United States and in many other countries and the fear of second wave of COVID-19 this winter or even before, once the restrictions are relaxed, are all factors over which we have very little control. As specialists working in pain management, we are going to face a deluge of patients who have been waiting or shielding all these months and it is imperative that we focus on re-starting our services running efficiently despite the adaptations stipulated to prevent the transmission of the virus. We shall also aim to resume the activities of the Society in the autumn. I look forward to meet you all soon and in time, to have once again the privilege to be able shake your hand and thank you for all that you have done in this time of Corona.

Remembering colleagues

The British Pain Society Pays Tribute to Dr Thomas Kenneth Hardy

The Society was saddened to hear of the death of Dr Thomas Kenneth Hardy, who passed away aged 92 on 13th April 2020. A founding member of the Society, Dr Hardy served as President of The Intractable Pain Society from 1989-1991 (later to become The British Pain Society in 2004) and helped to establish the multidisciplinary nature of the Society's membership.

Having gained his medical degree at Liverpool University and working as a GP, he travelled the world and worked with a team pioneering kidney transplants at the Peter Bent Brigham Hospital in Boston, USA. Settling in Wales, Dr Hardy or "Ken" to his friends, worked as a Senior Consultant Anaesthetist at Ysbyty Gwynedd District General Hospital in Bangor, Wales until his retirement.

With an interest in chronic pain, Dr Hardy set up a Pain Clinic in Bangor and believed that pain was more than just a symptom of a disease or injury and that it was a disease in itself that could be treated efficiently.

In his time as President, the Society developed key working relationships with representatives from the Nursing Profession, Basic Sciences and Clinical Psychology encouraging the inclusion of all healthcare professionals within the helped to created political awareness on issues relating to pain and in his final letter to the membership as President he stressed that

"the suffering of the patient in pain has a moral imperative even greater than the financial implication".

Under his leadership, the Society Council also helped establish links with other groups concerned with the welfare of pain patients, a key feature of the current work of The British Pain Society today in developing areas of research and development in all fields of pain with external organisations. After his presidency he was made an Honorary Member of the Society.

Friend and colleague Dr Chris Wells said: "Ken was a great friend and mentor to me in my early days in Pain Medicine, part of the Liverpool, Manchester, North Wales axis which often met up and shared ideas where we discussed difficult cases, awkward patients and deficiencies in service provision. He dealt out common sense wisdom and practical tips and he will be missed by his colleagues".

Paying tribute to Dr Hardy, Current BPS President, Dr Arun Bhaskar said: "We thank Dr Hardy for his involvement and time

with the Society and for helping to develop the collaborative multidisciplinary nature of The British Pain Society in tackling all issues related to pain management and furthering understanding around chronic pain. On behalf of the Society, I send my deepest condolences to his family at this time".

Dr Hardy was a keen admirer of the Welsh language and also supported and worked with other charities during his life, including the Samaritans.

The British Pain Society Pays Tribute to Members Dr Rajesh Gupta & Dr Peter Toomey

The Society was also saddened to learn of the deaths of members Dr Rajesh Gupta & Dr Peter Toomey.

A member of the Society since 2008, Dr Gupta passed away on the 25th May 2020. He had been recently appointed to a substantive post at Wexham Park Hospital after having completed a period as a locum consultant at Frimley Park Hospital and was working on the frontline in the fight against Covid-19.

Rajesh was an outstanding clinician and had a passion for the practice of pain medicine and authored books in both pain management and regional anaesthesia. He was a faculty member for the University of East Anglia regional anaesthesia course.

In his spare time, he was a gifted poet, painter, photographer and avid cook with a love for Bollywood films. He is survived by his wife Gitika and their 12-year-old son, Rahan.

Longstanding BPS member Dr Peter Toomey passed away on the 11th May 2020.

Peter worked as a consultant in anaesthesia and pain medicine at York Hospital where he had been since 1995 after working as a consultant at Stoke Mandeville Hospital and as an assistant professor at Oregon Health Sciences University.

Peter was active in improving pain services both locally and nationally and was on the organising committee for the Neuromodulation Society of UK and Ireland and was the local organiser for the British Pain Society Meeting in York. In his later years as a consultant, Peter became a tutor for medical students at Hull York Medical School as well as an instructor on national and international cadaver-based pain intervention courses.

In his spare time, he enjoyed flying and sailing. He is survived by his wife, Anna and their three sons Luke, Robert and Ed.

With thanks to William Campbell, Arun Bhaskar, Mohjir Baloch, Raj Munglani, Bernard Nawarski and Chris Wells for their contributions.

Integrating the art of healing with the science of curing

Paul Dieppe *Emeritus Professor, University of Exeter and University of Bristol*



In Search of Medicine. За лекарством Vladimir Makovsky. 1884; Russian Federation. Tretyakov Gallery, Moscow, Russia.ⁱ

Vladimir Yegorovich Makovsky (Russian: Влади́мир Егорович Мако́вский; 26 January (greg.: 7 February) 1846, Moscow – 21 February 1920, Petrograd) was a Russian painter, art collector and teacher. Makovsky was the son of collector, Yegor Ivanovich Makovsky, who was one of the founders of the Moscow Art School. Vladimir had two brothers, Nikolay Makovsky and Konstantin Makovsky, and one sister, Alexandra Makovsky, all of whom were famous painters. Vladimir studied at the Moscow School of Painting, Sculpture and Architecture. He finished his studies in 1869 and the following year became one of the founding members of the Association of Travelling Art Exhibitions, where his many years of prolific work brought him to a leading position.ⁱⁱ

Introduction: we live in two different worlds

Health care professionals today seem to be living in two separate worlds: at work we have our very clear scientific one, with its protocols and guidelines, while at home we cope with our messy set of everyday human experiences. Our working lives are dominated by materialistic positivism, with its belief in absolute truths, reductionist scientific experimentation and the 'god' of science (scientism). In contrast, our personal lives include religious and spiritual beliefs, the experience of strange phenomena that we cannot explain, such as our sense of love and beauty, as well as intuition, and the central richness of connectivity with others and with nature. Many of us experience some form of paranormal event, or 'noetic' moments (noetic – from 'gnosis' – insight into what it is to be human): those moments of sudden understanding of the connectivity of the whole universe and our connection to it; or those moments of pure, perfect joy and delight. These are very real and powerful experiences. But within our rigid scientific and medical worlds, they get dismissed as nonsense.

Our research project on healing

The project described here, that my colleagues and I are working on, is in part trying to find bridges between these two worlds. We are trying to understand what the strange phenomena of healing are about, if we should incorporate them into our scientific approach to medical practice, and if so, how. We are not anti-scientific – the science of medicine has been fantastic in many ways – but it's not always helpful for things like chronic disease, or general 'dis-ease' and distress. Healers take a different approach and feel that anyone can be helped by healing, whether there is anything 'wrong' with them or not. We believe that we may need to integrate the modern science of curing with the art of healing, which has been around for a lot longer.

My own ideas about what healing is, and the difference between healing and curing, are evolving all the time; my present position isn't in any sense final, it's a part of my journey of understanding; the views below were my ideas as of 2019, they may be different next year.

The difference between curing and healing

Curing is the province of modern biomedicine. It is about dealing with ‘abnormalities’ of body or mind. Western medicine is driven by an obsession with pathological processes, and the need to get rid of them to restore the body and mind to a state of ‘normality’. We assume if you’ve got pain or some other symptoms, there must be something causing it that we can detect (diagnose) and alleviate or get rid of with our drugs, surgery and devices that attack the pathology (treat or cure).

Healing is completely different. First, it is not just about body and mind, it involves our spirituality and ‘soul’ as well. It is about a journey to a state of integrity and harmony of all aspects of our being.

'Soul' or spirit are difficult concepts for many – but consider two situations that I have witnessed. First the person with severe dementia – their minds, memories and reasoning by which they previously defined themselves have gone, but the essence of who they are is still there. Media such as music or pictures can still allow contact with that person, and with the essence of who they are – their 'soul' is still intact. Second, consider the experience of severe post-traumatic stress disorder (PTSD), which is something I have had. While ill you feel dislocated, incomplete and distanced. A soldier who had also suffered explained to me that this was 'soul separation' and as he said that I immediately understood, and agreed. ('Soul separation' is a concept prevalent in many societies, and some shamanistic healers regard it as something they may be able to help with.) When I recovered, one of my patients, who had been seeing me on and off for years, came into the consulting room, took one look at me and said 'oh good, the lights are back on' – I was no longer separated from my soul, I had healed.

You can die healed, or be in chronic pain but healed. There are many definitions of healing, a word that can be used as a noun, an adjective or a verb, and definitions may be inappropriate. But an approach taken by Thomas Egnew is one that I like; he says that healing is 'transcending suffering'. But healing is also an experiential issue rather than a 'thing' that can be examined by reductionist science. I have been fortunate enough to have experienced healing in both directions; both of having a painful physical ailment of my own relieved by healing and also the weird experience of (under instruction) healing a horse with a gastrointestinal complaint. These were 'noetic' experiences of a sort that I cannot dismiss. You cannot go back or deny such things after these experiences; you have to incorporate them into your way of thinking about the world.

People's views on the nature of healing

Our interdisciplinary research group has been exploring what people think healing is in a variety of different ways, using qualitative research methods within a phenomenological framework. Here I briefly summarise some of the techniques we have used and what they have revealed. Most of this work is published in articles with the first author being myself or my colleague Dr Emmylou Rahtz.

Provide a single key word related to healing

One of these involves a simple procedure: we ask people to write down the one word that they think is most important in relation to healing. We have done this with both health care professionals and members of the public, and the results are much the same. The word cloud below illustrates the most commonly used words – love, acceptance, compassion, nature, trust, balance and presence.



Tell us your healing story

Another research technique we use is to ask people to write stories about their healing experiences. We often encourage these stories to be short, providing just a small postcard, for example, to try to help people get to the essence of the thing. These stories are usually about *change for the better*. They are not about being cured, or being rid of symptoms like pain, they are not about returning to normal – they are about becoming a different person, and one who is able to function fully. Healers describe themselves as the facilitators of these changes. Many

of the healers we have spoken to in the United Kingdom talk about 'energy change' as being a feature of these beneficial changes that they can help facilitate. This is a difficult concept for those of us with a contemporary scientific training to get our heads around, because we cannot measure any such energy, but is akin to many ancient forms of science, such as Indian 'prana' or Chinese 'chi'.

Here is a brief story told to me by an energy healer:

So there was this person with terrible back pain. And I was just there to help; but it was all very strange; we suddenly understood. That often happens in healing. She said it felt easier, but then she came back later in the day and said it had gone completely; she had this big smile on her face. Now she is a completely different person. And her partner is delighted. It is not just that the pain has gone, but that she is someone else now. I was just the facilitator of that change; it was the energy and the client who made the change.

Draw us a picture about healing

A third method we have used is to ask members of the public, selected at random, to draw a picture of any image that comes immediately to mind when asked 'what does the word "healing" mean to you?' We record what they say as they draw. The language of healing is metaphor, because it is an experiential issue that is difficult to explain in words, so drawing pictures is one of the best ways of expressing the metaphors that mean the most to people.

Three inter-related themes have emerged from analyses of these pictures and what people say about them:

1. Healing comes from outside (often illustrated as 'energy' coming from the sun or the heavens);
2. Healing is about connecting with others (illustrated by pictures of connectivity with people, animals or nature);
3. Healing comes from within us (illustrated by pictures of growth, or of hearts).

Many people combine these views in their descriptions of healing, saying for example that it involves energy from the universe, channelled by another, that helps us activate our innate healing abilities from within. Some people describe healing outcomes, but the majority talk about it as a process.

Healing in clinical practice

What I think we have learnt from healers, their clients and the general public is that healing is a part of the life and experience of many people, and one that is fully accepted

outside of scientific circles. It involves assisting people on their journey of change to a new state of harmony and integrity, which can allow transcendence of suffering, and wholeness. Furthermore, it seems that the key to the facilitation of positive change in others is 'healing intention', through what I call 'focussed attention with good intention'.

A lot of researchers have investigated such ideas; their findings are reported more in the nursing and sociological literature than in mainstream medical journals, and much of the data come from North America. There are, for example, many randomised controlled trials that show that healing intention 'works' to induce positive changes in animals and plants as well as humans, as summarised in a recent meta-analysis carried out in Northampton University in the United Kingdom (Roe et al., 2015).

In spite of what I would consider cast iron evidence for the efficacy of the reality of healing and healing intention, the medical profession remains dismissive – perhaps because it cannot understand how 'intention' alone can induce positive change.

A man convinced against his will / is of the same opinion still. (Attributed to Dale Carnegie)

I think we should not dismiss these phenomena as 'woo-woo'. I believe we can help our patients by paying attention to this research. For example, I think we can help our patients 'heal' in our clinics by our being fully 'present' for the other, by attentive listening, and by genuine caring for the patient. To be able to do this, I think we need to spend more time preparing ourselves before we do clinical consultations; we need to be in the right place mentally, physically and emotionally. Our body language and attitudes, as well as our words, matter to our patients.

Another key facilitator is a feeling of safety. There is conventional scientific evidence to support the importance of this in terms of the polyvagal theory developed by Steven Porges. His work shows us that if you feel unsafe you cannot relate properly to others. So we need to work in environments in which both practitioner and patient can feel safe and at ease with each other. The environment in which we work matters as well as what we say and do.

Validating and invalidating our patients

Another important psychological theory about human interactions, relevant to our understanding of how to facilitate a positive, healing clinical consultation, is the validation/invalidation construct. The key to this is to realise that it is about the patient's perspective, not the health

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professional's – it should not be about us trying to validate the other, we need to concentrate on whether the patient feels validated. Our patients may feel invalidated if they think the doctor does not properly understand or care for them, even when they are doing their best to be empathic and compassionate. For example, we have found that patients may feel invalidated by a doctor who says something like 'I don't think there is anything serious wrong with you' with the best of intention and in a compassionate, empathic way, thinking that this will be reassuring. The patient can interpret this as 'she thinks I am making this up and that there is nothing wrong with me, she obviously does not understand the pain I am in'. And the results of such invalidation can be serious, the patient deciding not to consult with the doctor again.

We need to be able to connect with our patients as another human, struggling to make sense of the world, as well as a professional.

Non-local consciousness: a possible explanatory framework for healing phenomena

In conclusion, healing is real; it has been practised throughout history and in all cultures. There are still many healing practitioners active in our society today, many of them working incognito, and the public in this country in general accept healing as a part of the human experience. Our modern science – in the shape of rigorous trials – supports the concept that healing intention can result in positive changes in all living things. However, the 'problem' is that our science has had no way of understanding how this could possibly be, and is thus dismissive ('woo-woo').

But the concept of 'non-local consciousness' could help bridge the gap between our modern science and the ancient

'inexplicable' practices of healing. 'Non-locality' is an idea born out of quantum mechanics some time ago, now gaining ground through physics as well as some neuroscience. The central idea is that the universe *is* consciousness; that it is the primary thing in the universe and the physical world is a product of consciousness. The originator of quantum mechanics, Max Planck, said, in an interview given to the Observer in 1931, 'I regard consciousness as fundamental. I regard matter as derivative from consciousness'. Many neuroscientists now accept that there is no evidence in support of the current (very new) idea that consciousness is a product of brain activity, but rather that the brain is the receiver, not the originator of the phenomenon. Such thinking can also explain some paranormal things that we come across in medicine, such as near-death experiences, which are now very well-documented phenomena.

We need to be more open-minded in medicine, and learn from other approaches, and other types of science, so that we can accept healing and learn from healers, who have been working on this earth for a lot longer than doctors and nurses have.

References are available from the author on request: p.dieppe@exeter.ac.uk.

This paper is based on a talk given at June 2019 Philosophy and Ethics SIG meeting at Rydal.

The transcript of that meeting now being available to download from the web page: <https://www.britishpainsociety.org/philosophy-ethics-special-interest-group/>

Notes

- i. <https://www.wikiart.org/en/vladimir-makovsky/in-search-of-medicine-1884>
- ii. <https://www.wikiart.org/en/vladimir-makovsky>

Medical cannabis: a missed opportunity for managing pain

Mary Biles *Medical Cannabis Journalist and Author*



Cannabis: obtained with kind permission from Don Goofy 2013.¹

Almost 18 months have passed since the legalisation of medical cannabis in the United Kingdom. On 1 November 2018, around the country activists and patients alike celebrated what they hoped would mean greater legal access to cannabis-based medicines. However, this jubilation has since turned to frustration as only a handful of patients have been issued prescriptions through the National Health Service (NHS).

Crucially, in guidelines issued by the National Institute for Health and Care Excellence (NICE),² a stated lack of robust clinical evidence for the treatment of chronic pain with cannabis-based medicinal products (CBMPs) has meant patients who use cannabis to manage their pain will not be able to access it through the NHS. Their remaining options include finding upwards of £1,000 a month to go the private route, continue buying their 'medicine' from drug dealers (with all the risk that entails), or to illegally grow their own.

According to Professor Mike Barnes, Chair of the Medical Cannabis Clinicians' Society, since legalisation only 177 patients have been given prescriptions for CBMPs. With roughly 1.4 million people³ using street cannabis for a diagnosed condition, a large proportion of whom suffer from chronic pain, we can assume over a million vulnerable patients

currently break the law to get cannabis because the medication they are prescribed does not adequately manage their pain.

Which begs the question – does the current method for determining clinical efficacy of CBMPs in chronic pain reflect patients' real experiences? And if not, are both patients and clinicians being deprived of a valuable therapeutic tool for managing pain?

Since 1961 when the United Kingdom and 184 other countries signed the Single Convention on Narcotic Drugs, cannabis has been classified as a Schedule 1 drug with limited therapeutic value and serious risk of abuse. A consequence of this has been the stymying of scientific research into the therapeutic benefits of the plant.

Professor Manuel Guzmán, Professor of Biochemistry and Molecular Biology at Madrid University and author of several ground-breaking studies⁴ into cannabis and cancer, describes the barriers faced by researchers:

Doing clinical research with cannabinoids is very complicated because cannabis is controlled by the United Nations and is a Schedule 1 drug, subjected to very strong restrictions in the production, manufacturing, and exporting etc. That means that many clinicians and many investors get frightened. They don't want to get into so much bureaucracy and they prefer to go for substances that are easier to get into clinical trials.

In the United Kingdom, a vital step in the legalisation of CBMPs has been moving cannabis from Schedule 1 to Schedule 2. However, we are now playing catch-up for 60 years of restricted research.

Some pharmaceutical companies have been ahead of the curve, in particular the British biopharmaceutical company GW Pharma. Pioneers in the field, they alone have managed to get approval by the Medicines and Healthcare products Regulatory Agency (MHRA) for a cannabis-based drug, namely Sativex, for spasticity in multiple sclerosis and more recently, Epidyolex, a purified cannabidiol (CBD) drug for paediatric epilepsy.

Medical cannabis: a missed opportunity for managing pain

Sativex, containing roughly 1:1 ratios of THC (tetrahydrocannabinol), the psychoactive compound in cannabis, and its non-intoxicating cousin, CBD, have also been used in randomised clinical trials (RCTs) for chronic pain. While it showed some promise for treating neuropathic pain in MS,⁵ as an adjunctive therapy for chronic pain in cancer patients, it did not fare so well.⁶

These mixed results were reflected in the NICE findings which included RCTs for Sativex, and the synthetic THC drugs, nabilone and dronabinol. Overall, only a 0.4% improvement in pain on a 0–10 scale was found and there was also no evidence of a reduction in opioid use. NICE concluded, ‘the potential benefits offered were small compared with the high and ongoing costs, and the products were not an effective use of NHS resources’.

Had NICE accepted observational data reflecting the experience of chronic pain patients who actually use medical cannabis, they might have got a different result.

Professor Mike Barnes believes efforts by NICE to shoehorn medical cannabis into a process designed for pharmaceutical medicines is a major factor behind the disappointing findings:

‘They have their rules and regulations and they do not fit the cannabis plant and they didn’t even recognise that’, says Professor Barnes. ‘How many double-blind placebo studies are there, and the answer is only a few, because the plant doesn’t lend itself at all to double blind placebo-controlled studies and they just dismissed all the other evidence’.

Barnes is referring to the complex mix of molecules found in the cannabis plant which includes over 100 cannabinoids, terpenes and flavonoids. Together they are believed to create an ‘entourage effect’ whereby usually inactive compounds potentiate the therapeutic effect of key players like THC and CBD.⁷

This could explain why patients report superior pain relief using ‘whole plant’ cannabis oils or even smoked street cannabis, compared to the synthetic or isolated cannabinoid medicines commonly used in medicine. And yet, because full-spectrum cannabis products are inherently difficult to standardise and patent, they are of little interest to a pharmaceutical industry driven by profit.

However, in the burgeoning private medical cannabis clinic sector prescribing clinicians, including pain consultants, are embracing the use of whole plant cannabis products with their patients.

Medical cannabis – a clinician’s experience

Dr Mike Platt, a senior consultant in pain medicine and anaesthetics at Imperial College Healthcare NHS Trust, is

clinical director of the recently opened Sapphire Medical Cannabis Clinics:

‘I think what’s fascinating is if you take out a single molecule like THC or CBD and use it’, he says, ‘it doesn’t appear to be as effective as if you give it with all the other molecules. And that’s what we don’t understand. We need to understand a lot more about what all these molecules are doing together’.

It’s been a steep learning curve for Dr Platt since joining Sapphire Clinics. Like many consultants entering the field, he has received much of his training from doctors in Canada, where medical cannabis has been legal since 2001.

For Platt, key to learning how cannabis can be prescribed to patients has been gaining a greater understanding of the endocannabinoid system, a homeostatic regulator comprising a vast network of receptors in the brain, central nervous system and immune system that are activated by fatty ligands, similar to neurotransmitters.⁸ Compounds in the cannabis plant, namely THC and CBD, have been found to activate the endocannabinoid system through different pathways:

‘What we’re finding is in patients that have really complex pain problems, many benefit from cannabis medication’, says Platt. ‘We don’t really understand why, but they do seem to have an extraordinary effect on them. I had one lady with severe Ehlers-Danlos syndrome who within two days just texted the pain clinic and said I’ve had the first good night sleep in fifteen years. So, it’s clearly having an effect on these patients, particularly the more complex ones. And it suggests that maybe we need to know more about the endocannabinoid system. It is not a simple molecular mechanism. It’s clearly working in several different ways’.

The complex nature of both the cannabis plant and how it interacts with the body means there is no ‘one size fits all’ approach for prescribing CBMPs and a ‘start low, go slow’ approach is commonly practised. As a rule, Dr Platt starts his patients twice daily on a CBD product, adding in 1 mg of THC at night:

‘We check for any adverse events and for any progress with pain and gradually increase’, explains Dr Platt. ‘Then we can gradually introduce THC during the day as well, if it’s very helpful. These patients do not get psychologically affected at all, but they get a noticeable effect on the pain and having the THC at night actually makes the sleep better. The pain is easier and they’re coping better as well’.

A common concern for clinicians is whether the oft-cited psychoactive side effects of CBMPs may prove difficult for patients to tolerate:

Platt: *Very few patients on the whole get significant side effects. The main one is in the elderly, frail patients who can report sleepiness in the daytime. Although they're having the THC just at night, they get a bit of a hangover in the morning. So, I ask them to take it earlier in the evening rather than just when they go to bed, and perhaps look at the dose as well.*

So far Dr Platt has not noticed any worrying drug interactions between CBMPs and other pain medications; quite the opposite, in fact:

'Some drugs seem to be potentiated by cannabis, which I find fascinating', says Platt. 'Some patients who are taking anti-neuropathic pain agents such as the gabapentinoids may find a boost in the pain relief. But they're also getting pain relief from the cannabis. So, they're getting a dual effect. It does increase the side effects as well slightly, so we reduce the dose of the other drug'.

Dr Platt has also found he has been able to significantly cut down on the amounts of opioids when patients are prescribed CBMPs. Indeed, reducing a patient's overall pill burden⁹ is a common consequence of prescribing CBMPs to patients with chronic pain, a cost-saving outcome which he believes could eventually convince NICE to change their position.

Of course, NICE guidelines are not only based on cost effectiveness and without data proving CBMPs clinically efficacy, their stance on chronic pain will remain unchanged. To try and combat this, a number of initiatives are currently taking place including Project Twenty21, a national medical cannabis registry, launched by Drug Science last November. It seeks to enrol 20,000 patients and create 'the largest body of evidence for the effectiveness and tolerability of medical cannabis'. Sapphire Clinics have also launched their own UK Patients' National Registry, designed to collate outcomes on medical cannabis prescribing.

For Dr Platt, CBMPs are just one other therapeutic agent that can be used to help relieve pain and get people back to normal life. However, he has witnessed some unexpectedly positive outcomes in patients:

'There was this fisherman', he recalls, 'who loved fishing off the cliffs of Yorkshire. As he was getting to a certain age, he was getting increasing arthritis, his finger joints were swelling and starting to bend. He just wasn't coping

at all and was on large doses of anti-inflammatory and pain killing drugs. He came to see me, and we started him on medical cannabis. I created a plan of how to start and what dose to go up to. I saw him four weeks later and he was a completely different man. His arthritis was better, his fingers were actually straightening. I found that fascinating. Now he's fishing again and is a very happy man'.

These single case studies may not be enough to turn the tide of opinion of many pain consultants. However, Dr Platt hopes there will be a general softening of attitudes among his peers:

'I would urge the medical profession to have an open mind about medical cannabis', he says, 'to explore further its many possible uses, to actually embrace it, to have open dialogues with patients, and explore its benefits with a combination of observational and randomised control studies'.

To find out more about the subject ...

<https://www.buzzsprout.com/989611/3433234-dr-mike-platt-prescribing-medical-cannabis-for-chronic-pain>

To hear a chronic pain patient's perspective, listen to episode 1 with Carly Barton – the first patient to get a medical cannabis prescription in the United Kingdom after legalisation. Interesting that she chose to go back to vaping her homegrown cannabis after a month of 'legal' cannabis – which was not only prohibitively expensive but less effective and gave her anxiety ...

<https://www.buzzsprout.com/989611/3264361-carly-barton-optimist-fighter-and-chronic-pain-patient>

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Cannabis and analgesia

Michael P Barnes



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1 November 2018 was an important day in the history of UK cannabis medicine. On that day, the government moved 'cannabis-based medicinal products' from Schedule 1 to Schedule 2 of the Misuse of Drugs Regulations 2001. This enabled doctors on the specialist register to prescribe cannabis. The regulation change was actually quite liberal and allowed for prescription for any condition and for the prescription of any product meeting good-quality production standards (EU Good Manufacturing Practice). Unfortunately, since that point there has been no prescription of a full extract cannabis product on the National Health Service (NHS). There have been some continuing prescriptions of the two licenced cannabis products – Epidyolex and Sativex – both produced by GW Pharma. Thus, at the moment the only way for a

patient to obtain a full extract cannabis product is through the private sector. This is regrettably very expensive, mainly due to the inadequacies of the current supply chain. Indeed, it has been well publicised that parents of children with drug-resistant epilepsy are having to pay around £2,000 per month for medication. The average price of medication for an adult with pain is around £800 per month. Thus, sadly, we have developed a two-tier system for those who can pay and those who can't pay. Why is prescription so limited?

There are a number of reasons. Foremost, doctors have not been educated in cannabis medicine. This is not a criticism as at the moment the endocannabinoid system and the cannabis plant are rarely taught in medical schools and there is a paucity of post-graduate teaching programmes. These are now emerging, such as the Academy of Medical Cannabis (<https://taomc.org/en/>) (conflict declaration – I am the Director of Education). The Medical Cannabis Clinicians' Society (<https://www.ukmccs.org/>) is also now in existence and is a not-for-profit forum for clinicians who wish to be educated about cannabis medicine. The Society has an annual conference and is currently putting on roadshows around the United Kingdom and offers a peer support forum, and soon will be publishing an online evidence database. Second, another obstacle to prescription is the guidelines produced by the Royal College of Physicians (RCP) and National Institute of Health and Care Excellence (NICE). Both of these have, in my view, come out with an unnecessary negative view of cannabis in the context of analgesia. Their negative view has been counterbalanced by a most positive attitude from the Medical Cannabis Clinicians' Society who have recently produced their own guidelines and which are available online.² The RCP and NICE guidelines are not mandatory but nevertheless are a barrier to prescription. A doctor on the NHS willing to prescribe cannabis needs to gain approval from his or her Trust and so far, no Trust has been brave enough to agree to prescription against those recommendations. The third reason for lack of prescription is that cannabis (except Epidyolex and Sativex) is an unlicensed medicine which means that the prescribing doctor takes more responsibility and liability than usual. Fourth, many doctors feel there is simply insufficient evidence to warrant prescription of cannabis as an analgesic. Let me now address the latter issue.

First, some basics. There are over 120 cannabinoids in the cannabis plant but really only two have been extensively studied. These are CBD (cannabidiol) which is the non-intoxicating cannabinoid and tetrahydrocannabinol (THC) which in isolation causes the 'high' sought by recreational users. There is relatively little known about the other cannabinoids, but all so far studied have medicinal properties. The plant is further complicated by the presence of terpenes which gives cannabis its characteristic smell and the flavonoids, which give it colour. Once again, the terpenes and flavonoids so far studied also have medical properties. However, by necessity we have to focus on CBD and THC. Are these cannabinoids analgesic? The answer is unequivocally 'yes'. There are extensive animal studies demonstrating analgesic properties in standard animal models of pain.³ THC is a more potent analgesic, probably through its binding to the CB1 receptors. However, CBD is also analgesic but somewhat less efficacious, but nevertheless has other properties which can be helpful for those with chronic pain, such as improving sleep, lessening anxiety and improving appetite. In people with pain secondary to relevant neurological conditions CBD is also anticonvulsant and anti-nausea.

While it is clear in animal models that both CBD and THC are analgesic, do these animal models equate to analgesia in man? In my view, the answer is clearly 'yes'. This is also the accepted position by a number of review bodies, including the National Academies of Science, Engineering and Medicine which concluded that the evidence for cannabis being an analgesic agent was 'substantial'.⁴ Other review studies have come to a similar conclusion in some cases, whereas others have been more cautious. The review of reviews published by Banerjee and McCormack, for example, stated, 'the guidelines report that cannabis-based medicines may be considered as a treatment option for patients with neuropathic pain, with chronic non-cancer pain and with chronic non-cancer, non-neuropathic pain, but with some caveats'.⁵ The European Pain Federation concluded that 'The quantity and quality of evidence are such that cannabis-based medicines may be reasonably considered for chronic neuropathic pain. For all other chronic pain conditions ... the use of cannabis-based medicines should be regarded as an individual therapeutic trial'.⁶ Other reviews have generally supported the view that while more evidence is clearly needed, cannabis can be useful for the management of chronic pain.⁷⁻⁹

The problem with the evidence is that there are very few double-blind placebo-controlled studies. This was recognised in the NICE report and indeed the NICE Committee rejected the vast majority of the evidence in order to focus purely on

double-blind placebo-controlled results. In my view, this is a great pity and, indeed, misguided. While one has to accept that the gold standard of evidence is a double-blind study, it is unacceptable to reject all other evidence. At this point, it is worth emphasising that cannabis is not a single medicine and does not readily fit into a pharmaceutical model. It is a whole family of medicines. It is difficult to envisage a complex plant with many modes of administration and different dosages lending itself very readily to the classic single-molecule double-blind placebo-controlled trial. There are very good-quality observational trials and case studies and a host of anecdotal reports. While one has to accept that one anecdote is simply an anecdote, thousands of anecdotes pointing in the same direction, backed up by good-quality large-scale observational studies, should be taken as some evidence for efficacy. After all Sir Michael Rawlins, ex-Chairman of NICE and current Chairman of the Medicines and Healthcare products Regulatory Agency (MHRA), said in his Harveian Oration in 2008

The notion that evidence can be reliably placed in hierarchies is illusory. Hierarchies place RCTs on an uncomfortable pedestal, for while the technique has advantages it also has disadvantages. Observational studies have defects but they also have merit. Decision makers need to assess and appraise all the available evidence, irrespective as to whether it has been derived from RCTs or observational studies; and the strengths and weaknesses of each need to be understood if reasonable and reliable conclusions are to be drawn Hierarchies of evidence should be replaced by accepting – indeed embracing – a diversity of approaches (This) is a plea to investigators to continue to develop and improve their methodologies; to decision makers to avoid adopting entrenched positions about the nature of evidence; and for both to accept that the interpretation of evidence requires judgement.¹⁰

The other side of the coin is safety. Is cannabis safe? No medicine is entirely safe but it is clear that cannabis, prescribed properly and appropriately by a knowledgeable physician, is actually very safe. CBD has very few side effects despite the bizarre conclusions of the recent Food Standards Agency guidance which has suggested that a 70 mg daily dosage of CBD (in over-the-counter preparations) is the maximum daily dose.¹¹ As the average dose for pain, anxiety, sleep and appetite issues is between 60 and 100 mg daily, this is a slightly bizarre conclusion that is based on no scientific evidence whatsoever. CBD, of course, can cause some difficulties, such as fatigue, sedation, dry mouth, stomach cramps and diarrhoea, but usually in high doses and often only in a small

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proportion of people. THC has more problems but it should be remembered that CBD is a negative allosteric modulator for THC and counteracts some of its negative effects. Indeed, most cannabis physicians would only prescribe a high THC compound in combination with CBD, so as to mitigate the THC side effects. THC can cause dizziness, dry mouth, sedation and the euphoric 'high' sought by the recreational user. There are also contraindications. The evidence is fairly clear (but not definitive) that a high THC compound, particularly in a young male user, can trigger a psychotic episode, particularly in those with a history of psychosis or schizophrenia or such a history in a first-degree relative. It is clearly wise not to prescribe cannabis in such an individual. THC can also cause a tachycardia which can be an unwanted problem in people with some types of cardiac dysrhythmia or a recent heart attack or stroke. Caution is wise in those with liver disease (particularly hepatitis C). The evidence of hepatotoxicity is limited although has been noted with very high CBD isolate doses. Most problems occur in the high THC street cannabis that is not 'covered' by CBD. The complications seen in the street user are very rare in the medicinal user who has been prescribed the medication by a knowledgeable physician. Drug interactions may occur as both THC and CBD interact with the cytochrome system and thus have a potential to interact with many drugs, but the actual clinical experience is that cannabis does not have significant drug-to-drug interactions, with a few exceptions, such as clobazam with CBD.

One important point in terms of analgesic therapy is the 'opioid sparing' effect of cannabis. Opioid deaths are a real issue, particularly in the United States, but beginning to be a problem in the United Kingdom. Over 46,000 people died in the United States last year of an opioid overdose. There is now robust evidence that once cannabis is introduced into a jurisdiction, then the quantity of opioids prescribed reduces and an individual can often reduce the dose of opioids or even stop that medication altogether.^{12,13}

Overall, cannabis is definitively analgesic in man. There is considerable and robust clinical evidence of efficacy although much of that evidence is in 'real-world' data from observational trials and case studies. These should not be lightly dismissed, given that cannabis has been used as a pain killer for thousands of years (the first use was described about 5,000 BC). It is now available as an analgesic agent in 48 countries. It is strange that the governing bodies in the United Kingdom have adopted such a negative view. It is certainly not a first-line analgesic but if all or most of the standard licenced medications have been used, either with limited result or with unacceptable side effects, then surely it is reasonable to alleviate suffering rather than leave that individual in chronic

pain – all for the sake of further double-blind placebo-controlled evidence. There are many medicines that we prescribe, particularly in paediatric practice, that have not been through double-blind placebo-controlled studies, yet we are happy to prescribe them. Why is cannabis an exception? Yes, we need more evidence but let us prescribe cannabis in a safe and responsible manner and learn as we go along. We have to do our best in medicine, sometimes not in ideal circumstances. In my view, allowing a patient in chronic, severe pain, that is unresponsive to licenced medication, not to have the chance of some improvement on cannabis medicine is immoral.

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<https://www.profmichaelbarnes.co.uk/>
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God and suffering: does a religious belief alleviate pain and suffering?

Patrick Sookhdeo



Jesus On The Cross Peter Griffin Public Domain¹

Abstract

Suffering in relation to pain of the body or the mind is an inevitable experience for all humans. There are varying responses to suffering that can arise from the religious, or other, belief systems of individuals. Questioning the purpose of suffering is a commonplace preoccupation. The prevailing post-modern secular culture is dismissive of the value of religion to society and human wellbeing. However, anecdotal and study evidence points to religious belief alleviating suffering and improving quality of life. The major world religions offer differing constructs for understanding and responding to human suffering, which are explored.

Introduction

How to respond to the related, but distinct, phenomena of pain and suffering, our own and that of others, is a question that has preoccupied humans since the beginning of history. Pain can be quantified in physiological terms, and assessed as a medical problem, but this does little to help us understand our relationship with suffering or how to respond when it comes into our lives. The universal question of all religious believers is 'Why is there suffering?' or more existentially 'Why do we perceive events as suffering?'

Why does a good and all-powerful God permit his creatures to suffer pain and death in the world he created?

In the Old Testament, Job, a very virtuous man, suffers an overwhelming loss of family members, reputation, possessions and, finally, his health. Nothing about his suffering makes any sense and he has done nothing to deserve it. But Judaism, Christianity and Islam all hold the belief that Satan had been given permission by God to test the depth of Job's faith through various trials.

This paper explores the important role Christianity and other major world religions and ideologies have in our approach to the problem of bodily or mental pain and suffering. In a 'post-values' secular world, religion is often dismissed as worthless, or worse, and there is little hope or comfort for sufferers. Yet, there is compelling anecdotal and growing research evidence that suffering is alleviated when it holds meaning for the sufferer in the context of belief. A recent Office for National Statistics (ONS) study² linking religion and health, found that people who have faith tend to feel healthier or happier with their health. A 2016 study found a strong positive correlation between spirituality and happiness.³ More recently, it was also found that with an increase in religious belief the level of suffering decreased for sample group of haemodialysis patients.⁴

Religious belief systems re-affirm the innate value of humans and restore our dignity. Some can even offer a management strategy for our suffering that can lead us beyond a hopeless cycle of rejecting, escaping and being defeated by our pain.

Coming face-to-face with suffering

Recently my mother died in excruciating pain in a hospital ward, at the age of 93. Three weeks previously, apart from her 'ailments', as she always described them, she had seemed set to reach 100 and receive the Queen's telegram. But that was not to be. She was rushed to hospital one evening complaining of severe pain. As the days went by, the intensity of the pain in her lungs grew. She was diagnosed with cancer. Soon the ferocity of the cancer was such that she could hardly breathe. Looking on at her bedside, I felt helpless and powerless.

In the midst of her suffering, how should my mother have responded? Take Job's wife's advice: curse God and die? And how should I have responded: bow at the altar of despair and hurl accusations against God for causing my kindly mother

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such intense suffering? The question has been asked throughout time: if God is good and all-powerful why does He allow His creatures to suffer pain? All the major religions of the world have sought to address the problem of suffering. For, as the Old Testament tells us, '*man is born to trouble as surely as sparks fly upward*'.¹

Once when the pain was causing her to scream at high pitch, I went to find a nurse to see if the pain could be lessened. I found the nurses sitting and joking together; their only answer to my request was that I should wait and see the doctor. I have to say that this kind of response was an isolated and unusual example, for other nurses, in particular the Macmillan nurse, could not have shown greater understanding and sympathy. The doctors were exceptional in their care for her.

During that time, I sat with my mother and prayed for God to intervene, to heal if it be His will, to give her grace to bear the pain, or to take her so that she would be released from her suffering. But God was silent, or so it seemed.

The Church was silent too. I requested the hospital chaplain visit my mother, who was a Christian believer. Despite my repeated messages and phone calls, the chaplain never visited.

Confucianist, Buddhist and Hindu views of pain and suffering

The ancient philosophy or way of life of Confucianism, sometimes viewed as a religion, is still strongly influential in China and among Chinese people across the world. Its focus is on social harmony, collectivism and the family (past and present). Group goals and needs are prioritised over an individual's desires or rights. Conversely, a person's physical or psychological pain is seen as a family event, not an individual's problem. Admitting to pain can be considered shameful and to cause loss of face for the whole family, so there is often a reluctance to discuss pain with health professionals because they are outside the family circle. A health care provider may need to visit many times, gradually building a relationship with the family as a whole, before the patient will be frank about their problems. Indeed, Chinese people generally take a stoical attitude to pain, with the result that they will not moan or scream and will even deny they have pain because they believe that to admit to it is a weakness.⁵

In the Buddhist view, pain is an experience and suffering is the way we relate to it – the story we create of the pain we experience. As a person's attachments, cravings and desires diminish, so does their capacity to suffer, and the end of suffering comes when the mind is free from all attachments. This state of enlightenment is called *nirvana*, in which there is no anxiety or trouble of any sort.

Suffering is the central theme of Buddhism, which has no belief in God. The Four Noble Truths that comprise the essence

of Buddha's teachings are the truth of suffering, the truth of the cause of suffering, the truth of the end of suffering, and the truth of the path that leads to the end of suffering. In fact, the word *dukkha*, usually translated as 'suffering', has a much more complex meaning, comprising the following three elements:

- *Dukkha-dukkha* (ordinary pain or suffering) – physical, emotional, psychological
- *Viparinama-dukkha* (impermanence) – anything that is not permanent
- *Sankhara-dukkha* (conditioned experience) – lack of satisfaction because everything disappoints and our desires cannot be properly fulfilled

'*Life is dukkha*', said Buddha. To be freed from *dukkha* a Buddhist must realise that it is not external things which create suffering but the ignorance of our minds and their erroneous thought-processes. So the ultimate solution to *dukkha* is the Eightfold Path of practical disciplines to eliminate the desires that cause *dukkha* and to achieve *nirvana*:

- Right view
- Right intention
- Right speech
- Right action
- Right livelihood
- Right effort
- Right mindfulness
- Right concentration

By contrast, Hinduism does not see any immediate possibility of escaping from suffering, for it is an integral part of life, albeit that life is nothing but transient appearances. Suffering must therefore be accepted and various schools of Hinduism teach different religious practices to try to achieve this. Yoga, for example, is one way of trying to recondition the mind and body for this purpose:

*Hindu traditions promote acceptance of pain and suffering as the just working of karma. The practice of acceptance is also a means to a greater end. By accepting one's condition, one becomes less attached to changing it. Acceptance of pain and detachment from any struggle with the experience of pain means that painful or pain-free states would be accepted equally. Detachment from the world, in order to be focused on God/The Ultimate, is a primary goal in Hindu traditions.*⁶

There is, however, a future possibility of suffering-free existence, if a soul can escape the cycle of birth-death-rebirth called *samsara*. Desires and demonic nature (selfishness) are seen as the root cause of human suffering and the resultant bondage to

the *samsara* cycle, whose ‘symptoms’ include ageing, sickness and death.

An individual’s suffering in any one life is determined by *karma*, the principle that governs the unfolding of events, and is based for a person on the integrity with which they lived their previous lives. So Hinduism is not a fatalistic religion, as one’s destiny is shaped by one’s virtuous self-effort in the past. The more faithfully one follows one’s *dharma* (guidelines for living one’s life), the less one’s suffering in the next incarnation, but everyone hopes for *moksha* (complete release from *samsara*). For the ordinary Hindu, *bhakti* (devotion, worship) offers their best hope of gaining the grace and mercy of the Divine and thus a better state in their next incarnation. Individuals who believe that suffering is a consequence of bad actions in a previous life may refuse pain treatment, on the basis that they should accept their own *karma*.⁷

The three monotheistic religions’ perspectives on suffering

The three monotheistic religions, Judaism, Christianity and Islam, share the same perspective on the reason for suffering: either it is the painful result of sin, whether as a divine punishment or as cause and effect, or it is a God-ordained test.

Judaism, in its non-philosophic form, acknowledges the reality of evil and suffering. Indeed, God himself is often described as suffering with humankind. Humans have a responsibility to try to relieve the suffering of others, wherever they can. This may be a reason for the historic Jewish predilection for medicine and social reform. Jews are also commanded to suffer with the sufferer, and not indulge in their own enjoyment while another is in pain. Where suffering cannot be remedied it must be borne uncomplainingly.

Muslims are taught to see suffering as primarily a test of faith, enabling God to discover who is truly righteous. For suffering reveals a person’s soul to God. A true Muslim will remain faithful to God throughout the trials of life. So God not only allows our various troubles and struggles but has a purpose for them; he uses suffering to look into the characters of humans and to correct unbelievers. In Islam, sin is associated with unbelief, the logic being that the *kufr* (unbelievers) typically focus on their passions rather than on God. In such a case, suffering may be God’s punishment. Islamic faith, by contrast to unbelief, is fundamentally submission (the actual meaning of the word ‘Islam’) and surrender to God. Suffering is a lesson to teach the believer: endurance with hope and unwavering faith. The faithful Muslim does not resist suffering or question why it has come, but accepts it as God’s will and aims to live through it, drawing comfort from the fact that God is in control and believing that he will never ask more of them than they can endure. Like Judaism, Islam teaches that its followers should give

generously and in other ways do all they can to alleviate the sufferings of others. The performance of good works of this kind may relieve their own suffering as God looks mercifully on them in response to their righteousness.

Shi’a Islam has a particular focus on self-sacrificial suffering and martyrdom. Both physical suffering and grief are embraced, not only as a test, but also as an opportunity to ‘join the meta-historical group of righteous believers’.⁸

Pain and suffering have a uniquely central place in Christianity. For the Christian message is that the pivotal event in all time and space was the crucifixion of Jesus, an event that was not only physical agony but also spiritual as he, though sinless himself, took on the sins of the world. The writers of the four Gospels dedicate a huge proportion of their texts to his ‘passion’, as it has traditionally been called – the suffering of his last few days and his death. They showed that Jesus knew that he was going to suffer and also knew that afterwards he would be vindicated.

In the years of ministry before this, Jesus wept and grieved as he helped others. The early church historian Eusebius wrote of Jesus in words that, whether consciously or unconsciously, reflected the words of Hippocrates: ‘*He was like some excellent physician, who, in order to cure the sick, examines what is repulsive, handles sores, and reaps pain himself from the sufferings of others*’.⁹

Therefore, Christianity goes one step further than the other monotheistic faiths and teaches believers to embrace suffering – not only to accept it and submit to it – but to welcome it, even with joy, as a means of fellowship with Christ.

The early Church sought simplicity and poverty, an attitude which perturbed the pagan Romans, who found it baffling and sinister. Christians have traditionally believed that at times of suffering they can experience the presence and power of God at a deep and profound level, which is impossible to attain at other times. A young woman in fourteenth-century England, known to us only as ‘Julian of Norwich’, prayed fervently to be allowed to suffer with Christ:

*And so I asked for an actual sight – through which I should have more understanding of the compassion of our Lady and of all his friends who saw his agony and pain at that time. I wanted to be one of them and suffer with him.*¹⁰

Like Jews and Muslims, Christians see the possibility of a divine purpose in their suffering. For Christians, this is often summed up as growing in Christ-like character and being equipped to console other sufferers more effectively.

Most Christians would not seek suffering, although, in earlier centuries, a painfully ascetic lifestyle was deliberately followed by some monks and nuns, as it was by Muslim mystics, in their efforts to draw close to God. Some Christian

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denominations even have a doctrine of redemptive suffering, believing that the suffering of one human can, in the spiritual realm, help all humankind; this is why Trappist monks even today choose a lifestyle of harshest hardship, as they seek to save others from their sins.

Desperate measures: negative coping responses to suffering

This may be the theory, but what happens in practice?

Tragically, religion has often been the cause of suffering rather than a means to cure it or endure it, as believers inflict untold sufferings on others who do not share their beliefs, practices or ideology. Furthermore, for many ordinary and poor people, the answer in times of personal trouble, especially sickness of body or mind, is sought in folk religion and occultism. To ease their pain, they turn to a spiritual healer or religious leader said to be imbued with power. Sadly, there is also the charlatan faith healer who offers, in return for payment, 'cures' that may be of dubious effectiveness or even harmful. Some leaders of this kind forbid their followers from using normal medicine, telling them they should trust only their holy book. The ultimate damage is inflicted when, in the event that healing does not occur, the 'healer' tells the sufferer that it is their own lack of faith which has prevented the promised cure.

Doctrines that brought comfort and strength to Christians in times and places where life was difficult and uncertain tend to be neglected in contexts where safety and luxury are the norm. Research has shown that personal suffering is one of the main reasons young people are leaving churches in the West; when troubles come the Church offers them no 'coping mechanism', neither eternal perspective on the reason nor solace in the here and now. Wrestling with the problem of why an omnipotent God of love would allow them to suffer, their faith fails.

Furthermore, a comfortless theology of divine impassibility and divine immutability has become embedded in Judaism, Christianity and Islam. God, it is argued, is free from all emotion and desire. He cannot be influenced from the outside. He is therefore incapable of suffering and incapable of change. This philosophy was developed by Philo of Alexandria, a first-century Hellenized Jew who was a theologian, historian and philosopher. He produced a synthesis of Judaism and Greek philosophy, thus laying the foundations for the development of Christianity as we know it today in both the West and the East. He held strongly to the idea of God's impassibility and immutability. His philosophy was in effect a contemporary version of Platonism including Stoicism. The Stoics admired *apatheia*, which was not apathy in the sense of indifference but meant 'incapability of feeling'. They considered that subduing one's emotions was the supreme moral task of an individual, and that *pathos* (meaning suffering, experience or

emotion) was dangerous; therefore, by an act of will, reason should be made to dominate emotion. Plutarch, born in AD 46, just a few years after Philo's death, considered that it was impossible for God to be involved with or affected by human affairs. For Plutarch, it would have been beyond belief that God could be moved with compassion in the way that is so often depicted in both the Jewish and the Christian scriptures.

In contemporary Judaism, perhaps the greatest writer in the modern period is Abraham Herschel, who rejected the doctrine of divine impassibility of both Philo and Maimonides, arguing rather for the divine *pathos*, that God in his nature has the capacity to feel pain and to suffer.

In Islam, the issue of God's impassibility was much debated in the eighth century, in particular focusing on why God allowed the suffering and death of children. Asharites represented the traditional Islamic belief that all life is predestined by Allah's will, making Allah the author of both evil and suffering. The Mu'tazilites, whose focus was reason, argued that is therefore right to seek to understand the nature of evil and suffering and not simply to lay them at the doorstep of the Divine.

In the Christian tradition, the carnage of the First World War, which pitted Christian against Christian, bred a generation of poets venting their anguish at the horror in horrifying ways. Wilfred Owen's poem on Abraham and Isaac recounts the Bible story, but with a surprise ending. For when God provides a ram to sacrifice

... the old man would not so, but slew his son,

And half the seed of Europe, one by one.

In his poem *Death*, Ewart Alan Mackintosh foresees a lingering agonising end on the battlefield, when he will pray:

Oh, God of battles I pray you send

No word of pity – no help, no friend,

That if my spirit break at the end

None may be there to see.

This bitter hopelessness in the face of pain and suffering did not spring from nowhere in 1914. It was well rooted in the nineteenth century. Dostoyevsky in Tsarist Russia saw the suffering of the ordinary man, oppressed by a rich and powerful church. For him, suffering had no divine purpose, no meaning. It did not bring the believer closer to God but alienated them. In Dostoyevsky's eyes, suffering was pure wretchedness where God had no place.

Fifty years later, Camus took a similar view of suffering in an empty and indifferent universe. It was for him futile and 'absurd', in an incomprehensible universe devoid of God or meaning. Writing after the Second World War, Czech-born author, Milan Kundera, went further. Suffering for him was mundane, commonplace and banal – a non-event. The modern age with its technological advancement, its digitalisation and interconnectivity is creating a barren human landscape devoid of compassion. In a post-value age, humanity has lost its value. Life is cheap. The meaninglessness of suffering, its absurdity and banality are producing a new age of indifference to suffering.

Indifference to others' suffering can be exacerbated by the role that culture and ethnicity play in our response. Charitable donations are often greater for those of the same ethnic group. A British journalist spoke of how reporting on the Rwandan genocide was simply a professional job that left her unmoved, but when reporting on the Serbian/Bosnian conflict – which had far fewer deaths – she was reduced to tears because a woman lying on the ground resembled her own mother. She admitted that her response to these two kinds of suffering was based on her ethnic identification with one and not the other.

Theology of suffering

The major works on the theology of suffering occurred after the Second World War. The Japanese theologian Kazoh Kitamori, having experienced the suffering of war, the nuclear bombing of his country and the crushing shame of defeat, produced perhaps the most significant work by a non-Western Christian author. His focus was on a God whose suffering included pain. In Jeremiah 31:20¹⁰ there is a Hebrew word which can be translated to 'pain', because God feels deeply for his people when they go away from him and rebel. His heart is broken and full of pain, a pain that is born of love. The love of God is not neutral and abstract, not an attribute emanating from him, but forms the very essence of the Divine; therefore, the heart of God has the ability to feel pain and to endure suffering.

This was followed by the German theologian, Jürgen Moltmann, also writing from a ravaged and defeated country that had experienced the evil of Nazism and the Jewish Holocaust. In *The Crucified God*, Moltmann argued that

a God who cannot suffer is poorer than any human. For a God who is incapable of suffering is a being who cannot be involved ... he cannot be affected or shaken by anything. He cannot weep, for he has no tears. But the one who cannot suffer cannot love either. So he is also a loveless being.¹¹

One might also add that the followers of a God who cannot suffer will surely have difficulty entering into the pain and suffering of others; they would tend to be devoid of compassion or sympathy, let alone empathy.

Pain versus suffering – of body and mind

Pain and suffering often overlap, but are distinct. There can be pain without suffering. The self-inflicted pain of runners, cyclists and rowers, as they train and compete, is one example. There can also be suffering without pain. In *Conceptualising Suffering and Pain*, Noelia Bueno-Gómez points out that pain is only one source of suffering:

Social problems like poverty, social exclusion, forceful social inclusion (like peer pressure), forced displacement and uprooting; existential and personal problems like grief and stress; conditions like nausea, paresthesia, a non-painful illness, anxiety or fear can likewise be a cause of suffering. Although pain and suffering are unpleasant, they are not per se either destructive or constructive forces which tear down or build up the self. Rather, they are part of a person's life, and the self is the result of various experiences including pain and suffering, which have an existential dimension inasmuch as they depend on the person's attitude, resources for their management, as well as choices and commitments related to that person's attachment to life and the world.¹²

Indeed, according to Juan Carlos Marvizon

most of our suffering has nothing to do with pain. It is induced by negative emotions like sadness, shame or guilt, or by situations like deprivation of freedom, loneliness, distress, depression, empathy, social rejection, oppression, etc. Like its opposite happiness, suffering is neither a sensation nor an emotion, but a state of being that encompasses the whole mind.¹³

One example of such suffering without pain, which I myself have endured, is the shame of false accusation leading to trial in court. This suffering brought stress leading to illness that still affects me. During the worst time, a doctor who was a Hindu urged me to bring my agonising thoughts under control by meditation, a practice which I had previously followed. Engaging in this practice gave me the necessary resources to deal with the suffering and so I had no need for medication.

There can also be bodily suffering without mental suffering. Solzhenitsyn wrote of his time spent in the Soviet Union's Gulag Archipelago as having taught him about the nature of suffering and the ability of people to find contentment even in the harshest of conditions. He noted that some prisoners, with sentences of 25 years, lived a blissful existence. 'They were people who had withdrawn so deeply into the life of the mind that no bodily suffering could upset their spiritual equilibrium'.¹⁴

It is not suffering *per se* that sets us free from ourselves and our comfortable numbness but the acceptance of suffering. If

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suffering is not accepted it embitters us. It twists us. It shrivels us. Accepted suffering can set us free.

An older lady of my acquaintance had lived comfortably all her life. Her one complaint was that she did not get to spend as much time with her beloved husband as she would have liked, for he was busy earning the money that funded their lifestyle. Eventually, he retired and she looked forward to many more years of enjoying the good things of life, but this time with her husband always at her side. Then one day she found him lying dead in the bathroom. He had slipped and hit his head. This sudden and unexpected bereavement, admitted my friend, was the first time she had ever suffered. It destroyed her. For the rest of her life, she was embittered, eaten up with self-pity, and angry at the God whom she had worshipped faithfully. None of us know how we ourselves might react to such a blow. Would we be able to accept the mental anguish, even to embrace it?

When suffering is viewed as a calling

As war loomed in Europe in 1939, American friends of Dietrich Bonhoeffer got him out of Germany to save his life. But soon the pastor and theologian felt he must return to his country:

His friends [in Britain, to which he had moved from the US] quickly realized that Bonhoeffer's heart belonged to his oppressed and persecuted fellow Christians in Germany and that he would not desert them at a time when they needed him most.¹⁵

He returned, was arrested by the Gestapo and imprisoned. At his hearing, he boldly admitted that, as a Christian, he was an implacable enemy of the totalitarianism of National Socialism. He was never formally tried, but was hanged in early 1945. Not long before that, he had written a poem entitled 'New Year 1945'. It included the lines:

Should it be ours to drain the cup of grieving

Even to the dregs of pain, at thy command,

We will not falter, thankfully receiving

All that is given by thy loving hand.

Bonhoeffer drew strength from the feeling that God Himself was sharing his suffering. 'Bonhoeffer's standing with God in his hour of grieving explains, ultimately, why he did not take his own suffering seriously and why his courage was so great and uncompromising'.ⁱⁱⁱ

For Bonhoeffer, suffering was to be embraced because it was a calling. 'I am sure of God's hand and guidance', he wrote, 'You must never doubt that I am thankful and glad to go the way I am being led'.

Religion or faith affirms the value of those who suffer

We now live in what is termed a post-values world, a world in which fundamental values are fast disappearing. Religion, though often deemed irrelevant, can have an important role to play in the management of pain and human suffering. Freud's assertion that religion is of no value¹⁶ in seeking to alleviate suffering is not tenable when set against the evidence of the many religious believers who derive hope and endurance in their suffering from their beliefs.

Religions – and many non-religious belief systems too – affirm the innate value of human beings, their dignity and worth. If we enter an age in which humanity loses its value, then we become indifferent to human suffering and human life. To lose our fundamental dignity is to lose who we are. The management of pain addresses itself to humanity's suffering. At the heart of it are love, compassion and empathy to enter into the pain and suffering of the other, because they are of worth.

According to the Dalai Lama, head of Tibetan Buddhism, speaking to Joanna Lumley, in the face of the overwhelming suffering in our world today, our response must simply be compassion, as taught by all the world religions.^{iv}

William Barclay's translation of the second beatitude runs: 'O the bliss of the man whose heart is broken for the world's sufferings and for his own sin, for out of his sorrow he will find the joy of God!'^v

Holding my mother's hand, as she grasped mine, seemed to bring some comfort to her. To have her loved ones close beside her brought consolation, and the wonderful compassionate care of the nurses and doctors did all that was possible to relieve her suffering. And so she died, clutching a cross that she had asked me to bring to her in the hospital, a sign of the faith that sustained and comforted her to the end.

Conclusion

There are no easy answers to the question of 'Why pain and suffering?' but all the major world religions offer some form of meaningful construct with which to navigate and cope with our own pain and suffering as well as that of our loved ones. Suffering, like quality of life, is difficult to measure and highly subjective to individuals and their unique experiences. Irrespective of the religious belief system, the possibility of constructing meaning from our suffering experiences seems to alleviate them as well as offer more hopeful and successful coping strategies for sufferers. Those of us with belief in a loving God as creator and saviour can come to terms with pain and suffering as part of a larger spiritual purpose for our lives. Suffering is also something that we can view as bringing us to a closer relationship with God.

In an increasingly secular and impersonal world, it seems to be of value to investigate the benefits of religious belief for

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individuals experiencing pain and suffering, as some recent studies suggest. There is also considerable scope to expand the clinical and non-clinical dialogue between those of all faiths, and none, around this important topic.

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<https://barnabasfund.org/en>

Notes

- i. Job 5:7
- ii. 'Is not Ephraim my dear son, the child in whom I delight? Though I often speak against him, I still remember him. Therefore my heart yearns for him; I have great compassion for him, declares the LORD'. (NIV Bible)
- iii. Leibholz, 'Memoir', pp. 19-20.
- iv. *Joanna Lumley's India*, episode 3 (ITV, screened 19 July 2017)
- v. Matthew 5:4. Usually translated as 'Blessed are those who mourn, for they will be comforted'. See William Barclay, *The Gospel of Matthew*, Vol. 1, Chapters 1 to 10, revised edition, Edinburgh, The Saint Andrew Press, 1975, p. 95.

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A contemplation on sexual trauma and the Pain Clinic: understanding our patient's journey in life

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Школа для крестьянских детей в Вяркяй. School for Peasants Children in Verkiai. Vasily Sadvnikov. 1848. Public Domain.¹

Vasily Semyonovich Sadvnikov (Russian: *Василий Семёнович Садовников*) (28 December (O.S. 16 December) 1800 – 10 March (O.S. 26 February) 1879) was a Russian painter, and a leading Russian master of perspective painting.

Vasily Semyonovich Sadvnikov was born in 1800 in Saint Petersburg into the family of a serf belonging to Princess N. P. Golitsina (nicknamed 'Princesse Moustache'). He obtained his freedom in 1838, after her death, when he was already a well-known artist.²

A consultant in Pelvic Pain Medicine ruminates ...

"you only know what you know,

you don't know what you don't know"

Adverse childhood events

Rajesh Munglani wrote an excellent article on adverse childhood events (ACEs) and chronic pain in the March 2020 issue of Pain News. This started me thinking about *'what we know and don't know about those we care for'* and *'what do we do with the information that we have'*. This article discusses those two questions.

'Next to God is a Doctor'

For 26 years I have run Pelvic Pain Clinics in one form or the other. My original training was from the basic science aspects, working with Stephen McMahon and Pat Wall on nerve injury including bladder pain; then over the past 20 plus years undertaking joint clinics with urologists, urogynecologists, neurologists, neurosurgeons, renal surgeons, psychiatrists, psychologists, physiotherapists and radiologists. I have attended many meetings from other disciplines and right from the start have attended multidisciplinary team (MDT) meetings. I currently sit on the European Guidelines Committee for Chronic Pelvic Pain and have done so for 18 years, as well as IASP and NHS England committees. I still do not know everything about the subject and learn every day.

My father-in-law (a doctor) was once told 'Next to God is a doctor'. As clinicians we have to be very careful with the information given to us and need to avoid any form of superiority – our actions will seriously impact on our patients; and whereas we can't always get it right a starting point is to debunk the myth of 'next to God is a doctor'.

The patient's journey

As well as always learning about the science of the field we work in, we will never fully understand the journey of our patient's life. In his article Raj touched upon the importance of understanding that journey. How do we achieve that?

Passive listening and active listening, passive enquiry and active enquiry

Understanding the patient's journey

Over the years many have lectured me on the importance of giving the patient time to talk; but, within a time constrained NHS can we afford the time to do that? There are debates both ways. The Faculty and BPS have argued for our employers to allow us adequate appointment times, but sometimes an hour can stretch into 90 minutes and we still have not fully understood the patient's concerns and needs. We may struggle to separate out events, to balance distress and reality, to understand if it is the pain or the implications

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that most bother the patient. This is particularly true for understanding and treating pelvic pain:

For me, the most important part of a consultation is having an enquiring mind

How does the information that we are given relate to the reality of the situation? If that is true, why is it true? How does that make sense and how can we explain the other? I disagree with a tick-box consultation, though use tick-box aide-memoires to ensure I have covered everything:

For the patient the most important part of the consultation is that they are heard.

I will often start the consultation by telling the patient *'their journey is unique and whilst I have been working with pelvic pain for over 25 years, they (the patient) are the expert in their own condition'*. As a consequence, I explain that I will stop and start them as they talk. If I don't hear and understand their story, I can't help them. If they have a written history, I ask them to refer to it rather than I read it. At the end of actively listening to the history, I give them time to reflect. If I interrupt during my active enquiry, I explain why and so I am reinforcing my active listening as I actively enquire. My questions may be closed if there is a specific idea or fact that I don't follow, or open.

There are many who will disagree with this approach; however, most of my patients have seen multiple doctors and been to at least one if not several pain clinics and the full facts have often not been previously fully disclosed. With this approach I often pick up on things that the patient has never divulged, things that need discussion as a minimum prior to any other action/intervention. As an example, I detect an ACE or a negative sexual encounter (NSE), previously not declared, every few weeks.

I am not a psychologist, though psychologists have been a part of my working life for 30 years. As I am not a psychologist, I am not the best to tell you how to ask difficult questions. But my view on this is, if you listen, the clues are there and the time to ask opens up. Returning to tick-box consultations, the question about NSEs is on page 3. However, asking very early on during the history (page 1) or towards the end of the consultation (page 7) may be more appropriate, depending on how the story unfolds. Sometimes asking during the discussion around the examination is an appropriate time. Listening, being intuitive and asking relevant questions in a sensitive manner is more important than just asking the question and ticking a box. I don't always get it right and as a consequence ...

When you ask, always give an explanation. That explanation may be simple,

I am sure that you understand that we have to ask some difficult questions about personal matters including sex; but, for some patients it is very important to the patient that we have asked. Are you happy for me to ask you such questions?

would be one such example. In other cases, the explanation may need to be more specific for the patient.

Forewarned

For our pelvic pain patients, prior to the consultation we send out an explanation sheet about the appointment, including some information around personal aspects that may be discussed (as well as around the examination). At the start of the consultation, as well as telling them 'their journey is unique ...', I explain that 'some of the questions may be personal', 'an examination may be necessary, but we can discuss that closer to the time'.

So what might these questions open up ...

ACEs

These may be physical abuse, sexual abuse, neglect or emotional. Childhood starts from pre-birth and extends to a young person's 18th birthday. However, the abuse may continue into adulthood if the perpetrator is still around or if the adult is vulnerable – be aware, you can't afford to miss ongoing trauma.

Safeguarding children is everybody's business

For many years, *'All those who come into contact with children and families in their everyday work, including practitioners who do not have a specific role in relation to child protection, have a duty to safeguard and promote the welfare of children'* (HM Government, 200606. What to do if you're worried a child is being abused).³ The statutory requirement of us extends beyond the children directly under our care and includes the children of our patients, and even has implications for our private lives.⁴ All of us should work within an environment that can support us if we have concerns, both within the NHS and the private sector.

EVERY YEAR IN HIGH INCOME COUNTRIES

4-16% of children are physically abused

10% are psychologically abused or neglected

80% of this abuse is carried out by parents

5-10% of girls and 5% of boys are sexually abused (penetration)

Three times this number are sexually abused in other ways (such as forced to watch pornography)

25% of abuse is by parents

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Less than 25% is reported to agencies. The above figures come from the UCLH mandatory training. It is clear to me that all of us in clinical practice need to have mandatory training in this field up to date as we are very likely to be involved in identifying and supporting the victims. The numbers are embarrassingly unable to convey the experiences people have gone through and we must actively support, not just label.

Adult abuse

Abuse is treatment of an individual that causes significant harm and can result in the deterioration of a person's physical, emotional, social or behavioural development. The event(s) may be physical, domestic violence, sexual, psychological, modern slavery, discriminatory abuse, organisational abuse, neglect and acts of omission. Sixty-five percent of abuse occurs at home. Once more, we have a duty of care to protect 'vulnerable adults'. However, for many issues of abuse where the individual has capacity our roles are more difficult. If in doubt, speak to someone in your team who knows (in every hospital there should be systems in place) or speak to your medicolegal defence union. Remember your actions can increase the risk to the individual; don't rush in, get advice.

The prevalence of adult abuse

The Crime Survey for England and Wales estimated that 1:40 (2.5%) women and 1:250 (0.4%) men were victims of a sexual event in the previous year. Sexual assault by penetration was

estimated at 1:200 (0.5%) women, 90% knew their attacker. For men the figure was 1:1,000 (0.1%) (Office for National Statistics for 2012/13, published 2014).

Not all NSEs are criminal.⁶

As you would expect, the results are higher for more vulnerable individuals. Men are affected as well – by other men, but also by women.

The Crime Survey for England and Wales estimated the

	Women	Men
% experiencing attempted sex against their will	19%	5%
% experiencing completed sex against their will	10%	1.4%
Median age at which it occurred	18	16

lifetime incidence of sexual assault is 19% for women and 3.4% for men. The Natsal study doubled those figures.⁷ The perpetrator is only a stranger in about 15% of those cases where the victim is over 16. If under 16, it is nearly always a member of the family or an acquaintance. Coercion due to inappropriate pressure is a major issue perceived by those under the age of 18⁸ (Young People, sex and relationships: the new norms, 2014).

It is generally accepted that the reported figures for adult sexual trauma are an underestimate of the reality. Also, as mentioned above, the numbers fail to reflect the personal trauma. As a specialist in pain medicine, I feel it is our responsibility to be non-judgemental, supportive and to provide clinical help. It is not our responsibility to enter into the arguments around the nature of the event, the issue of consent, the type of force or coercion involved. Whereas these will have legal implications (and, as a consequence, affect definitions and statistics), the person presenting to us is looking for help and understanding where our actions need to be clinical or directing the patient to where they can obtain support and safety.

Sexual trauma in war and torture

These are difficult areas for us to fathom. In 1993, a European Community committee stated that the mass rapes and/or sexual torture of women in Bosnia-Herzegovina must be considered systematic, ordered acts and an important element of Serb warfare strategy.⁹ In a paper by Pia Moisander¹⁰ in 2003, they looked at patients from Bangladesh, Iran, Peru, Syria, Turkey and Uganda. Post-traumatic stress disorder (PTSD) was identified in 69%–92% by country (overall average 79.8%) of individuals, with rape in 28% and a similar figure of



Kopf eines leidenden Mannes: Head of a suffering man.
Albrecht Dürer. 1503 Northern Renaissance. Public domain.⁵

28% also suffering genital torture. The majority of the rape victims were men. As a consequence, we need to be aware of refugees, especially if they have been interned. *Remember that these vulnerable individuals may not be prepared to discuss such events in the presence of an interpreter whom they do not know/trust.*

Fewer than half of those affected by sexual trauma will have told anyone about their sexual assault and only 13% of women and 8% of men had told the police; despite the significant psychological implications, few will have received help. As a consequence, in an average clinic, we will see a victim and it is likely that we could be the first professional to know. That is certainly my experience.

It is clear that childhood non-consensual sexual acts will have a significant effect on the victim, as mentioned in Raj's article. There is also a literature that supports the fact that in adult victims there will be a greater prevalence of psychological problems, including alcohol misuse and self-harm, that is understandable. Not only are women affected.¹¹ Also it is likely, chronic pain and particularly chronic pelvic pain may be more likely.

However, there are a number of important considerations here as well. In 2008, in a chapter I wrote for our book, *Urogenital Pain in Clinical Practice*¹² I stated (with a slight change in emphasis as I re-read it):

Whether such non-consensual acts predispose to chronic pelvic pain is unclear from the literature; the prevalence of non-consensual sex acts reported in our urogenital pain clinics at University College London Hospitals, is probably no greater than in the general population. As a consequence, we must assume that there are other more significant mechanisms other than abuse producing urogenital pain for most patients?

I go on to say:

The pain can significantly stir up memories of the abuse causing significant psychological distress; patients often question the relationship of the pain to the abuse and may not be able to separate the two out. As a consequence, a history of abuse must always be considered and managed appropriately.

I would emphasise, even when there is a history of a NSE, in my experience of working with patients, the pain is real. The NSE may need intervention in its own right and management of the pain condition separately, in other cases the two will be intertwined. In some cases, the NSE has been managed and is not an ongoing major issue.

Mesh-related injury and other medical assaults

It is not my intention to discuss the injuries sustained by individuals who have undergone the insertion of mesh as a part of their surgery, or who have had a surgical/medical complication. The reason I mention it here is that those involved will often feel violated and traumatised and they may need support for those aspects as well as around the pain.

Normal sexual function and when is it abnormal?

If you manage pain you need to understand the normal anatomy, physiology/function, pathology/treatment of the conditions/areas you are involved in. The depth of that knowledge will vary depending on the complexity of the issue. However, from a patient's perspective, they will lose confidence if you do not understand the implications of their pain. For some patients the implications may have greater significance than their pain. For pelvic pain, this includes understanding bladder, bowel, musculoskeletal and neurological function as well as sex.

Is it important to ask about a patient's normal sexual activity?

Quite simply, we should never ask a question without it having a clinical purpose, in the same way that we should not examine a part not clinically relevant or order an investigation that will not impact on clinical management.

Asking about sexual practice can be appropriate if considering mechanisms of pain, the effect of sexual activity on the pain and the effect of pain on sexual activity. Again, I think this is a page 3 question that you ask when it appears relevant and not when you get to page 3. As well as the question, an explanation of why you are asking is required and it is good practice to ask the patient if they understood why you asked. If the question is relevant and can be seen to be relevant, most patients will be pleased you asked.

Sex is complicated!

John Bancroft's book *Human sexuality and its problems*¹³ (now in its third edition) is a key reference here. In my chapter 'Men and urogenital pain' (*Urogenital Pain in Clinical Practice*, Edited by Baranowski, Abrams and Fall, 2008), I try to summarise the data and put it into context for the pain patient. *Sex by numbers*¹⁴ by David Speegelhalter (2015) is a more chatty scientifically based review of sexual behaviour.

Desire (sexual interest/appetite), arousal (heightened sexual awareness – central sensitisation response with increased tactile and thermal sensitivity), physical response (erection (potency)/vaginal receptiveness), sexual satisfaction, orgasm/

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orgasmic sensation and time to orgasm (intravaginal latency/premature ejaculation, inability to achieve orgasm) are all different. There may be overlapping mechanisms but the mechanisms may be incremental or independent. For instance, having an erection does not always equate with sexual arousal. I will let you work that one out ...

When is it abnormal?

A consensual sexual activity is abnormal when it gives concern to the patient or when it has changed from their normal, excluding antisocial and criminal behaviours (Baranowski's definition, but consistent with definitions of premature ejaculation as an example). I am keen not to give examples, but rather suggest that you don't judge what the patient tells you by your own practice and social attitudes.

Whereas asking about sexual activity may help us understand a mechanism, often concerns of a change in what a person has considered normal may be more important. To put change into context, the clinician needs to know the patient's expectations and experience of normality as well as the published mean/range of normality for a population.

The stories I can tell ...

But I will not ...

It is important to realise that our own experiences, values and understanding of the literature should not colour our opinions of what we are told and how we handle that information which we are given in trust. We should not repeat what we are told to others ...

you only know what you know,

you still don't know what you don't know

So now you hopefully know what you know, you know something that you did not know, and you are aware that there's something else to know, though you may still not know what that is.

What do you do with the information?

I have alluded to much of that as I mentioned the sort of information we might collect. The knowledge that we gain by this approach has to be used with care and consideration:

- Always record the information clearly in your notes.
- For children and vulnerable adults, we have a legal duty of care to report and take action – find out how you need to

do this locally within the service in which you work. It is not only wrong to keep this to yourself, but illegal.

- Never provide the information to someone who does not need the information that includes unintentionally. For instance, we would never write specifics in a general letter; rather we would use phrases such as, 'past events that need specific management'.
- In high-risk situations speak to those who need to be informed.
- We have to have the skills to support the patients as they tell us about the issues that have affected them. Suicide risk and self-harm are likely to be high. As a consequence, get training, know what the suicide risk policy is for your service.
- Sensitively use the information in your explanations to the patients.
- Never label patients; the information is only a part of the story.

So, what next?

- Hopefully some of my thoughts will have inspired you to go out and read more and to learn more about adult traumatic experiences, child adverse experiences, NSEs, what is normal sex and what is abnormal.
- Hopefully, you will see an understanding as to why gentle, sympathetic enquiries around these areas are important when trying to understand the patient journey around their chronic pain symptoms. Those enquiries may help with diagnosis but are essential if we are going to have a full understanding of the patient's experience.
- It is important that we work as a team to support the patient but also to support the team members, as the stories can be very traumatic for us as well. Consider how you support yourself and the team when you are exposed to traumatic information. The doctors and nurses are at particular risk as we don't usually have in place the same support systems as our colleague psychologists and psychiatrists.

It is important not to label patients, but to accept their experience. In patients with a traumatic past, the experience may predispose to chronic pain, as Raj indicated in his article. However, many patients with chronic pain suffer as a result of their pain and not because of any other instance. As a consequence, previous traumatic experiences may be independent and not directly related to the pain the patient is presenting with. However, the previous experience may require management in its own right or as a part of the pain condition.

Over the last 30 years or so, I have thought on this information and tried to use it wisely in the clinical setting. Hopefully, you will also be inspired to think about the relevance

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of these issues to your patients and clinical practice; and, also to go out and learn more.

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What is truth?

Nicholas Hacking



Что есть Истина, Христос и Пилат

What is Truth. Christ and Pilate Nikolai Ge 1890 Public Domainⁱ

Nikolai Nikolaevich Ge (from his French ancestral surname 'De Gay') (Russian: Николай Николаевич Ге, lang-uk, translit. Мико́ла Микола́йович Ге; 27 February (O.S. 15 February) 1831 – 13 June (O.S. 1 June) 1894) was a Ukrainian realist painter and an early Ukrainian symbolist. He was famous for his works on historical and religious motifs. He was born in Voronezh to a Ukrainian noble family of French origin. His grandfather immigrated to Russian Empire during the 18th century. His grandfather, Osip Ge, married Daria Korostovtseva, the daughter of the Poltava landowner Yakov Korostovtsev. The father of the artist Nikolai Osipovich Ge was married twice. After the death of his first wife Elena Sadovskaiiⁱⁱ

Dicit ei Pilatus: 'Quid est veritas?'. Et cum hoc dixisset, iterum exiit ad Iudeos et dicit eis: 'Ego nullam invenio in eo causam'.

John, 18:38 which is rendered in the vulgar as

Pilate saith unto him, 'What is truth?' And when he had said this, he went out again unto the Jews, and saith unto them, 'I find in him no fault at all'.

And here we are, a couple of thousand years later, feeling that we, like Jesus, are faultless and wondering, like Pilate, about the nature of truth. In this analogy, I suppose that National Health Service (NHS) England (NHSE) and the Clinical Commissioning Groups (CCGs) are the noisy rabble, keen to bring an end to us and our proselytising.

I'm talking about periarticular lumbar facet joint injections in particular, and in general about the entire practice of Pain Medicine. We have, we know, a weak evidence base for much of what we do. Weak, that is, if we buy in to the tyranny of randomised controlled trials (RCTs) in large populations.

The NHS doesn't like facet injections because they are 'ineffective'. What sophistry. We have all seen patients who do very well with one or two injections a year. I personally had one a few years ago and it got me back to work in a couple of days. The truth, as I see it, is that they can be extremely effective. The problem is that, for most folk, the pain relief wears thin after 2 or 3 months. A few might get 6 months of symptom improvement. I'll bet that we all have a couple of patients each who have one injection a year. But, if we are honest, 3 months is a good outcome for the majority.

And that's what NHSE doesn't like: huge numbers of people having repeat treatment. Whatever you do, please don't tell the bean-counters about diabetics needing several insulin injections a day or they may just decide to let my daughter die. And, for Heaven's sake, let's not drop the epileptics and the asthmatics in it: if NHSE realises that they need on-going treatment, they might just pull the plug on them too.

But hang on, I don't want to treat every patient who has back pain with endless facet injections. I want to be able to try one when I think that a patient needs a quick rescue. I want to be able to offer them to patients who get 6 months or more of symptom relief. If we need to repeat facet injections every 3

months, then we should be trying diagnostic medial branch blocks with a view to Radio Frequency.

No, Nicholas, you cannot continue to practice in this way: NHSE has decided. You might as well try to pick an argument with Stalin.

Well, I wonder, how can it be that NHSE can decide that facet injections are 'ineffective' and yet I have a small cohort of patients who are mostly older, appear to me to be sensible, who keep going with my injections? And by keep going, I mean that they avoid useless and damaging analgesics; they support family members; they continue in paid employment; the benefit to these folk, and to society, is immeasurable. But NHSE doesn't trust my judgement. It knows better. It wants to condemn them to a painful useless death because it is incapable of seeing the bigger picture.

And now we come to it. Is NHSE populated by evil people who want to increase human suffering? It's a hypothesis, to be sure, but I doubt it. The issue is that they have looked at the 'evidence' and decided that facet injections are a waste of money. They really do want to make sure that tax payers' money is spent usefully.

I've been a Pain Doctor for years. I want to treat pain, so I devise putative remedies, I give them to my patients, and I see which ones help them.

But, here's a problem. The problem is with the evidence. The problem is with the nature of truth. My patients' replies are nothing more than anecdote. Perhaps they have a placebo response. Perhaps they are mis-reporting? How to get these troublesome humans to give me scientific answers?

Let us have a pain scale. 0 can be no pain. 10 equates to the worst pain ... surely, science lies in numbers? I ask my patients: 'what pain level could you cope with?' The answers tell me a lot about the pain score, the most important of which is that pain scores are meaningless. And, by extension, research based on pain scores is at best suspect. I'm pretty sure that I could, if I wanted, manipulate them to give me a high number (8+) or a low one (3-). What does this tell us? That pain and pain-reporting are entirely subjective. Any evidence which is based on an average population response might tell us something about the population, but it tells us nothing about the individual patient.

Measure my blood pressure. Measure my height. Weigh me. Note my shoe size. But measure an emotion? Has the World gone barking mad? If you ask me my pain score as I type this: I'll say 0/10. When I've been wearing a lead apron for eight hours: 4/10. When I hurt my back in the tug-of-war: 12/10

(ooh, yellow flag there). These numbers are meaningless to anyone other than me. Pain is multidimensional, yet we try to 'measure' it with a one-dimensional score. Worse, people start aggregating pain scores over populations and then attempt to compare them.

And so the man who is unable to work because of his 6/10 pain is lumped in with the girl who could get back to college if only we could reduce her pain to 7/10.

I'm referred patients for whom conventional medicine has no answer. So, dear reader, are you. Many, possibly the majority of these patients, have somatoform disorders. If the NHS is going to stop funding treatment for this difficult group, let the politicians stand up and say so. If it wants me to do what I can, let me do it.

We have shifted away from the conventional model. Some of our colleagues outwith pain medicine are moving the same way. Why do the RCT junkies continue to judge us with pain scores? Are patient-reported outcome measures (PROMs) not more valuable? Or, should we not trust patients' pain reporting?

'You are mis-scoring your pain. You have had the State-approved treatment. You must now be feeling the benefit. Please re-submit a pain score that is acceptable to The Party'.

Oh, Brave New World.

We KNOW that all pain is essentially affective. We have a huge amount of psychological research which tells us that mood and pain are inextricably linked. We have imaging techniques which demonstrate that the frontal, affective, component of pain is all-important. When all is said and done, pain (I'm preaching to the converted here, I know) is the emotional response that humans normally associate with tissue damage. Tissue damage does, often, generate pain. There is a massive body of evidence which blows holes in the notion that tissue injury is proportionate to pain. We cannot measure pain any more than we can measure lust, or envy, or altruism, or inner peace. These are feelings that are confined within us and so we have to accept that we are trying to help patients with an unquantifiable problem. Pain (particularly 'chronic pain') is often seen with minimal or no 'organic' factors to explain it. And yet we still look to these wretched pain scores for answers and, worse, perform pseudo-mathematical operations upon these numbers.

Do you love your husband? You do: how much? Is 1/10 still love? It may well be enough to keep some marriages together. Other people may start to drift apart when one of them no-longer feels 10/10. And, hate: how much do you

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hate HMRC? What about repressed jealousy? How much do you wish that the Lamborghini in the car park was yours, instead of the BMW that you are going to have to drive home?

Does this mean that we should be able to offer whatever treatment we like to whomever we wish? Pretty obviously not, at least as far as the NHS is concerned, but we should shift our focus to those things that we can measure. This is why I am a great supporter of PROMs. If I establish that my patient wants to be able to grow cabbages and his pain stops him from doing this – why, then, if he can tend his cabbages after my treatment, it has succeeded. Even if there is no statistical shift in his pain score. Even if, now

that I've denervated his lumbar facets, his shoulders are just as sore.

Let us, please, stop using simplistic notions when we discuss pain. 'Scores' are at best naive and, at worst, nonsense. Blanket recommendations and bans have their place in the regulation of health expenditure, but not in something so complex and multi-dimensional as pain treatments. Where we can do good, let us do it.

Notes

- i. <https://www.wikiart.org/en/nikolai-ge/what-is-truth-christ-and-pilate>
- ii. http://en.wikipedia.org/wiki/Nikolai_Ge

Group interventions for chronic pain: what are the active ingredients? A reflection on change processes

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Young Woman of the People, Amedeo Modigliani 1918; Paris, France.
Style: Expressionism. Los Angeles County Museum of Art (LACMA), Los Angeles, CA, US Public Domain.¹

Introduction

The question of what is the effective factor in therapeutic interventions has been asked and investigated over many years and yet it continues to be difficult to conclude exactly what the ingredient of change is. This report revisits this question in relation to group-based interventions in chronic pain.

Factors such as therapeutic alliance,^{2,3} the characteristics and expectations of the client, and the model or therapeutic technique used⁴ are reported as influencing change processes in individual therapy. In addition, within therapeutic groups, cohesiveness,⁵ social support which can increase an individual's willingness to engage in increased activity⁶ and opportunities for shared learning and identification with one another⁷ have all been reported to impact therapeutic gains.

Cognitive Behavioural Therapy (CBT)-based Pain Management Programmes (PMP) have been established by strong supporting evidence for quite some time.⁸ Pain management programmes include a combination of education, psychological therapy and physiotherapy. It is the combination of these factors that is believed to help people experiencing chronic pain live better with pain by enhancing their understanding of pain experience, reducing avoidance and providing psychological techniques and understanding to enable motivation to try new skills and increase movement/activity.

The reported benefits of PMPs have shown a positive impact across multiple aspects of patients' lives, including reducing levels of anxiety and depression,⁹ improving coping skills and reducing reported pain intensity¹⁰ and have shown overall improvements in health-related quality of life.^{9,10}

In recent years, the relevance and benefit of aspects of Acceptance and Commitment Therapy (ACT) has been found in the treatment for Chronic Pain and thus CBT PMP programmes generally include elements from ACT such as mindfulness training and values-based living. Mindfulness practice alone also has a growing evidence base, demonstrating that this intervention can improve experience of reported pain, depression symptoms and quality of life for patients with chronic pain.¹¹ Furthermore, when mindfulness has been compared with multidisciplinary pain intervention programmes, such as PMPs, it has been found to be equally effective in decreasing pain intensity and pain-related distress¹² and in decreasing levels of anxiety and depression.¹³

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Despite consistencies in the content of pain management programmes, they do not generally follow standardised manuals and thus there will be slight variations in the delivery of programmes across the country. Therefore, the active ingredients of change may be hard to conclude.

A service audit (no randomisation took place) was completed to look at the question of change processes in group-based interventions in chronic pain services; a comparison between three different groups developed for people with chronic pain were used in the service audit. The three different groups included (1) a traditional PMP; (2) a tai chi-based seated movement group; (3) a well-being group with an emphasis on mindfulness practice. All are established group interventions used by the Isle of Wight NHS Chronic Pain Service to which patients are referred, depending on appropriateness of individual clinical need.

Comparisons were made by looking at the pre- and post-group scores on two shared self-report measures used across the groups and by examining qualitative feedback reported on experience questionnaires. The two outcome measures used across the groups included, first, the Pain Catastrophizing Scale (PCS)¹⁴ which is a 20-item self-report questionnaire that assesses a person's thoughts, feelings and worries regarding their chronic pain. This measure combines rumination, magnification and helplessness to gain an overall catastrophising score. A score of 30 or above is considered clinically relevant. The second outcome measure is the Patient Health Questionnaire 4 (PHQ-4)¹⁵ which is a brief scale used to measure levels of anxiety and depression. Total scores can range from 0 to 12. A score of 0–2 indicates a normal level, 3–5 indicates a mild level, 6–8 indicates a moderate level and 9–12 indicates a severe level of anxiety and depression.

The comparisons between the three intervention groups demonstrate similar positive psychological shifts for individuals in relation to pain catastrophising, anxiety and depression irrespective of which group was attended as reported using the PCS and PHQ-4. Thus, if the intervention styles are all effective, the question is raised as to whether the content of a programme is important for positive psychological change or whether it is something else?

Therapeutic alliance (i.e. the relationship between the healthcare professional and client) is commonly cited as an active ingredient of change in therapy^{4,5,16} significantly influencing outcomes in psychotherapy and pharmacotherapy.¹⁷ The facilitators for each group were different. Facilitators included clinical psychologists, a physiotherapist, an assistant psychologist and a tai chi instructor, all of whom were highly experienced in their intervention methods. Although the facilitators were different,

the participant feedback questionnaires provided a great amount of positive associations with the facilitators across the groups, including gaining a sense of validation, valuing being listened to and having trust in the knowledge of the facilitators. Indeed the impact of therapeutic alliance has been assessed and concluded from two well-cited meta-analyses as the most consistent and strongest predictor of treatment success.^{2,3} Therapeutic alliance (and client motivation) reportedly account for more therapeutic change than the therapy style used.¹⁸

Another factor that may be relevant in understanding the positive changes in group scores is group cohesiveness. Group interventions allow the development of relationships for every member.⁷ This sense of belonging and alliance between group members also appears to positively impact intervention outcomes.⁵ The individuals across the intervention groups reported gaining benefit from having a shared understanding of each other's abilities and struggles which may have enabled them to develop positive relationships with each other.

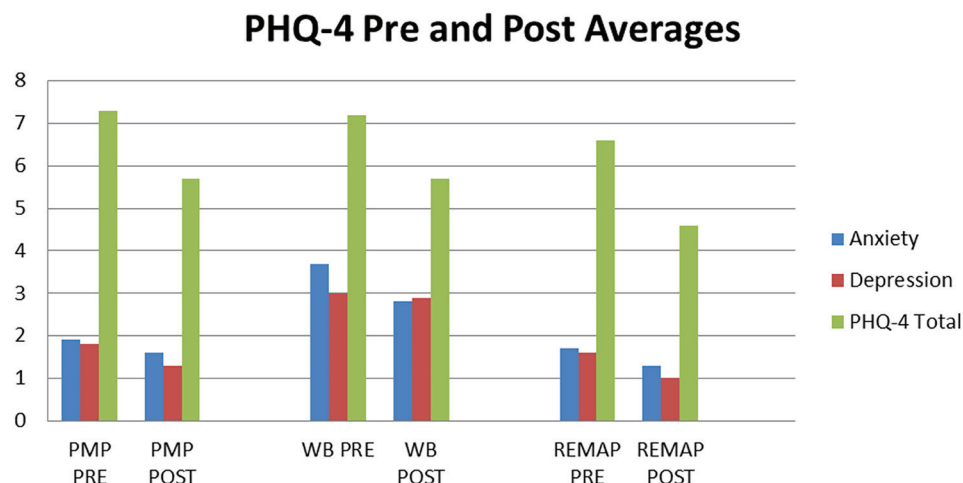
A shared sense of identity enhancing group cohesion may enable people to feel more at ease, thus enabling individuals to engage fully in the process of the group.⁵ Indeed, the main remaining theme that emerged from qualitative feedback was that individuals felt their confidence and ability to manage pain had increased. Improved confidence and greater self-management skills are factors that are associated with reductions in fear about pain¹⁹ and improved mood and reduced anxiety.²⁰ In addition, group members sharing their experiences with each other may have also provided the opportunity for learning and increased skill (and confidence) development for other members of the group. Holmes and Kivlighan⁷ reported that additional learning from group members sharing knowledge and information is another benefit of group interventions.

Group comparisons

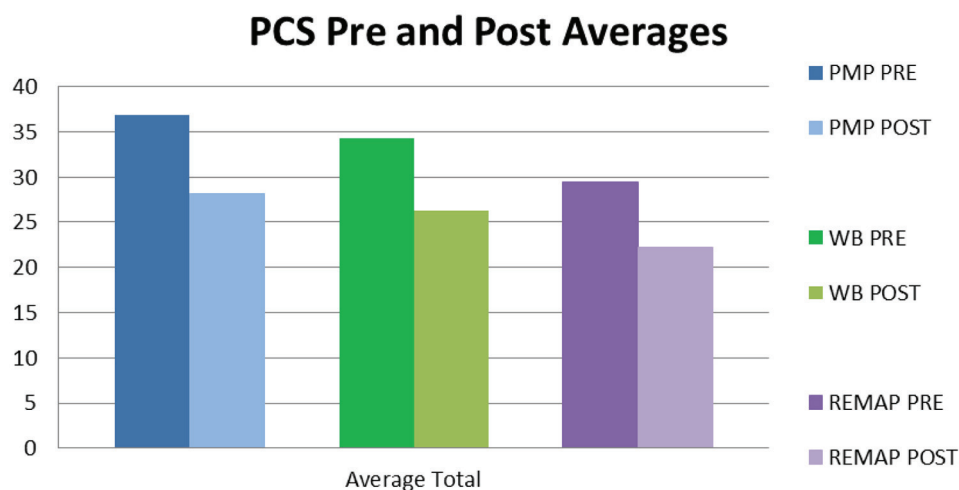
The qualitative feedback from the Patient Experience Questionnaire (PEQ) accumulated multiple thoughts, ideas and feelings regarding each of the group interventions. While no formal qualitative analysis has been undertaken, some themes emerged from feedback across the groups presented below.

1. Shared group understanding/ group cohesion

The most prominent theme from the PEQ across all of the groups showed that individuals found being part of a group with others with similar conditions beneficial. Individuals appeared to have found that having a shared understanding of

Figure 1. A chart to show the changes in average group scores for the PHQ-4.

PMP: Pain Management Programme; WB: wellbeing (mindfulness-based) group; REMAP: tai chi chair-based exercise group.

Figure 2. A chart to show the changes in average group scores of the PCS.

PMP: Pain Management Programme; WB: wellbeing (mindfulness-based) group; REMAP: tai chi chair-based exercise group.

each other's abilities and struggles meant that they were more relaxed, felt at ease and were thus able to engage in the group and continue to attend sessions. This is demonstrated through the following comments:

'As well as going to do the purpose of the class it becomes a social event, which in itself makes you feel better'
'I enjoyed the company and the sharing'

'Being with like-minded people in similar circumstances always helps'

'Being with people with similar problems, immediate rapport and understanding'

'It was lovely to be with a group of people who understand'

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'This course enabled me to make friends'

'It was nice to hear other people's experiences and how this helps them as well as me'

2. Relationship with facilitator(s)/ therapeutic alliance

A further theme that emerged from the feedback was that individuals attending the groups felt they had been listened to, supported and positively impacted by the healthcare professional(s) delivering the interventions. Individuals gave feedback on the interaction between themselves and the facilitator(s):

'A calm and caring teacher, in a short space of time she has taught us a lot'

'I felt listened to and the programme was delivered really well'

'They were very kind, helpful and engaging, included me in every aspect'

'They were very supportive and encouraging and I am extremely grateful to them'

'They are a very understanding person and made me feel very welcome and comfortable'

'They were empathetic, really knowledgeable, included everyone in the group, listened intently and reflected comments back to people'

3. Sense of increased self-management skill/confidence

The final main theme that emerged reflected the benefits reported about experience of pain and ability to cope. Individuals noted their ability to better self-manage their pain, psychological shifts towards acceptance and overall better wellbeing:

'We can control the pain and not let the pain control us and our lives'

'Each week I have been motivated to move more'

'This course has given me tools that really work'

'Given me a greater understanding of pain and how I can manage my pain better'

'It gave me more ideas on how to manage my condition'

'I am now able to cope better with my pain on a daily basis'

Discussion

The comparisons between the three intervention groups demonstrate similar positive psychological shifts for individuals in relation to pain catastrophising, anxiety and depression irrespective of which group was attended, as reported using the PCS and PHQ-4. Thus, if the intervention styles all are effective, the question is raised as to whether the content of a programme is important for positive psychological change or whether it is something else?

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Another factor that may be relevant in understanding the positive changes in group scores is group cohesiveness. Group interventions allow the development of relationships for every member.⁹ This sense of belonging and alliance between group members also appears to positively impact intervention outcomes.⁵ The individuals across the intervention groups reported gaining benefit from having a shared understanding of each other's abilities and struggles which may have enabled them to develop positive relationships with each other.

A shared sense of identity enhancing group cohesion may enable people to feel more at ease, thus enabling individuals to engage fully in the process of the group.⁵ Indeed, the principal remaining theme that emerged from qualitative feedback was that individuals felt their confidence and ability to manage pain had increased. Improved confidence and greater self-management skills are factors that are associated with reduction in fear about pain¹⁹ and improved mood and

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reduced anxiety.²⁰ In addition, group members sharing their experiences with each other may have also provided the opportunity for learning and increased skill (and confidence) development for other members of the group. Holmes and Kivlighan⁷ reported that additional learning from group members sharing knowledge and information is another benefit of group interventions.

In summary, the patient experience questionnaire comments encapsulated the positive effect the intervention groups have on attending patients. The responses demonstrate how being in a group with other people with similar conditions can combat feelings of isolation that living with chronic pain can bring. A shared identity and social support can indeed lead to a greater willingness to engage in increased activity.⁶ Thus, the social aspect (and sense of connectedness) of the groups appears to be vitally important in enabling people to engage with the learning and skills development of their pain self-management. A larger-scale comparison of group interventions across services would be interesting and beneficial to gain further understanding of the active ingredients of change of group interventions for chronic pain patients.

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Managing a patient in pain clinic with suicidal ideation: a practical guide

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Key points

1. Patients with chronic pain are several times more likely to contemplate, attempt or complete suicide than the general population.
2. We could consider high-risk individuals to be people with: severe forms of pain, common psychiatric disorders, psychological distress, history of suicidal behaviour, perceived disconnection from others and a sense of burdensomeness.
3. A thorough risk assessment can help clinicians to make the right decision and prevent loss of life.
4. Suicide prevention is an important consideration for all services working with members of the public.
5. Familiarity with known warning and protective signs is recommended.

Learning objectives

By reading this article you should be able to:

- Discuss key demographic, social and psychological risk and protective factors associated with suicide for the general population and the chronic pain population.
- Assess for risk of suicidal thoughts and behaviour.
- Describe appropriate management of suicidality based on assessment of risk.

Working within any pain service patient complexity can include the management of high levels of emotional distress and suicidal ideation, in the context of both pain and non-pain related stressors. This commentary piece includes information regarding relevant research and suggestions for the management of this expression of distress. It is not designed to be a unilateral framework for patients with suicidal ideation.

Introduction

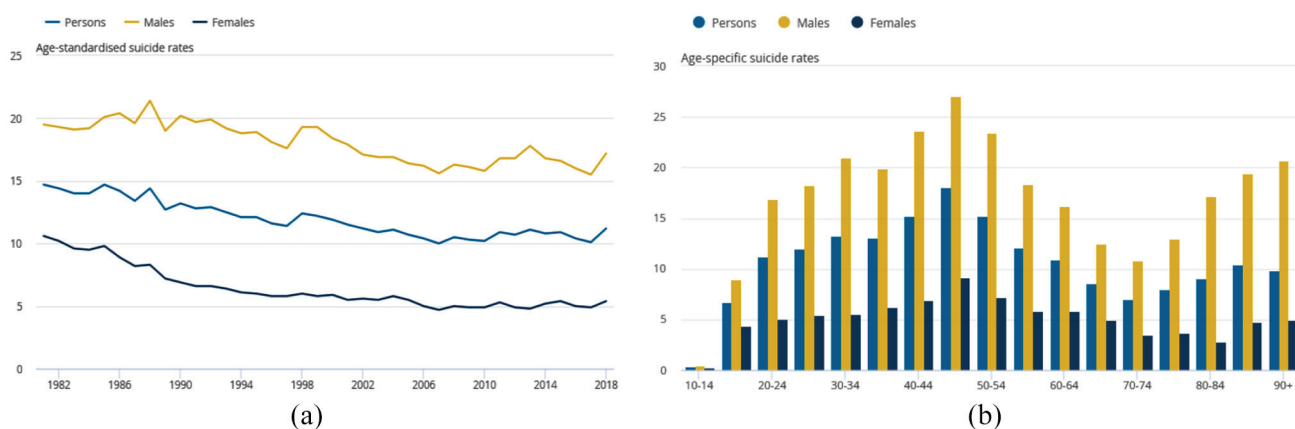
Suicide is described as a fatal act of self-harm initiated with the intention of ending one's own life. It is often viewed as impulsive but can be associated with years of suicidal behaviour including suicidal ideation or acts of deliberate self-harm.¹ Self-harm is defined as any act of self-poisoning or self-injury irrespective of motivation and is associated with an increased risk of suicide.¹

Information from the Office for National Statistics² states that there were 6,507 suicides registered in the United Kingdom in 2018, with this being significantly higher than that in 2017 and is the first increase since 2013. Of these 6,507 suicides registered in 2018, a total of 4,903 (three quarters) were male and 1,604 were female. Males aged 45 to 49 years had the highest age-specific suicide rate (27.1/100,000 deaths). The age group with the highest rate for females was also 45 to 49 years, (9.2/100,000 deaths). Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly for females aged 10 to 24 years old, where the rate has increased significantly since 2012 to its highest level with 3.3/100,000 deaths (see Figure 1).

Past research has identified many risk factors for suicide listed in Table 1.^{3–6} It is widely accepted that individuals with mental illness have a higher suicide risk than the general population,⁷ with a previous suicide attempt being the single biggest risk factor for suicide.⁸

Specific psychological factors have also been identified in addition to these more overt and measurable factors. The Interpersonal Theory of Suicide, suggested by Thomas Joiner in 2005, highlights the interpersonal processes within an individual that, together, lead to suicide attempts.⁹ It proposes that the simultaneous presence of thwarted belongingness and perceived burdensomeness produce the desire for suicide, which alone will not result in death by suicide. The third process of acquired capability (that is, the acquired ability to overcome one's natural fear of death) must also be present.

Figure 1. (a) Age standardised UK suicide rates by sex between 1981 and 2018. (b) Age-specific UK suicide rates by sex and 5-year age groups in 2018.



Source: Reproduced from the Office of National Statistics website 2019. Public Domain.

Table 1. Risk and protective factors for suicide.

Risk factors	Protective factors
<p>Previous suicide attempt or previous self-harm</p> <p>Male gender (three times more likely than women), Age (currently highest in the age group 45–49 years) Concurrent mental disorders or previous psychiatric treatment Unemployment</p> <p>Homelessness Alcohol and drug abuse Physically disabling or painful illness, including chronic pain Low socio-economic status, loss of a job Certain professions Low social support/living alone Significant life events – bereavement, family breakdown, institutionalised – eg, prisons, army Bullying (a factor in children and adolescents)</p>	<p>Children in the home (except among those with postpartum psychosis) Pregnancy Deterrent religious beliefs Life satisfaction Reality testing ability (to recognise the difference between the external and internal world) Positive coping skills Positive social support Positive therapeutic relationship</p>

We can see from the literature available that suicide is a complex multi-factorial event. The literature also identifies protective factors which keep people from acting on suicidal ideation, listed in Table 1.¹⁰

Suicidal ideation within the chronic pain population

Previous research has looked at suicidal risk within the chronic pain population. Tang and Crane¹¹ reported that suicidal ideation within the chronic pain population was 20% and that

chronic pain sufferers are several times more likely to contemplate, attempt or complete suicide. In addition, the lifetime risk of death by suicide is double that in chronic pain patients: between 5% and 14%.¹¹ Specific suicidal risk factors in chronic pain include type of pain, intensity and duration, sleep-onset insomnia, which appeared to be pain specific, helplessness and hopelessness, desire to escape from pain, pain catastrophising and avoidance, and problem-solving deficits. Research has shown that suicidal risk is much higher

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in back pain and abdominal pain populations, with risk being lower in neuropathic pain patients and arthritic pains.¹²

Smith et al.¹³ suggested that the presence of co-morbid insomnia with pain is an important associated factor, with 67% of the variance accounted for predicting suicidal contemplation. It is suggested that, as patients frequently report experiencing ruminating negative thoughts through the night, this process can exacerbate distress and sense of hopelessness, as insomnia means reduced respite from the pain or self-destructive thoughts.

Williams et al.¹⁴ suggested that the desire for escape from pain is an important risk factor to be aware of, particularly when sleep is also disrupted. A desire to escape suffering, together with a sense of defeat with pain, can lead to feelings of hopelessness which is widely accepted as a strong predictor of suicidal ideation and action. The concept of mental defeat within chronic pain populations is specifically explored by Tang et al.,¹⁵ who suggest it may be one of the strongest predictors of heightened suicide risk.

Relating these experiences to the Interpersonal Theory of Suicide, feelings of social connection are reduced in chronic pain patients whereas feelings of being a burden to others are increased.⁹ Several authors have found that these two conditions favour suicidality in people with pain, suggesting that perceived burdensomeness and thwarted belongingness induce an unpleasant psychological state and indirectly increase the risk of suicide.¹⁶ Providing further support for the Interpersonal Theory of Suicide, Wilson et al.¹⁷ found that both distress in interpersonal relations and self-perceived burden to others were significant predictors of suicidal ideation, even after adjusting statistically for demographic characteristics, pain severity and duration, functional limitations, catastrophising, and depression.

From the information presented above, we could consider high-risk individuals to be people with severe forms of pain, common psychiatric disorders, psychological distress, history of suicidal behaviour, perceived disconnection from others and a sense of burdensomeness.

Suicide prevention

Suicide prevention is an important consideration for all services working with members of the public. The House of Commons Health Committee published a report in 2017, following a suicide prevention inquiry, and recommends improved training for clinicians in the assessment of suicide risk, also stating, *'The clear message we have heard throughout our inquiry is that suicide is preventable. The current rate of suicide is unacceptable and is likely to under-represent the true scale of this avoidable loss of life'*.¹⁸

Better engagement of suicidal patients at the point of presentation and with the correct service that can provide

support is essential. It is helpful to recognise the responsibility clinicians have for preparing for these experiences within Pain Clinics when working with people who are in chronic pain. Having service policy documents and agreed protocols as a team, specific to your area of health care provision, can be very helpful. Having copies of support lines readily available when you are in clinic is also very useful. Regular Continuing Professional Development (CPD) training and refreshers in suicide prevention as a service can be very useful, to remain aware and up to date.

Your role in pain clinics

For clinicians working in pain medicine, it may be initially perceived that risk to self and suicidal ideation are for other health services to be aware of or for more specialist professionals to assess and identify. However, the above information suggests that it may be at this point in a patient's health care journey that serious risk of suicide may be identified and appropriate support sought. Hogan and Grumet¹⁹ suggest that detection, assessment and referral should happen from community public services and primary health care up through to secondary care hospital services.

Pain Consultants and other clinical specialists working in pain services may not receive formal training to manage patients at risk of suicide as part of their standard professional training but are very likely to encounter patients expressing suicidal ideation in their clinics and are required to manage these patients appropriately and safely.

Practical advice

A thorough risk assessment can help clinicians to make the right clinical decision and prevent loss of life. Assessment should include information gathering regarding known risk and protective factors, and should cover the following areas:

- Social (debt, work, social isolation, legal stressors)
- Personal (relationship breakdown)
- Life events (recent/current)
- Psychiatric (contact with psychiatric services, alcohol or drug problems)
- Psychological (hopelessness, impulsivity, burdensomeness)
- Motivation (desire to die, to obtain temporary escape, to lessen burden to others)

Familiarity with known warning and protective signs is recommended.

Clinicians' own anxiety and concerns about saying the right or wrong thing can affect how the assessment is experienced. There are several common myths about suicide that people can perceive to be true, for example: 'people who talk about

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suicide are only trying to get attention'; 'They would never really do it' or 'Don't mention suicide to someone showing warning signs, it may plant the idea in their mind'. Accurate factual information can help clinicians have confidence in managing the situation and therefore benefit patients. The fact that talking

about suicide does not cause someone to be suicidal, and can lead to patients feeling relief that they have the opportunity to have an empathic conversation, is very reassuring for many clinicians.²⁰ Knowing this information means that clinicians can then directly ask about the following key points to complete a

Table 2. Example questions and communication considerations.

Example questions	Communication considerations
How have you been feeling recently? Do you feel low in mood?	Make eye contact with the person
Have you had any suicidal thoughts?	Demonstrate empathy and compassion
How often do you experience these?	Acknowledge the distress of the situation and state you would like to help
Have you made any plans for acting on these thoughts?	Be direct – use the word 'suicide'
Have you taken any steps towards acting on these plans?	Don't minimise or dismiss, make judgements (e.g. 'do you have . . . silly thoughts' / 'you mustn't think that')
What stops you from acting on these thoughts?	Listen (don't over talk)
	Be prepared – have information to hand

Figure 2. Management plan for (a) suicidal ideation *with* protective factors and, (b) suicidal ideation with *limited or no* protective factors.

Suicidal ideation with protective factors:

- 1) No need for immediate referral to mental services
- 2) It is advisable to ask if they have stored any harmful drugs or are in possession of other lethal means. Review the patient's medication, checking for drugs that could be used for lethal overdose.
- 3) Give patient information about where to go if needs help in the future: GP / A&E / helpline numbers / Crisis Team (if known to mental health services)
- 4) Urgent letter to GP sharing information regarding suicidal ideation and protective factors
- 5) Request review and monitoring

(a)

Suicidal ideation with limited / no protective factors:

- 1) Explain plan to patient.
 - 2) Advise not be alone
- Options:
- 3) Phone GP urgently
 - 4) Refer to local Crisis Team for assessment. State that it is an urgent referral and an emergency assessment is required.
 - 5) Follow up your telephone calls with a fax, letter or email to confirm the referral.
 - 6) If you judge that the patient is at **high risk**, encourage them not to leave until appropriate safety measures are in place.
 - 7) Send to A&E with family or escort with accompanying letter.
 - 8) Phone police for welfare check (if patient leaves clinic and you have concerns about safety)

(b)

Figure 3. Example service document to aid assessment and decision making when managing patients with suicidal ideation.

See supporting information on Page 2		Supporting Information	
<p>1. Suicidal thoughts – not judged to be an immediate risk <i>suicidal ideation with protective factors</i></p> <ul style="list-style-type: none"> Give patient information about where to go if they need help in the future: GP / A&E / helpline numbers (see supporting information page 2) Send urgent letter to GP sharing information regarding suicidal ideation including both risk and protective factors Make an appointment to see the patient within 6 weeks to maintain contact 	<p>Questions to ask if you suspect a Patient may have suicidal thoughts <i>in your own style</i></p> <p>Have you had any suicidal thoughts recently? How often do you have suicidal thoughts? Have you made any plans for acting on these thoughts? Have you taken any steps towards these plans? What stops you from acting on these plans? Could include: friends, family, hope for the future, fear of not doing it correctly</p>		
<p>2. Suicidal thoughts – judged to be high risk of suicide <i>suicidal ideation with limited/no protective factors</i></p> <p>Patient has made credible plans to commit suicide with intention to do so.</p> <ul style="list-style-type: none"> Accept that managing this patient correctly will delay your clinic Share your plan (to call GP) and explain its importance to the patient Call the GP Practice and speak to a GP whilst patient still in the clinic and explain the situation. Ask GP to consider a review or involving the Crisis Team if they think it's appropriate. Feed back to patient after speaking to GP. Send an urgent letter to GP (as above) to reach them by fax or email within a couple of hours 	<p>Style of interview when discussing suicidal thoughts</p> <p>Make eye contact Be empathic and compassionate Acknowledge the distress of the situation Make it clear that you would like to help Be direct – use the word <i>suicide</i> Don't minimise or dismiss suicidal ideation (e.g. you mustn't think that) Don't be judgemental, accept the patient's story Listen to the patient (don't over talk) Be prepared – have information to hand</p>		
<p>3. Suicidal thoughts – judged to be imminent risk of suicide <i>suicidal ideation with no protective factors</i></p> <p>Patient judged likely to leave clinic and commit suicide</p> <ul style="list-style-type: none"> Accept that managing this patient correctly will delay your clinic Encourage patient to stay with you in clinic until safety measures can be put in place Share your plan (to send to A&E) and explain its importance to the patient Send patient to A&E with escort (significant other or clinic nurse) and a letter to the A&E clinical staff including risk assessment information If the patient leaves the clinic and you judge them to be at risk of taking their own life phone 101 and ask for a Police Welfare Check. 	<table border="0"> <tr> <td> <p>Warning signs of suicide</p> <p>Expressing suicidal feelings Evidence of depression Feelings of hopelessness Social isolation Past suicide attempt or self-harm Psychiatric disorder Challenging life events Making a will Giving away valuable positions Planning suicide Increased drug/alcohol</p> </td> <td> <p>Protective Signs</p> <p>Expressing hope for the future Not wanting to cause pain to friends or family Religious beliefs A supportive network</p> </td> </tr> </table> <p>Support Agencies</p> <p><i>NB Section removed as regional specific information however this should include phone numbers for national and local mental health services that provide support for people who feel suicidal.</i></p>	<p>Warning signs of suicide</p> <p>Expressing suicidal feelings Evidence of depression Feelings of hopelessness Social isolation Past suicide attempt or self-harm Psychiatric disorder Challenging life events Making a will Giving away valuable positions Planning suicide Increased drug/alcohol</p>	<p>Protective Signs</p> <p>Expressing hope for the future Not wanting to cause pain to friends or family Religious beliefs A supportive network</p>
<p>Warning signs of suicide</p> <p>Expressing suicidal feelings Evidence of depression Feelings of hopelessness Social isolation Past suicide attempt or self-harm Psychiatric disorder Challenging life events Making a will Giving away valuable positions Planning suicide Increased drug/alcohol</p>	<p>Protective Signs</p> <p>Expressing hope for the future Not wanting to cause pain to friends or family Religious beliefs A supportive network</p>		

risk assessment: low mood, suicidal thoughts, plans, active steps towards these plans and protective factors, to answer for themselves if it is safe for this person to leave the clinic. It is important to ask these questions with an open and compassionate interpersonal style. Knowledge of your own traits and habits when in clinic is important as it enhances clinicians' ability to self-regulate and amend any unmeant non-verbal and verbal communication. Table 2 suggests some example questions and important communication considerations.

The risk assessment aims to establish the degree of risk associated with suicidal ideation which should then dictate the necessary management responses. Degree of risk can be classified into two categories:

- 'Suicidal ideation **with** protective factors' and
- Suicidal ideation with **limited or no** protective factors'.

The following management plans are suggested in Figure 2.

The above document was produced within a tertiary care pain service for clinicians to refer to, supporting assessment and decision making when managing patients with suicidal ideation (Figure 3) and may be helpful as an example service document.

Conclusions

Several general and pain-related factors have been identified as potential predictors of increasing suicide risk. In addition, new emergent psychosocial factors, such as mental defeat, pain catastrophising, hopelessness, perceived burdensomeness and thwarted belongingness, have been found to be associated with suicidality.⁶ It is likely that any clinical professional working in Pain Services will meet a patient who is experiencing suicidal ideation. It is therefore important that clinicians feel able to assess the potential associated risk, using evidenced based information, to identify known risk and

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protective factors to then either share information appropriately or access the correct level of support for their patient. Pain services should ideally develop frameworks to support clinicians to actively manage these situations, providing useful support and signposting for patients in distress with suicidal ideation. Regular CPD covering this topic is essential for updating information and refreshing assessment and risk management skills.

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Improving awareness and dissemination of good practice interventional pain medicine guidelines

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In the December 2019 issue of the British Pain Society (BPS) Newsletter we published 'Awareness of the Guidelines Published by the Faculty of Pain Medicine and the British Pain Society: A National Survey of Pain Medicine Consultants'.¹ The survey highlighted the need for developing guidance for health care professionals to help prepare, communicate and implement the guidelines effectively. We also suggested that the Royal Colleges and specialist societies that publish good practice guidelines and clinical management pathways should develop either a generic or speciality-specific implementation tool (document) and resource to guide members, NHS medical managers and commissioners to improve the uptake and impact of guidelines to positively influence clinical practice and reduce variation. The Faculty of Pain Medicine has recently published 'Guidance Document: A guide to development, dissemination and review'.²

Our survey indicated that if pain physicians were aware of the guidelines and other resources to support implementation, then this will enable them to provide safer, better and standardised patient care. Adopting updated good practice guidelines in clinical practice for pain medicine across NHS trusts can reduce the wide variation and thus has the potential to reduce clinical negligence claims. As an example, if there was good awareness and adoption of the series of articles published in BPS Newsletter^{3–5} on 'Consent in Pain Medicine' and General Medical Council's (GMC) Consent guidance,⁶ then, there is potential to reduce medical negligence claims in relation to consent in pain medicine practice. However, in practice this needs support for pain medicine consultants from their employers to resource the pain service in line with published standards.⁷

By way of this article, we aim to disseminate and assist in the process of implementing the below mentioned two good

practice guidelines which were initially published in 2014 and 2015 and have been updated in 2020.

1. Recommendations for good practice in the use of medial branch block (MBB) injections and radiofrequency denervation (RFD) for low back pain of lumbar facet joint origin
2. Standards of Good Practice for Spinal Interventional Procedures in Pain Medicine

Both the documents are set out under the following headings: consent process, preparation and identification of patients, environment, anticoagulants, sedation, technique, record keeping and follow-up and discharge planning. As MBB are diagnostic injections, the guidelines also include an assessment form.

As the two documents are discussed under similar headings, we have decided to publish a summary of the MBB and radiofrequency denervation document below and the spinal interventional procedure document can be accessed via the web link:

https://www.britishpainsociety.org/static/uploads/resources/files/BPS_and_FPM_Spinal_Intervention_Guidelines_PDF_Final_May_2020_2_new_ISBN.pdf

Recommendations for good practice in the use of medial branch block (MBB) injections and radiofrequency denervation (RFD) for low back pain of lumbar facet joint origin

Since the publication of the MBB and RFD document in 2014 the NICE guidelines for 'Low back pain and sciatica in over 16s: assessment and management' (CG59), was published

Table 1. Summary of the main differences in the updated MBB and RFD document compared with the previous document.

- 11 Anti-coagulants: The updated guidance published in Regional Anesthesia and Pain Medicine in 2018 on anticoagulants and spinal interventions informs that lumbar MBB injections and RFD are a low-risk interventions.¹⁰ However, if patients have other comorbidities they should be considered as intermediate risk. Risk and benefits of stopping anticoagulants should be considered.
- 22 Sedation and Fasting: The current guideline encourages physicians to use locally developed sedation policy for patients having conscious sedation. The sedation practice varies across the United Kingdom based on who is performing the procedure and the available support. The updated guidelines provides more flexibility and improves the chances of clinicians adhering to the guidelines.
- 33 Technique: MBB: The updated guidelines informs that patients should be encouraged to maintain a pain diary in which the pain at rest and activities of daily living before and after the MBB are recorded at various time intervals. An example of the pain diary is available in Appendix 1. The outcome of the MBB determines if a patient is likely to benefit from RFD.
- 44 Technique: RF needle size: It is the responsibility of the pain physician to gain and maintain competency in using RF devices and the most effective technique. A survey showed that clinical practice varied significantly both in the United Kingdom and the United States and the size (Gauge) of RF needle used varied between 22G and 16G.¹¹ As there was no published evidence to suggest which needle Gauge has the best outcome, the committee did not recommend to use 18G RF needle as was done in the previous edition of the guideline. However, the guideline recommends that the Gauge of the RF needle be recorded.
- 55 X-Ray images: The updated guidelines suggest that appropriate fluoroscopic images should be saved and preserved in the patient's records for clinical and legal purposes. This is in contrast to the recommendations in the previous edition of the guidelines which says "Images taken in 2 planes (such as AP tunnel or gun-barrel and oblique views) sufficient to determine the final positions of the RF needle tip in relation to the target are saved". The fluoroscopic images used by pain physician to ascertain appropriate placement of needle before MBB and RFD varies and hence it was felt that the current document should not dictate practice but should allow pain physician to perform the procedures using the most appropriate technique and save appropriate fluoroscopic images.
- 66 Post MBB assessment form: Assessment of the effects of spinal injections (Medial Branch Block) should be recorded on a standardised form and an example is provided.

MBB: medial branch block; RFD: radiofrequency denervation; RF: radiofrequency.

in 2016 and informs 'Only perform radiofrequency denervation in people with chronic low back pain after a positive response to diagnostic medial branch block'.⁸ In addition, the NHS England's National Low Back and Radicular Pain Pathway was published in 2017 and recommended MBB followed by RFD for low back pain of facet joint origin.⁹

See Table 1 for the summary of the main differences in the updated MBB and RFD document compared with the previous document:

Introduction

This document describes the BPS and the Faculty of Pain Medicine of the Royal College of Anaesthetists (FPMRCA) consensus opinions regarding standards of good practice for clinicians carrying out medial branch block (MBB) injections and radiofrequency denervation (RFD) as part of the management of facet joint pain in adults with persistent spinal pain. This document describes the desirable facilities required to safely carry out these procedures.

Discussions regarding the evidence base for these procedures are beyond the scope of this document. Thus, the indications for facet joint procedures, choice of specific medicines to be administered and comments on the published evidence to inform the decision to carry out MBB injections and RFD are omitted.

The BPS and the FPMRCA recognise that MBB injections and RFD are performed by clinicians from a number of medical disciplines. The FPMRCA have responsibility for the professional standards of Pain Medicine Specialists and this guidance outlines the standards of good clinical practice expected for this professional group and the setting in which the procedure should be carried out. These recommendations apply both to pain physicians in training who perform MBB injections and RFD under varying levels of supervision and to established practitioners in non-training grades.

Consent

You should work in partnership with your patients when performing pain interventions. You should view obtaining informed consent as a process of discussion and joint

Improving awareness and dissemination of good practice interventional pain medicine guidelines

decision-making. This will involve providing information to patients in a way that they can understand before asking for their consent.⁶ You should identify and discuss with the patient adverse outcomes that may result from the proposed treatment including the potential outcome of taking no action. You must follow guidance provided by the GMC.⁶

The information you provide should be in proportion to the nature of their condition, the complexity of the proposed treatment and the seriousness of any potential side-effects, complications or other risks. Factors such as age, ethnicity, cognitive/communication skills and capacity must be considered. You should be aware of current recommendations about safeguarding vulnerable patients and the provisions of the 2005 Mental Capacity legislation.¹²

If you are the pain physician providing treatment, it is your responsibility to discuss this with the patient. If this is not practical, you can delegate this responsibility to another pain physician, provided you make sure the person to whom you delegate is suitably trained and qualified, has sufficient knowledge of the proposed treatment and understands the risks involved; they should understand and act in accordance with GMC guidance.

Written consent should be obtained but this is just the end point of the consent process. You should use the patient's medical records or a consent form to record the key elements of your discussion with the patient.

Preparation and identification of patients

All hospital inpatients should wear wristbands (identity bands) with accurate details that correctly identify them and match them to their care. All patient identification procedures should follow national guidelines. Allergies should be checked and noted according to local policy and practice.

The World Health Organization safer surgery checklist should be used for all procedures to ensure appropriate checking of patient identity, site and nature of planned procedure, patient preparation, and readiness of equipment.¹³ In females of child-bearing age, when fluoroscopy is to be used, pregnancy status should be confirmed prior to the procedure according to national guidelines.¹⁴ Siting an intravenous cannula should be considered dependent upon hospital policy and practice. Patients should be fasted prior to the procedure according to hospital policy and practice. If the patient is to have conscious sedation, they must follow local sedation policy.

Environment and facilities

MBB injections and RFD should be performed aseptically in an appropriate environment that adheres to local guidelines with regards to minimally invasive procedures. Infection prevention and control, monitoring, imaging and availability of assistance

should all adhere to local policies and national guidelines. The clinical area should be large enough to accommodate the staff and equipment necessary for safe minimally invasive procedure practice. It should have a fully equipped and staffed post-anaesthesia care facility in close proximity. Resuscitation equipment and facilities must be immediately available.

Anticoagulation

Lumbar MBB injections and RFD are considered a low-risk intervention. However, if patients have other comorbidities they should be considered as intermediate risk. It is recommended that practitioners should follow the current guidelines for MBB and radiofrequency denervation in patients taking anticoagulants or with pre-existing clotting abnormalities.^{10,15}

The benefits and risk of the procedure should be considered on an individual basis and if appropriate a multidisciplinary team involvement of supervising cardiologist, local haematology services and patient's GP may be necessary. This is important because abrupt withdrawal of anticoagulants may risk serious thrombotic episodes, whereas the continued use carries an increased risk of bleeding.

Sedation

Sedation may or may not be offered to the patient depending upon local practice and policies. Sedation, if used, should be provided in accordance with local sedation policy.^{16,17}

Technique

Lumbar MBB injections

The procedure is performed in a room that is suitable for an aseptic procedure with fluoroscopy C-arm facilities. The pain physician should be trained in the use of fluoroscopy to obtain the appropriate images and thereby have reliable information about needle position. It is the responsibility of the pain physician to gain and maintain competency in using the most effective technique. Appropriate fluoroscopic images should be stored.

The outcome of the MBB should be assessed to assist in deciding if the patient will benefit from radiofrequency denervation. Patients should be encouraged to maintain a pain diary in which the pain at rest and activities of daily living before and after the MBB are recorded at various time intervals, an example of which is available in Appendix 1.

Radiofrequency denervation

The pain physician must be familiar with and competent to operate the RF generator. They should be trained to interpret fluoroscopic images to obtain the appropriate images and thereby have reliable information about electrode position. It is the

responsibility of the pain physician to gain and maintain competency in using RF devices and the most effective technique. Appropriate fluoroscopic images should be saved and preserved in the patient's records for clinical and legal purposes.

Record keeping

Standards of record keeping should be audited in accordance with local clinical governance arrangements. Records should include details of indication for injection, date/time of procedure, type of procedure performed, name of clinician performing procedure, position of patient, sedation (if used), spinal level of injection, size of needle (gauge), radio-opaque contrast and dose if used, injected drugs and doses, and any difficulties encountered.

If RF is performed, stimulation parameters, temperature, duration of lesion and the number of lesions at each level should be recorded. Post-procedure observations should be recorded.

Follow-up and discharge planning

On the day of procedure, patients should be seen by a member of the treating team or a specifically assigned member of staff on admission and prior to discharge. Limbs should be checked for numbness and/or weakness; the patient asked about urine retention or headache. Usually patients should be ready for discharge 1–3 hours after the procedure. Usual medication can be resumed on the day of the procedure. If there is unexpected significant limb weakness, sensory loss or headache, an unplanned overnight admission may be necessary, with review the following day before discharge.

After discharge, a reliable telephone contact number should be provided so that the patient can report any acute complication such as headache, fever, prolonged numbness/weakness or urinary retention. This should be provided by day surgery units as part of the normal discharge procedure.

Other health care providers who may be involved in the patient's care after the injection (e.g. the primary care team, emergency department or day care staff) should know how to contact a member of the treating team or hospital staff by telephone to help make management decisions if necessary.

A standard letter, with a copy provided to the patient, should be sent to the patient's GP detailing the procedure and follow-up arrangements. The letter should emphasise that fever, severe back pain or worsening neurological and/or urinary symptoms are potentially serious and the patient be monitored at primary care level for any such complications.

Emergency full spine MRI scanning should be available. Arrangements must be in place for urgent referral for neurosurgical or spinal surgical opinion.

Follow-up arrangements should be made for all patients after MBB injections and RFD. The time of review will depend on the patient's condition and the indications for the injection.

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Improving awareness and dissemination of good practice interventional pain medicine guidelines

Society, Patient Liaison Committee Representative, Dr Manohar Sharma (Faculty of Pain Medicine Representative), Dr G Baranidharan

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Balasubramanian, Dr G Baranidharan, Dr Anthony Hammond, Dr Vivek Mehta, Dr Rajesh Munglani, Dr Sherdil Nath, Ms Sara Payne, Ms Stephanie Stokes, Dr Manohar Sharma, Dr Karen Simpson, Dr Simon Thompson, Dr Stephen Ward

Appendix 1

Assessment of effect of spinal injections (medial branch block)

The injections that have been performed are to test if your pain comes from the structure/area that has been tested. It is therefore very important that you test the effect on your pain after today's injections. We would like you to evaluate your pain level and mark it with an X on the chart below.

Type of injection: _____
Time of injection: _____ Date: _____

Pain Assessment: Please indicate how much of your 'normal' pain you have left at rest and at activities that would normally cause pain at every time interval as per the chart.

0 % means that all your pain has gone. 100% means that your pain is unchanged.

If your pain is increased then please mark with an X in the square on the right.

Before the block 100% (This is your pain today)

0% _____ *100%
More Pain

First assessment after the block
0% _____ 100% ?

1 hour after block
0% _____ 100% ?

2 hours after block
0% _____ 100% ?

4 hours after block 0%
0% _____ 100% ?

6 hours after block
0% _____ 100% ?

Day after block
0% _____ 100% ?

1 week after block
0% _____ 100% ?

At follow-up visit
0% _____ 100% ?

When did the pain return to your 'usual' level? Date: _____ Time: _____

Please bring this chart with you on your next visit

A pilot evaluation of the Self-Management Navigator Tool to enhance communication in primary care consultations about chronic pain

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Heather Wallace *General Manager, Pain Concern*



Self-Portrait Emma Ivanova¹

Introduction

Chronic pain is estimated to affect around 40% of the United Kingdom's population.² Treatment options are often limited, and supported self-management is the recommended intervention for chronic pain.³ Effective self-management should enable an individual to reduce the impact of pain on their daily lives.⁴ Clinical guidelines suggest that primary care services have a role to play in supporting the self-management of chronic pain.⁵ However, there are many barriers to self-management in primary care as evidenced in the Barriers Project carried out by Pain Concern.⁶

A common barrier to providing self-management support was the difficulties in communication between those with chronic pain and their healthcare providers. These difficulties are not unique to chronic pain and many have been well described elsewhere.^{7,8} Acknowledging these problems, particularly in medicine, has led to an expansion of communication skills training in the undergraduate medical curriculum.⁹ With regard to the chronic pain population, little has been done to improve matters. In order to address the problems in communication, and to attempt to advance greater promotion of self-management, the Navigator Tool was developed by Pain Concern. Pain Concern is a registered charity which has a track record over 25 years of promoting self-management activities for people in pain.

A project was set up by Pain Concern to develop and evaluate an intervention to overcome barriers to people with chronic pain getting support with self-management from primary care. It used two approaches – training for healthcare providers and use of the Navigator Tool – to facilitate self-management focused interactions at the initial consultation of patient and healthcare professional. This article summarises the findings of this project.¹⁰

Aims of the project

The aim of the Navigator Tool is to train healthcare professionals and prepare those with chronic pain to raise their concerns and questions at primary care appointments. If both parties were more confident about discussing chronic pain, this would advance the management of chronic pain in primary care. More specifically:

- Ensure that each healthcare professional consultation was focused on the concerns which the people in pain wished to discuss;

- Prepare people in pain for their consultations, empowering them to be a partner in their consultation not a recipient;
- Facilitate self-management discussions at the start of the chronic pain journey;
- Encourage adoption of the bio-psychosocial model of healthcare;
- Train healthcare professionals in skills to support self-management and make the best use of their time during the consultation.

Project participants

The healthcare professional group was small; it comprised of two GPs, two pharmacists and a physiotherapist. They attended training sessions organised by partners in Thistle Foundation which equipped them with knowledge and skills to promote self-management and move away from the medical model and encourage people with pain to do the same.

The patient group ($n = 35$) consisted of people over the age of 18 years who had suffered pain for over 3 months.

The Self-Management Navigator Tool

Based on expert opinion, an initial Navigator Tool was developed. This was refined using feedback that was obtained at a Stakeholder event. The finalised Navigator Tool was tested for how well it addressed concerns around health literacy and was approved by the Plain English Campaign.

The resulting Navigator Tool is a five-page booklet titled 'The Navigator Tool: Living Well with Pain'. In order to test its utility, it was given to patients with chronic pain, who were asked to complete it prior to their primary care consultation, to help them prepare for their appointment with the primary healthcare professional.

The first part of the Self-Management Navigator Tool is a form titled 'My Pain Concerns' which is divided into four sections – My Medications, Changes to My Life, Diagnosis and The Way I'm Feeling. Each section contains five statements commonly expressed by pain patients. Patients are asked to tick 'agree' or 'disagree' to each statement and then choose the three most important ones to take to their consultations.

The second part of the booklet, 'Questions to Ask Your Healthcare Professional', links each of the patient's concerns with two or three suggested questions to ask their healthcare provider.

The third part is a Self-Management Options Grid. This explains some common self-management strategies, which are colour-coded to match their identified concerns.

The last part is a Goal Setting Sheet to help the patient make a plan of how to take action towards the identified self-management techniques in practice and manage their pain.

Methods

The Navigator Tool was tested in a randomised controlled trial with healthcare professionals and chronic pain patients. Five healthcare professionals and 35 of their patients were enrolled onto the study. Quantitative data on self-efficacy, satisfaction with the consultation and participation in decision-making measures were collected. The different measures used were easily completed by the participants, but the data accrued were insufficient to be meaningfully analysed. Qualitative data, however, were obtained via feedback forms and interviews; these methods acquired feedback on the training carried out to support the use of the Navigator Tool and assessed the usability of the tool with a focus on patient satisfaction. These findings are summarised below.

Qualitative findings

Healthcare professional training

Training was perceived as positive as it enabled the healthcare professional to have the skills to support self-management and to be able to make best use of their consultation time. It was reported that their confidence was increased in terms of raising the topic of pain self-management with their patients. Suggestions were provided by the group to have future training specifically related to the Navigator Tool; others suggested peer support follow-up sessions to develop skills and share best practice.

Application of the Navigator Tool

All the healthcare professionals and 8 of the 15 patients who used the Navigator Tool took part in semi-structured interviews which collected information regarding the use of the tool in improving communications about supported self-management.

Healthcare professionals. It appears that despite the training, the healthcare professionals used the Navigator Tool in different ways. The physiotherapist followed the structure of the tool for each patient. One of the pharmacists photocopied different parts of it and used it with patients not involved in the study. One GP used the Navigator Tool to prepare his patients in advance of their consultation. The other GP used the Navigator Tool flexibly to guide their consultation.

Some suggested that the parts of the Navigator Tool could be separated to allow relevant parts to be given to the right patient.

Overall, the Navigator Tool was seen as a useful tool. There was some initial concern that the tool could be distracting and disrupt the normal flow of the clinical conversation. Naturally, there were also concerns about the challenges of fitting the tool into the usual, constrained consultation time. However, the following comments illustrate some of the benefits that the healthcare professionals found:

From a medical perspective we've got to work reasonably hard to help patients to understand pain, that there is a psychological element to pain, just simple concepts like that are hard to get across sometimes. But I think the tool quite effectively did that on its own. (GP)

... opened up areas that might not naturally come up in routine consultation. (GP)

I felt that the patients were taking ownership of the tool. So even though I'd been to these motivational interviewing courses that were all about how it's you as the HCP leading the patient, I felt they were leading me. (Pharmacist)

... one lady is speaking to her boss and managing it herself in that way; another lady is going to our community link worker to get help with benefits and money; the other guy has moved to go to the community pain service, which is group work which he wouldn't have cared about until we made a bit of progress. (GP)

People with pain. Fifteen people with pain completed the feedback forms. They did not necessarily use the Navigator Tool at home prior to their consultation as intended. In some consultations, the healthcare professional guided their patients in the use of the tool.

Eleven people felt that they were given comprehensive information on how to use the Navigator Tool and reported that it provided them with information that they could talk about and use at their primary care consultation about self-management.

Two-thirds of respondents reported that using the tool had improved their communication with their healthcare professional with over half of participants reporting 'very much so'. Fourteen of the 15 participants reported that the Navigator Tool was easy to use.

All 15 indicated the value of the different parts of the tool; the most used part was 'My Pain Concerns', which was used by 14 participants out of 15; 'Goal Setting' was used by 13 participants; 'Questions to Ask Your HCP' was used by 10 participants and the 'Options Grid' was used by 7 participants.

Participants were asked about the content, length and ease of use of the Navigator Tool. Two-thirds reported that the tool was 'just right'. Others reported that 'My Pain Concerns' was too simplistic, and the 'Options Grid' was too lengthy. Those participants who currently had a good relationship with their healthcare professional around their pain did not find the Navigator Tool useful.

Some feedback from the participants is summarised below:

instead of my thinking of all the negatives, I'm thinking of all the positives.

... helped me see how much I had come on.

Rather than worrying I was wasting my GP's time, this allowed me to talk about my issues with pain.

Discussion

This was a pilot evaluation of the usefulness of the Navigator Tool. While attempts to quantify benefits were ultimately unsuccessful, the qualitative feedback from both HCPs and patients was encouraging. Many of the comments suggested that using the tool improved communication and made it easier for HCPs to have productive conversations with patients about self-management options. It was reported that it helped both people with pain and healthcare professionals see the bigger picture of the pain condition. Participants felt that the Navigator Tool facilitated and engaged efficient communication between both parties. One of the clear benefits was that it highlighted a range of self-management strategies.

Feedback suggests that the Navigator Tool facilitates a more holistic, person-centred approach to the consultation. It provided a focus for consultations, could be used to monitor progress and signpost services more effectively and facilitated encouragement, planning and hope.

The main limitation of the project was the small numbers. Although we were unable to comment on the statistical significance of the benefits of using the Navigator Tool, we were able to obtain rich qualitative data.

Pain Concern was sufficiently encouraged by these findings to develop further resources to promote its further use. An edition of 'Airing Pain' and a podcast were produced, highlighting the value of the tool from the perspective of the participating healthcare professionals and the people with pain. Videos of patients and HCPs who used the tool, alongside additional information, have been made available on its website.

Discussion is ongoing with experts in the pain management community, and various options for further evaluation are currently being explored. We would invite any parties who are interested in further development and testing of the tool to contact us.

Conclusion

Despite the limitations of the study, the Navigator Tool has been found effective by both healthcare professionals and people with pain. Use of the Self-Management Navigator Tool appears to have resulted in more person-centred, holistic care provision, which was positive, targeted and timely.

The Navigator Tool and self-management training has stimulated discussion and debate within the pain community and among self-management proponents in the third sector. Such debate encourages further development and use of the Navigator

A pilot evaluation of the Self-Management Navigator Tool to enhance communication in primary care consultations about chronic pain

Tool, which could be transformational in primary care and make a major difference to the care of people with chronic pain.

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Dear chronic pain – it's time to break up with you

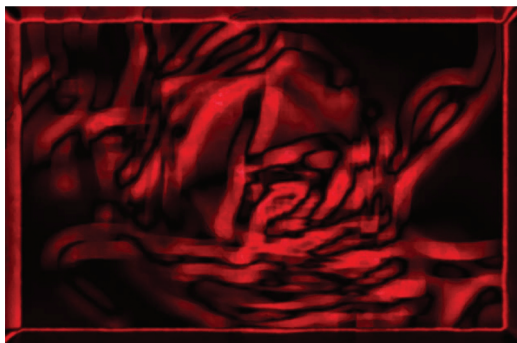
Liz Sirrell



Splitting up is never easy, especially if you've been in a long-term relationship. When you think it's time to break up, you can't just send a text and say, 'Hey, it's over. Been nice knowing you'. Okay, maybe some people do, but that's not right, is it?

It's Time to Break Up – But Breaking Up Is Hard to Do

I'm in a long-term relationship with my pain and I think it's time for us to break up. Breaking up is never easy, but breaking up with chronic pain is even harder because it just doesn't take the hint, no matter how blunt you are. You can swear, shout and scream at it and it just laughs in your face. I've had to learn to listen to my pain, but it doesn't tend to listen to me very often. It's time for me and my pain to go our separate ways, but since it won't listen to me, I decided to write my pain a letter instead. Writing the letter has been kind of therapeutic.



Pain Abstract Illustration. Rajesh Misra Public Domain¹

My break-up letter to my chronic pain

Dear Chronic Pain,
They say all good things come to an end. But our relationship was never actually good, was it? In fact, it should never have started in the first place. You have been my companion for about four decades, which is a long time to be together. But

now I think the time has come for me to say, enough is enough. We need to part ways. It's time for us to break up.

You came into my life uninvited and you've hung around ever since. And to be brutally honest, I can't say I've enjoyed your company. You've been a horror to live with. You are a control freak. A miserable, bullying control freak.

When you first hooked up with me, I kept trying to ignore you but you let me know that you didn't like that. You kicked, screamed and complained constantly. 'Stop ignoring me', you yelled at me, 'or I'll make you suffer more'. And you did. It took me a long time to realise I should just listen to you. But what did you expect? I was young. I wanted a normal life. Instead, I was lumbered with you.

I'll try to find positives

We've been together for a long time and it's definitely not been pleasant knowing you because, well, you're simply not nice to be around. You affect so many aspects of my life in a negative way, but I will try to take some positives from our relationship.

You force me to slow down and in doing so, I notice what's around me. I notice all the little things and I appreciate them. I've learned to be proud of all my achievements, no matter how big or small they are. You've actually taught me quite a lot about life. But you've also taught me things about myself. I realise that I can be happy and content despite you disrupting my life.

My Mum used to say I have the patience of a saint. Believe me, I need it with you hanging around all the time. You've also given me the ability to recognise other people who live a life similar to my own. When I see them, I think to myself, they've got a companion just like mine. I understand what they go through. Maybe you've made me have more empathy. No. I'm not giving you the credit for that. I'm a decent person. Any decent person can have empathy. I'd have empathy with or without you in my life.

Painful memories

I'm afraid there aren't many positives to take from our relationship because all you ever tried to do was make me suffer. You've always needed your presence to be felt. You get pleasure from poking and prodding me, taking the legs from under me or just hovering in the background. You're always

Dear chronic pain – it's time to break up with you

ready to remind me you're there. At one point, you felt like a lead weight across my back and I could hardly move for months. You tattooed that memory onto my brain. It will never be forgotten.

You weren't content with just affecting my back, though. No, that wasn't enough for you. You wanted me to feel you in every part of my body. My face, my feet, my fingers ... everywhere. You've made my head throb, my teeth have felt as though they're attached to a live electric wire and it feels like you've crushed my rib cage. My legs hurt, my joints hurt, my muscles ache. Every step I take, you're right there with me.

My doctor once asked me to colour a body diagram to explain where you affected me. There was virtually no white paper showing. She looked sympathetic but she couldn't set me free from your vicious claws. Being in a relationship with you is like being shackled to a ball and chain because I can do nothing without your interference.

You drag me down and beat me up. You get under my feet and you put obstacles in my path. I never get a minute's



Chained Prisoner Prisonero encadenado

Date: 1806–1812 Romanticism Location: Musée Bonnat, Bayonne, France Public Domainⁱ

peace. You are in my face constantly. You're there 24/7. Do you never sleep? If you want to stay awake all night, that's your choice, but why do you insist on keeping me awake too? You've made me feel embarrassed and awkward. I've been stressed because of you and I've felt guilty. You've haunted

me with memories and filled me with fear and anxiety because I never know when you'll do your worst. You've taken so much from me. I had to take early retirement when I was 28 to appease you. I didn't have children because of you. You've had a habit of really getting in the way of everything that matters to me.

It's time to stop. It's time to break up. I've seriously had enough of your miserable ways. You've inflicted me with enough poison. I don't want to see you again. Nor do I want you to become attached to anyone else because nobody deserves a companion like you. I think it would be best if you could just quietly disappear into oblivion.

Perhaps NASA could drop you into a black hole

I did consider contacting NASA and asking them for help. Let's face it, there's so much money invested in space projects so perhaps they could take you on a trip and drop you into a black hole somewhere in outer space. I don't suppose they'd do that, though. They'd probably tell me there's no government funding to help people like me get rid of companions like you.

You're an uninvited guest – it's time to go

You're like an uninvited guest who's overstayed their welcome. It's now time for you to leave because I want to get on with living. I want to experience life without you. I've had to spend the last four decades listening to you but it's now time for you to listen to me. You need to understand that enough is enough. It's time for you to go.

Yours no longer,
Liz.

About me

I'm in my early fifties, but due to chronic pain, my body feels so much older than that.

I have scoliosis (curvature of my spine). This started causing chronic back and rib pain when I was a teenager. When I was 28, I had to retire from work due to my pain. My back pain is constant and disabling, but I live with another pain which is just as debilitating. It is a facial pain condition called trigeminal neuralgia.

In 2017, I was diagnosed with coeliac disease. My doctor was trying to get to the bottom of some of my pain and other issues and we were both surprised by a positive result of coeliac disease. This means eating absolutely no gluten. It can be challenging at times. If only my gluten-free diet helped my pain, but I'm afraid, it doesn't. I also have osteoporosis (diagnosed when I was about 40 years old), arthritis, Reynaud's and a few other problems. Life with health problems is far from easy, but I do try to keep smiling. It can

sometimes feel as though a huge cloud is always above, but I try to grasp any glimpses of sunshine and hold on to them. I enjoy the small things in life and most of the time, I cope fairly well. But I'm not superhuman. I can have my wobbly moments. Or days. Or even weeks sometimes. But I normally manage to pick myself back up, put the smile back on my face and get back to enjoying life, despite my pain.

A few years ago, I had an idea that I could write a book about coping with pain, so I started putting pen to paper. I hoped that my coping strategies might help other people who live with pain. Then I realised that writing a book was a crazy idea which would never happen. But, I still wanted to share my thoughts, therefore this blog was born. I want to explain what living with constant pain can be like. Most people think it's just about pain, but it's not. Stress, loneliness and guilt are just a few bonus extras.

But I don't want my blog to be completely negative. I want to share posts about my life despite pain and I will be

sharing coping tips. I hope that in some way, something that I write might help someone else. As my blog pages fill up, I'm sure I'll be learning, as well as writing. It will be a journey for me. But I'm not too keen on travelling alone, so please join me here on my blog and on my social media pages.

Drop me a comment – I love to hear what people think. Thank you for taking the time to be here. I hope you have a good day today. If you're in pain, I hope you have a good day, despite it.

www.despitepain.com

Notes

- i. <https://www.publicdomainpictures.net/en/view-image.php?image=232462&picture=pain>
- ii. <https://www.wikiart.org/en/francisco-goya/chained-prisoner-1812>

Pain and suffering as a foundation for art: a study in the life of Modigliani



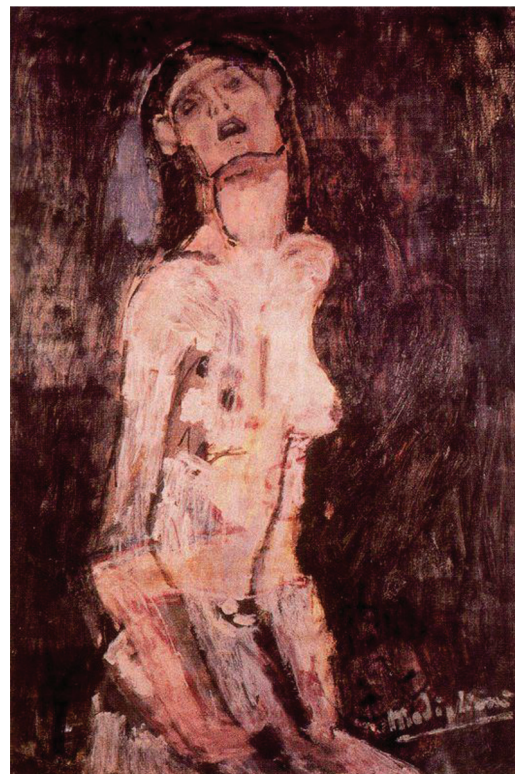
Caryatid Amedeo Modigliani 1911; Paris, France.
Style: Expressionism. Musée d'Art Moderne de la Ville de Paris, Paris, France.ⁱ

I would like my life to be like a rich river flowing joyfully on Earth.

– Amedeo Modigliani

Amedeo Modigliani was the epitome of a tragic artist. Born to a bourgeois family in Italy, he later shunned his academic upbringing and willingly devolved into a poverty stricken vagabond. He was formally educated as a life painter in his teens, quickly developing a lifelong infatuation with nudes. In 1902, he moved to Florence to study at the Academia di Belle Arti, at the 'Free School of Nude Studies', and a year later, he moved to Venice as a fledgling artist, where he smoked hashish for the first time. It was only after he discovered narcotics that he developed the philosophical belief that the only path to creativity was through defiance of social norms and disorder in life. Thus began a lifelong affliction with corrupted beauty, which would ultimately end with his untimely death and the suicide of his grief-stricken wife and their unborn child.

Modigliani contracted tuberculosis at an early age, and was constantly stricken by his deteriorated health, which may be



A suffering nude Amedeo Modigliani 1909; Paris, France.ⁱⁱ

one reason why he so willingly engaged in self-destructive behaviour. Living in Paris, he had affairs with women, drank heavily, smoked hashish and drank absinthe. In a drunken stupor, he would often strip naked at social gatherings. He was against all of the excesses of a Bourgeois lifestyle, and thus stripped them from his life, even destroying paintings that he had made in his earlier years.

Although he purposely created a life in which chaos, poverty and doom lurked in every corner, he was a prolific artist. He sketched furiously, sometimes drawing over 100 sketches in a day, but many of his works were either lost, given away or, in some cases, destroyed by Modigliani himself. His favourite subject was by far the human form, painting the likenesses of other artists, such as Pablo Picasso, Diego Rivera, Max Jacob and Juan Gris, who all sat for the artist. His formal works are characterised by an elongation of the human form and mask-

Pain and suffering as a foundation for art: a study in the life of Modigliani

like faces, and his work is so unlike any other of his time that it still defies classification. During his time, other artists emulated him by engaging in a self-destructive lifestyle, and today, his legacy lives on in nine novels, a play, a documentary and three feature films.ⁱⁱⁱ

Pain is inevitable. Suffering is optional.

Haruki Murakami



Portrait of Jeanne Herbuterne
Amedeo Modigliani Public Domainⁱ

Notes

- i. <https://www.wikiart.org/en/amedeo-modigliani/caryatid-1911>
- ii. <https://www.wikiart.org/en/amedeo-modigliani/a-suffering-nude>
- iii. <https://www.wikiart.org/en/amedeo-modigliani>

Jeanne Hébuterne was born on 6th April 1898. A beautiful girl, she was introduced to the artistic community in Montparnasse by her brother André Hébuterne,. She met several of the then-starving artists and modeled for them. Jeanne began an affair with the charismatic artist, and the two fell deeply in love. She soon moved in with him, despite strong objection from her parents.

Described as gentle, shy, quiet, and delicate, Jeanne Hébuterne became a principal subject for Modigliani's art. In the spring of 1918, the couple moved to the warmer climate of Nice on the French Riviera. While they were in Nice, their daughter, Jeanne Modigliani, was born on 29 November.

The following spring, they returned to Paris and Jeanne became pregnant again. By this time, Modigliani was suffering from tuberculous meningitis and his health, made worse by complications brought on by substance abuse, was deteriorating badly.

On 24 January 1920 Modigliani died. Hébuterne's family brought her to their home, but she threw herself out of the fifth-floor apartment window two days after Modigliani's death, killing herself and her unborn child.

Her family, who blamed her demise on Modigliani, interred her in the Cimetière de Bagneux. Nearly ten years later, at the request of Modigliani's brother, Emanuele, the Hébuterne family agreed to have her remains transferred to Père Lachaise Cemetery to rest beside Modigliani.

Her epitaph reads:

"Devoted companion to the extreme sacrifice."ⁱⁱ

Notes

- i. <https://www.wikiart.org/en/amedeo-modigliani/stone-head>
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Letter to the Editor



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Dear Editor,

I had the privilege of being the first Chair of the British Pain Society (BPS) Patient Liaison Committee when it was set up in 2000, and we had as our agenda three P's – we wanted to push the management of pain further up the Patient, Professional and Political Agenda. Our work included patient/professional seminars, and with Beverley Collett and Barry Shearman MP setting up the Chronic Pain Policy Coalition which led to the first Pain Summit. The BPS has achieved so much – the national audit, for example, and involvement with

the forthcoming National Institute for Health and Clinical Excellence (NICE) guidelines, but we know from patient experiences there is more to be achieved.

It was therefore good to read the President's Message in the March 2020 *Pain News* that his vision for the future was also three Ps – Patients, Partnership and Politics. Once we are over the pandemic, I look forward to reading more about how the vision will be achieved.

Jean Gaffin OBE HonDSc
(Honorary Member, BPS)

NEW
and



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The only Pregabalin in tablet form!

Prescribing Information

Pregabalin Neuraxpharm 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg and 300 mg tablets (pregabalin) – Abbreviated Prescribing Information

Refer to the Summary of Product Characteristics (SmPC) before prescribing.

Presentation: tablets containing either 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg or 300 mg pregabalin per tablet.

Indications: Treatment of peripheral and central neuropathic pain in adults. Treatment of epilepsy, as adjunctive therapy in adults with partial seizures with or without secondary generalisation. Treatment of Generalised Anxiety Disorder (GAD) in adults.

Dosage and administration: *Adults:* 150 to 600 mg per day, in either two or three divided doses, taken orally with or without food. Treatment can be started at a dose of 150 mg per day and increased based on individual patient response and tolerability. *Neuropathic pain:* Dose may be increased to 300mg/day after an interval of 3 to 7 days, and if needed, to a maximum dose of 600mg/day after an additional 7-day interval. *Epilepsy:* Dose may be increased to 300mg/day after 1 week. The maximum dose of 600mg/day may be achieved after an additional week. *Generalised anxiety disorder:* Dose may be increased to 300mg/day after 1 week. Following an additional week the dose may be increased to 450mg/day. The maximum dose of 600mg/day may be achieved after an additional week. The need for treatment should be reassessed regularly. Treatment should be discontinued gradually over a minimum of one week. *Renal impairment/Haemodialysis:* dosage adjustment necessary; see SmPC. *Hepatic impairment:* No dosage adjustment required. *Elderly:* Dosage adjustment required if decreased renal function. *Paediatric population:* Safety and efficacy in children below the age of 12 years and in adolescents (12-17 years of age) have not been established.

Contraindications: Hypersensitivity to pregabalin or any of the excipients.

Warnings and precautions: There have been reports of hypersensitivity; discontinue immediately if symptoms of angioedema. Some diabetic patients who gain weight may need to adjust hypoglycaemic medication. Occurrence of dizziness and somnolence could increase accidental injury (fall) in elderly patients. Advise patients to exercise caution since loss of consciousness, confusion and mental impairment have been reported. Visual adverse reactions have been reported, including loss of vision, visual blurring or other changes of visual acuity, and visual field changes. Discontinuation may result in resolution or improvement of visual symptoms. Renal failure has been reported which, in some cases, showed reversibility on discontinuation. There is insufficient data for withdrawal of concomitant antiepileptic medication, once seizure control with adjunctive pregabalin has been reached. Withdrawal symptoms suggestive of physical dependence have been observed in some patients after discontinuation of short and long-term treatment; see Side effects. The patient should be informed about this at the start of the treatment. Convulsions, including status epilepticus and grand mal convulsions, may occur during use or shortly after discontinuation. Data suggest

that incidence and severity of withdrawal symptoms after long-term treatment may be dose-related. Congestive heart failure has been seen, which may be resolved on discontinuation. Use with caution in elderly cardiovascular compromised patients. There is a possible increased risk of suicidal ideation and behaviour; patients should be monitored for signs and appropriate treatment considered. Advise patients and their caregivers to seek medical advice should signs of suicidal ideation or behaviour emerge. Events related to reduced lower gastrointestinal tract function (e.g. intestinal obstruction, paralytic ileus, constipation) have been reported when co-administered with medications having potential to produce constipation. Consider measures to prevent constipation when used in combination with opioids. Cases of misuse, abuse and dependence have been reported. Exercise caution in patients with a history of substance abuse and monitor for symptoms of pregabalin misuse, abuse or dependence. Cases of encephalopathy have been reported, mostly in patients with underlying conditions that may precipitate it. The incidence of adverse reactions, especially somnolence, is increased in patients treated with pregabalin for central neuropathic pain due to spinal cord injury; possibly due to additive effect from concomitant medications.

Interactions: Pregabalin is unlikely to produce, or be subject to, pharmacokinetic interactions; see SmPC. There are reports of respiratory failure and coma when taken with other central nervous system (CNS) depressants. Pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone and may potentiate the effects of ethanol and lorazepam.

Fertility, pregnancy and lactation: *Pregnancy:* Pregabalin should not be used during pregnancy unless benefit to the mother clearly outweighs risk to the foetus. Effective contraception must be used in women of childbearing potential. *Breast-feeding:* Pregabalin is excreted into human milk and the effect on newborns/infants is unknown. A decision must be made whether to discontinue breast-feeding or to discontinue pregabalin therapy. *Fertility:* No clinical data on the effects on female fertility. A clinical trial to assess effect on sperm motility showed no effect. Reproductive and developmental effects have been seen in rat studies but clinical relevance is unknown.

Effects on ability to drive and use machines: May affect ability to drive, use machines and engage in other potentially hazardous activities.

Side effects (see SmPC for full list): Very common ($\geq 1/10$) - dizziness, somnolence, headache; Common ($\geq 1/100$ to $<1/10$) - nasopharyngitis, appetite increased, euphoric mood, confusion, irritability, disorientation, insomnia, libido decreased, ataxia, coordination abnormal, tremor, dysarthria, amnesia, memory impairment, disturbance in attention, paraesthesia, hypoesthesia, sedation, balance disorder, lethargy, vision blurred, diplopia, vertigo, vomiting, nausea, constipation, diarrhoea, flatulence, abdominal distension, dry mouth, muscle cramp, arthralgia, back pain, pain in limb, cervical spasm, erectile dysfunction, oedema peripheral,

oedema, gait abnormal, fall, feeling drunk, feeling abnormal, fatigue, and weight increased; Uncommon ($\geq 1/1,000$ to $<1/100$) - neutropenia, hypersensitivity, hallucination, panic attack, restlessness, agitation, depression, syncope, stupor, myoclonus, loss of consciousness, psychomotor hyperactivity, dyskinesia, dizziness postural, intention tremor, nystagmus, cognitive disorder, mental impairment, speech disorder, hyporeflexia, hyperaesthesia, peripheral vision loss, visual disturbance, eye swelling, visual field defect, visual acuity reduced, tachycardia, atrioventricular block first degree, sinus bradycardia, congestive heart failure, dyspnoea; Rare ($\geq 1/10,000$ to $<1/1,000$) - angioedema, allergic reaction, convulsions, vision loss, keratitis, QT prolongation, sinus tachycardia, sinus arrhythmia, pulmonary oedema, ascites, pancreatitis, jaundice, Stevens Johnson syndrome, rhabdomyolysis, renal failure, oliguria, urinary retention; Very rare ($<1/10,000$) - hepatic failure, hepatitis. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients: insomnia, headache, nausea, anxiety, diarrhoea, flu syndrome, convulsions, nervousness, depression, pain, hyperhidrosis and dizziness. Data suggest that incidence and severity of withdrawal symptoms after long-term treatment may be dose-related.

Legal category: POM.

Marketing authorisation numbers, pack sizes and basic NHS prices: Pregabalin Neuraxpharm 25 mg - PL 49718/0023, 56 tabs: £3.99; Pregabalin Neuraxpharm 50 mg - PL 49718/0024, 84 tabs: £3.99; Pregabalin Neuraxpharm 75 mg - PL 49718/0025, 56 tabs: £4.79; Pregabalin Neuraxpharm 100 mg - PL 49718/0026, 84 tabs: £5.59; Pregabalin Neuraxpharm 150 mg - PL 49718/0027, 56 tabs: £5.59; Pregabalin Neuraxpharm 200 mg - PL 49718/0028, 84 tabs: £7.19; Pregabalin Neuraxpharm 225 mg - PL 49718/0029, 56 tabs: £6.39; Pregabalin Neuraxpharm 300 mg - PL 49718/0030, 56 tabs: £7.19.

Marketing Authorisation Holder: Neuraxpharm UK Limited, Unit 12 Farnborough Business Centre, Eelmoor Road, Farnborough, Hampshire GU14 7XA, UK.

Ref: NXUK05201

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Adverse events should be reported. Reporting forms and information can be found at <https://yellowcard.mhra.gov.uk/> or search for MHRA Yellowcard in the Google Play or Apple App store. Adverse events should also be reported to Neuraxpharm UK Limited on Tel: +44 (0)7930 005205 / +44 (0)7557 534231 or Email: pvlesiv@aziarta.com