

DECEMBER 2016 VOLUME 14 ISSUE 4

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



To heal or not to heal

New perspective on placebo

**Apps, Bots and Wearables : The future is here
at present**

**Educating secondary school students about
paediatric chronic pain**

Misuse of gabapentinoids

ISSN 2050-4497

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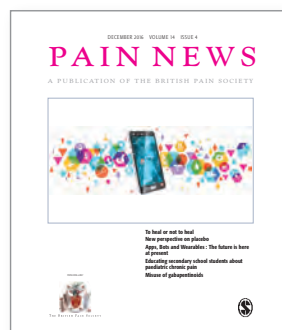
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PAIN NEWS is published quarterly. Circulation 1300. For information on advertising please contact Neil Chesser, SAGE Publications, 1 Oliver's Yard, 55 City Road, London EC1Y 1SP, UK. Tel: +44 (0)20 7324 8601; Email: advertising@sagepub.co.uk

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

Next submission deadline : 5th January 2017

Material should be sent to:

Dr Arasu Rayen
PAIN NEWS Editor
The British Pain Society
Third Floor Churchill House
35 Red Lion Square
London WC1R 4SG United Kingdom
Email pns.rayen@gmail.com

ISSN 2050-4497 (Print)
ISSN 2050-4500 (Online)
Printed by Page Bros., Norwich, UK

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

British Pain Society Calendar of Events

To attend any of the below events, simply book online at:

www.britishpainsociety.org/mediacentre/events/



2017

Patient Liaison Committee Webinar

Wednesday 18th January 2017

Online

The Patient Liaison Committee will be hosting two 45 minute webinars, these will be free to view and will have the facility to ask questions at the end.

50th Anniversary Annual Scientific Meeting

Wednesday 3rd – Friday 5th May 2017

Birmingham

Put the dates in your diary now for this flagship event – the 50th Anniversary Annual Scientific Meeting. We have an exciting and high profile line up of plenary speakers and parallel session topics for the Meeting. The ASM is a great opportunity to:

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

To view the list of plenary speakers and for further information please visit: <https://www.britishpainsociety.org/2017-asm-birmingham/scientific-programme/>

Living Well Right to the End

Philosophy & Ethics SIG Annual Meeting

Monday 26th – Thursday 29th June 2017

Rydall Hall, Cumbria

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

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

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

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

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

Gonnae no dae that! – exploring patient and clinician fears

Pain Management Programmes SIG Biennial Conference

14th & 15th September 2017

Glasgow Caledonian University, Scotland

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

Social events:

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

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

www.britishpainsociety.org/mediacentre/events/

Dr Arasu Rayen *Editor*
pns.rayen@gmail.com



Apps are everywhere. Your smartphone is just a brick if you do not have any installed Apps. Apps, even though started in the mobile world now, have invaded the PC world as well. In 2002, Blackberry was introduced, followed by iPhone in 2007 and Android phones in 2008. Because of its ease of use and multiple functionality, mobile phone adoption among general public escalated exponentially. Along with smartphone industry expansion, App world grew rapidly. It is estimated that Google Play has around 2.2 million Apps, and Apple's App Store has around 2 million Apps (<https://www.statista.com/statistics/276623/number-of-Apps-available-in-leading-app-stores/> – accessed on 10 October 2006). Apple's Mac series, Google's Chrome books and Microsoft's Windows 10, all have App

stores to download Apps and explore. Apps are invading health industry thick and fast. Stephen, Damien and Arun's third article in their series of articles on Technology in health, 'Apps, Bots and wearables' deals with Apps and more interesting technologies like Bots and Wearables which are already in use or in the horizon. The future is Apps; the future is technology. One thing to point out at this stage is about the App that The British Pain Society (BPS) will have for the Annual Scientific Meeting (ASM). Please read the President's message to know more about this.

Eric Berne was a prominent psychologist from Canada. In his best-selling book, *Games People Play*, he introduced a concept 'transactional analysis' – a method for studying interaction between people. Berne defined three ego states – parent, adult and child. He described that every single social transaction we make involves any of these three ego states in each individual. Similar to this Performance studies is a discipline which takes a whole system analysis to analyse human-to-human interaction. Sara

Goldingay, Researcher and Senior Lecturer, Department of Drama, University of Exeter, in her article, 'To heal or not to heal: the Hamlet effect', compares the medical practice to theatre performance. She compares the health professionals to the actors with pre-existing script like 'history taking' with white coat and stethoscope as props. Sarah has also presented a programme in BBC Radio 4 'The Problem of Pain, BBC Radio 4' (<http://www.bbc.co.uk/programmes/b061t68w>). Please read the article and listen to the podcast of the programme in BBC Radio 4 website.

We are fast approaching 2017. By the time you read this, Christmas is almost upon us. We are celebrating our 50th ASM Meeting Anniversary next year with an exceptional meeting in Birmingham. I would encourage you to book your study leave and get ready for great Celebrations. If you have any nostalgic memories of your yesteryears in BPS and ASM, please share it with us. You can write to me or if you have any photographs, please send them to me. I am eager to see them and publish them.



Pain News
2016, Vol 14(4) 139
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Dr Andrew Baranowski



What is the role of the President's Report in *Pain News*?

I have had a discussion with a number of people about the style of my President's Report in *Pain*

News. The discussions have been revolving around whether or not this is a report by 'myself' as President of The British Pain Society (BPS) or from the President of the BPS and I happen to be writing it? I am sure that all Presidents will have their own style and in the past many may have been more formal in their reports, but I see *Pain News* as your newsletter and not a formal audit report or prospectus that needs a Presidential approach ... I feel it is important to make this exciting newsletter as personal for you as possible. As a consequence, I am writing about my thoughts – I will not always be correct and I aim to listen to the responses that come out of my musing both as a result of this report and other contacts.

2017 is going to be a very exciting year for the BPS

Team BPS has been working on modernising our Society for several years and whereas there is still a lot to do, you will see change ...

The Annual Scientific Meeting

As I hope you will be aware, the 2017 is the 50th anniversary of our Annual Scientific Meeting (ASM), taking into account those meetings from the

inception of a national pain Society – which started as the Intractable Pain Society. This makes us the oldest Pain Society. We are also the only British multi-disciplinary Society.

The ASM that we have planned for May 2017 will reflect the importance of this anniversary and our multidisciplinary team (MDT). We have started advertising the outstanding programme that we have lined up, both within this newsletter and our social media; please prioritise this meeting as the BPS needs you and hopefully you will see the importance of the Society in supporting the MDT. I am clear that not only are the speakers highly regarded for their expertise and delivery, but because the Scientific Programme Committee have organised the meeting to represent a number of themes, we have maximised the impact for you. There will be items of relevance throughout the meeting to stimulate all those attending, whatever your level of expertise and discipline. This is one of the changes that we have instigated following feedback from our members, both those that have attended regularly in the past and others who are less frequently involved.

At the request of our members, we have reviewed the branding, design, presentation and advertising of the meeting. We have brought in a new company, 22 Design, to modernise our ASM documents bringing them in line with our new brand for the BPS (see below). Hopefully, this will provide a fresher and cleaner experience but more importantly simplify the paperwork so that life is easier for those attending.

As a part of modernising our documentation for the ASM, we will be introducing a conference App. This is an

App that we have specifically chosen for its ease of use, its ability to help members organise their meeting day and a functionality that will enable those attending to be much more involved with the speakers by facilitating questions and ratings. We hope to move away from more didactic presentations and to facilitate discussion as our members have requested.

The ASM party

The social side of the ASM is important to me (!), and I was pleased to support the re-introduction of the ASM Party a few years ago. Choosing the disc jockey (DJ) is the key, and the play list is essential if we expect you to get up and dance. If you have any recommendations for the DJ, please let us know. Please also consider emailing us five songs (band and title) that will drive you crazy on the dance floor and will get even the consultants up there with their team; please email to asm@britishpainsociety.org with the subject 'Let's get the party started', and we will see what we can do.

For our 50th anniversary, Team BPS is looking at other ways of making the venue a home away from home. We are working on moving away from 'holding slides' while you are waiting towards more and more interesting approaches – I see this as work in development. You will need to attend to be able to judge our early efforts and to know more!

Future ASMs

The new App will enable us to collect more information about your views of the ASM. It is your opinion that has informed change to date and will continue to inform change. As we begin to plan for

2018 and beyond, we are looking at smaller venues which hopefully will provide a warmer more cohesive atmosphere. That is only one of the changes, being discussed; if you have ideas, then please email to asm@britishpainsociety.org.

Rebranding

Over the past 6–9 months, we have employed a branding consultant. The aim was to modernise our appearance but not lose our heritage. Bill Wallsgrove has done a great job in sharpening our image but maintaining our traditional logo. It is important that we have a sharp clean image that is clearly associated with us and easily identifiable. However, rebranding was essential as The BPS brand will be rolled out across all our paperwork, social media and events, and, as a consequence, had to be appropriate for those media. Although, ultimately, it is also key for our fundraising.

Fundraising

The Society, over the past 5 years or so, has made cost savings where possible. Any further such approaches would potentially jeopardise the work that we currently undertake. The concept of the National Awareness Campaign was, partly as the title suggests, to increase awareness of the problems of those faced with pain and what the BPS does to support such individuals, but also to act as a means to enable fundraising so that we can support our members to support those who live in pain. The setting-up of the BPS trading arm was also to facilitate income generation by enabling us to explore new opportunities that a charity cannot do.

After nearly 18 months of research, proposals, business cases, debate and meetings (good for building character and for governance, so I am told!), we now have an agreed prospectus that can be used in our fundraising efforts. We

also have a collection of branded posters – these are quite dramatic and informative in a punchy way. Finally, we have some ideas!

Having been involved in this work for nearly 5 years, I am amazed as to how much time and effort has been required to move this forward from our Secretariat, Council Members, Execs and a significant number of volunteers as well as Bill. If we pull this off, it will be due to their altruistic efforts on the behalf of the Society and for its members.

Exciting ideas aimed at bringing in support for the work of the Society

To a certain extent, we are now the stage when we just have to do it. Currently, we have the following:

Cycle challenge

Glyn Williams, elected Council member, has drawn up a proposal for a cycle fundraising event. Hopefully, there will be more about this in the not too distant future. I have some inkling of what is involved, and I will need to be sure the ‘granny’ gears work on my bike. As well as involving members, we are looking at variations that may work with those that are living with pain, friends and relatives. Glyn and Team Cycle keep up working on the proposal.

What has become known as the ice bucket challenge?

A variation of the successful ice bucket challenge, where iced water is poured over someone in the name of charity (!), is being devised by Ann Taylor and Sam Ahmedzai. This is likely to morph but is an example of some of the background work happening.

Art awards

It is early as I write this report. The BPS is currently working on building up relations

with a number of famous artists and societies to launch an arts awards prize competition, awards ceremony and art show. To date, the discussions have been well received, and this may potentially be an ongoing programme. I’m very excited about the range of possibilities that this project may enable. In my mind, I feel it could potentially put us in closer contact with those who live with pain, it may help them to express their feelings about the problems they face, it will help us to spread the word and potentially facilitate us to develop close relationships with individuals and agencies that might look towards supporting the activities of the BPS and its members.

Proactive working with media

In the past, a lot of our BPS work with media (newspapers, magazines, radio and television amongst others) has been when we have been contacted for help. However, we have set up a small working group to look at being more proactive. The members have been asked to undertake a number of activities which include: developing a number of BPS standard responses so that we can respond quickly to requests from a well thought – out position. We are also looking to be more proactive in recognising where opportunities for media working exist (essentially monitoring publications and providing reports to agencies before they ask for them). We are looking at media training so that we can develop ‘BPS media gurus’ who sound good on radio or look good on television! Finally, we will work up some ideas around engaging media to include pain in their portfolio of activities, documentaries and even as a part of serial story lines. We want to position the BPS as the place to go to for advice and information around all issues related to pain. Thank you Austin Leach, Roger Knaggs, Alan Fayaz and Dina Almuli for taking this forward.

Dr Andrew Baranowski

Enhanced member engagement through improved communication

As you'll see, I am really keen that the members have the opportunity to interact with Council and Execs as much as possible. There is no doubt this has to be in a controlled manner as I already receive around 100 emails a day. For that reason, I am suggesting that we set up specific email addresses for certain issues (as above). We have also made the minutes from Council available under the members section of the website, and we are working on developing discussion forums within our website. This work is ongoing but should, over the next year or so, significantly open the Society for its members.

Enhanced website

As you are aware, John Goddard and his team revamped the website. Ann Taylor and Sam Ahmedzai, as Webmasters, have provided Council with further recommendations as to how to open up the website so that it is more user-friendly and how we can improve its functionality. Those developments will be undertaken in the context of the rebranding exercise. Zoey Malpus is currently leading a working group that is collaborating very closely with Ann Taylor to look at how we integrate many features from the Pain Community Centre website into our website. For Ann Taylor, to have facilitated this merger is a huge gift for our members. The merger of the two websites will significantly increase the amount of information that we have for patients and members as well as providing continued medical education facilities. We will have to strike a balance between what is free for members, what members are charged at a nominal fee and what non-members are charged. The fact that this is your website will be central to any decisions around that.

Recognising member contributions through awards

William Campbell in his capacity as Immediate Past President is leading a working group looking at our current awards system. There are a number of proposals, and, in due course, these will be presented to the members. However, there is one area that I am keen to push forward: *recognition of BPS members by their colleagues and patients*. The details are to be ironed out; however, at this stage, my thoughts are that members of the Society who are recognised (such as by a thank you letter) from their colleagues or patients will have their name, institution and a key paragraph or so published in a quarterly (possibly monthly) push email from the President to all our members. The details would also be published on our website. Every time we publish a new list, we would Tweet it. We are always happy to complain, we need to be more positive about promoting our members who have been acknowledged. I hope that you will all see the benefit of a system where your colleagues' achievements are recognised by the BPS and our members.

Regional meetings

Members have for many years requested that meetings are less London-centric. Paul Cameron and the Education Committee are currently looking at ways in which this could occur. Joint meetings between local departments, societies and agencies with the BPS are one such model. The benefit for the local team would hopefully come from the collaboration with the BPS and the badging of the meeting by our Society providing evidence that the meeting meets certain standards. I envisage that this would only be available where the organising committee has a significant number of BPS members, that it is a benefit for members.

Membership fees and what you as members benefit

Martin Johnson is involved in multiple discussions and meetings looking at the way we structure membership fees and the benefits of being a member. Despite a huge amount of work to date, there is still a lot to be done. We are listening to members as the team review membership.

In conclusion - there is a lot to do...

So, 2017 is a significant year. We will be instigating numerous changes to improve your experience, and we will continue to evolve as is right for a 50TH Anniversary. As I have said before, we need you. Please approach us if you have the time to work on BPS projects and are happy to be a work engine to bring about change that will improve what the Society can do to support its members to help those living with pain and to work towards the Society meeting its values:

ENABLING BEST PATIENT CARE:

So people in pain live their lives to the fullest.

SUPPORTING EFFECTIVE PARTNERSHIPS:

So health and social care professionals work together to provide comprehensive support.

MAKING PAIN VISIBLE:

So pain and its consequences are on the national health agenda.

INFORMING PROFESSIONAL EXCELLENCE:

So professional standards are elevated through research, audit and education.

INVESTING FOR THE FUTURE:

So we have sustainable financial growth to invest in our mission.

Professor Roger Knaggs



Pain News
2016, Vol 14(4) 143
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Special Interest Groups: the lifeblood of the Society

During the ongoing review of membership and recruitment, I have been reminded on numerous occasions that

The British Pain Society primarily is an organisation for its members. One of the many ways that the Society serves its members is by providing a range of Special Interest Groups (SIGs). The SIGs allow members who have a specific interest to discuss and debate their interest in more depth and the Society encourages the work of the SIGs as it demonstrates the multidisciplinary nature of the Society.

There are currently 14 SIGs which cover specific types of pain or specific populations (e.g. acute pain, headache and neuropathic pains, pain in children and older people), treatments for pain (e.g. interventional pain medicine and pain management programmes) to other aspects of clinical practice (e.g. medicolegal and pain education). SIGs only work with dedication and commitment of a relatively small number of members. I would

encourage you to think about how you contribute more actively to the SIGs that you are a member of or consider joining a new SIG, or if you feel an area of pain medicine is not represented by the current SIGs think about creating a new one.

Access to medicinal cannabis: meeting patient needs

No doubt you will have seen media reports from an influential parliamentary group, the All-Party Parliamentary Group (APPG) on Drug Policy Reform. After taking evidence from patients, medical professions and examining how medical cannabis is regulated in other countries, they proposed the legalisation of cannabis for medicinal purposes. A report commissioned by APPG that reviewed the evidence for use of cannabis for a range of conditions and the final report from the APPG are worth reading.

In an online survey of medicinal cannabis use in the United Kingdom, the most common indications were chronic and severe pain (24% of respondents), arthritis (12%), insomnia (21%), fibromyalgia (9%), post-traumatic stress disorder (PTSD) (7%), depression (30%) and anxiety (26%). There is also a summary from a survey of pain clinicians that was organised by the Chronic Pain Policy Coalition.

In response to the APPG group report, elected Council members issued the statement below:

The British Pain Society welcomes the interest of the APPG for Drug Policy Reform in expanding access to medicinal cannabis.

The expert report commissioned by the APPG identifies that there have been several studies that have investigated the effectiveness of cannabinoids for different types of persistent (chronic) pain although there have been other studies that have showed negative results too. In neuropathic pain specifically, cannabis and cannabinoids are not effective.

Like all medicines, cannabinoids have side effects and potential harms for users. There are significant concerns from the epidemiological literature that cannabis use has significant mental health risks in susceptible individuals and the degree of this risk for 'therapeutic' users is unknown.

The British Pain Society welcomes the APPG for highlighting the issue but recommends there is insufficient evidence to support its use in pain management at present.

Spotlight – Thanthullu Vasu

The width and breadth of BPS membership is testimony to the diversity within the organisation and in the pain world. The Editorial Board would like to acknowledge this richness by shining a spotlight on some of our members. In this edition, we speak to Dr Thanthullu Vasu, Consultant and Head of Pain Management Services, Leicester.



Dr Thanthullu Vasu
Consultant and Head
of Pain Management
Services, Leicester

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

As an enthusiastic trainee, I attended the British Pain Society (BPS) Annual Scientific Meeting (ASM) regularly. This paved the path for networking

among numerous friends in the pain specialty.

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

I was honoured to be elected as a BPS Council Member (2009–2012). The most exciting role was that of the Honorary Editor of the *Pain News*. Being the Editor helped me to establish productive professional relationships with a wide variety of multidisciplinary healthcare professionals.

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

It is said, 'You have to dream before your dream can come true!' I had the

unique opportunity to work with different Presidents of BPS including Dr Hester, Prof. Bond, Prof. Langford and Dr Campbell; I have realised that the role of the President is very challenging with huge responsibility! If this dream comes true, I will heavily subsidise the next ASM fees to make sure that many hundreds of members attend the 50th ASM meeting in Birmingham.

4. What are you known for professionally?

I am known for my skills in helping young children with persistent pain; this is made possible by our multidisciplinary team in Leicester. I also lead the pain service at the University Hospitals of Leicester NHS Trust.

5. What are you most passionate about professionally?

I am very passionate about our paediatric pain clinic and the achievements that we have made in the last 2 years (including winning the National Grunenthal Award for an innovative project for young children living with pain).

6. What do you have a knack for?

My biggest strength is in setting the patient expectations to the right level that could be delivered! I have high rate

of satisfaction from our patients. Furthermore, our paediatric chronic pain service achieves 100% satisfaction rate in the *Friends and Family* test.

7. Where can we find you in your spare time? What is your favourite way to spend a weekend or a Sunday afternoon?

You will find me walking with my friends along a scenic canal-side or in a rural farm side in Leicestershire during my spare time; I lead a walking club in Oadby, Leicester. I organise cultural events and take active part in dancing and debates in these events. My two children keep me very busy and happy during the weekend.

8. Any other volunteer activities apart from the BPS that you're passionate about?

I have linked with patient charity groups in and around Leicester and have used these links to start new services for patients with persistent pain. I am proud that these activities are publicised with appreciation in the local media.

9. Any favourite non-profit organisations that you support and why?

I support Leicester Hospitals Charity and they reciprocate by supporting our innovations. Recently, I have established

link with another patient charity 'A way with Pain' and have written patient information details for their website (<http://www.awaywithpain.co.uk/acupuncture-children>).

I want to be remembered as a compassionate and caring friend who will not hesitate to challenge when necessary but support at all times.

Faculty of Pain Medicine published this as very innovative project in their website (<https://www.rcoa.ac.uk/faculty-of-pain-medicine/useful-links>).

10. What would be impossible for you to give up?

Reading – I have to read at least 30 minutes every evening before bedtime. My favourite authors include Dan Brown, Paulo Coelho and Jeffrey Archer; I am addicted to the Tamil authors Balakumaran, Sujatha and Kalki.

11. How do you want to be remembered?

12. Any life achievements you are particularly proud of?

I changed the style and format of *Pain News* when I was the Editor; this was appreciated by the Executive committee, Council and the wider membership.

I am proud to win the National Grunenthal Pain Award for our innovative paediatric pain workshop; I was elated when the

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

BPS has given me a new dimension to my professional life and instilled the importance of team working. It is famously said, 'If you want to walk fast, walk alone; but if you want to walk far, walk together'. Let us all walk together to raise the profile of our Specialty. See you all at next ASM in Birmingham!

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

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



Thank you for supporting the BPS!



Follow the Society on twitter

Please follow the Society on twitter **@BritishPainSoc**

We will be sharing relevant information and updates from the Society.

Six years on, the Grünenthal Pain Awards go from strength to strength

Following the recent announcement of the 2016 winners of the Grünenthal Pain Awards, here we review their aims, the Overall Winners of the last six years and the impact this Award has had on the teams. We also invite entries for the 2017 Awards.

What are the Grünenthal Pain Awards?

The **Grünenthal Pain Awards** began in 2011; they are designed to recognise and reward excellence in the field of pain management and significant improvements in patient care. Being a finalist or winner of the Grünenthal Pain Awards can have a significant impact on your pain management service. Antony Chuter, Patient judge commented *"These awards improve patient care. Teams that win awards are valued and recognised by their patients and their Trust."*

The Grünenthal Pain Awards Judging Panel is an independent group who have agreed to oversee the evaluation, assessment and awarding of the Grünenthal Pain Awards. Awards will only be made available to institutions for the benefit of patients and the NHS and not to the individual healthcare professionals. These awards and the event ceremony including hospitality have been organised by Grünenthal Ltd. All costs, including catering and judging honoraria have been paid by Grünenthal Ltd.

2011

Overall Award Winner

Rachel Goodwin and team, University Hospitals Bristol NHS Foundations Trust

"Using performance is a powerful way of enabling patients to see how they respond to situations and make choices as to how they live their lives." Rachel Goodwin, Specialist Pain Management Physiotherapist

Summary of entry

Using drama in pain management and chronic conditions management settings

To use drama to help participants reach acknowledgement and acceptance so that they can move on with making life choices in line with their own personal values, and to roll this out to a wider audience.

What impact has this Award had?

"Our DVD that has rolled out from the Award enables others to use this valuable tool to help manage their pain." Rachel Goodwin



2012

Overall Award Winner

Vathana Sackett and team, University College London Hospitals NHS Foundation Trust

"Pain, timings and geography make it difficult for patients attending clinics, so our project outlined an internet-based service. This new way of working challenged how we maintained governance and confidentiality."

Vathana Sackett, Clinical Specialist Physiotherapist, Adolescent Rheumatology

Summary of entry

Live web self-management intervention for adolescents with chronic pain

Delivering live group sessions facilitated by a therapist on the web, promoted patients sharing experiences and problem-solving. The benefits of a more accessible and cost effective intervention will mean adolescents receive more support and feel better prepared for discharge and transition.

What impact has this Award had?

"The Award was an amazing opportunity to raise the profile of the service and to engage stakeholders." Vathana Sackett



2013

Overall Award Winner

Dr Scot Richardson and team, St. Andrews Group Practice, Hull

"Some MS patients have very complex pain, and ATS can be beneficial. It stimulates the body's own action potentials. We want to use the services available in the area, and assess the appropriateness of therapy, including the potential use of APS therapy, to improve patients' lives." Dr Scot Richardson, GP Registrar ST3

Summary of entry

Action Potential Simulation (APS) therapy: a novel approach for management of MS-related pain

To develop a holistic community primary care-based service for patients in Hull with multiple sclerosis (MS)-related pain, including the use of APS therapy, a micro-current electric therapy, to enhance existing services and improving access for patients with MS living in Hull.

What impact has this Award had?

"Since winning the Award, our project has gone from strength to strength in our delivery of services to people with MS. The recognition we got from the CCG, secondary care and community services opened doors for further collaboration in the Hull region which has been very positive for our patients, us as a team and the Trust." Dr Scot Richardson



Thinking of entering the Grünenthal Pain Awards for 2017?

If you are thinking of entering the 2017 Awards, remember that entries are considered from all healthcare professionals working in pain management. *"It is not only specialists in pain management that now enter these awards; there are a diverse range of applications from a range of healthcare professionals managing pain every day. If you are part of a project that you think offers a good service, apply for this Award as it can offer you a multitude of benefits,"* advises **Dr Scot Richardson, 2014–2016 judge and 2013 Overall Award Winner.**

Dr Hannah Twiddy, 2015 Overall Award Winner, adds *"If you are thinking of entering this award, do it! It is not hard to complete the application forms, and you gain recognition of your work. Bringing your work to life in a video was a great experience for the entire team, and allows you to show off your department, your team and its services."*

2014

Overall Award Winner

Professor Tara Renton and team, King's College Hospital NHS Foundation Trust

"This service will help to streamline pain management and services for patients with orofacial pain, as well as allow the collection of valuable research data." Professor Tara Renton, Professor of Oral Surgery

Summary of entry

Facilitating artificial intelligence diagnostics for chronic orofacial pain via a dedicated website

The development of a specialist website for orofacial pain (OFP) for patients and clinicians providing information and advice with appropriate links to existing patient specialist groups and data collection, with the ultimate aim of improving patient care.

What impact has this Award had?

"The benefits of winning this Award have been significant. We have been developing the multimedia aspects and content for the website (orofacialpain.org.uk that has already had 16,000 visits). We have recruited 500 patients for a research project that has resulted in several publications, and will soon be filming patient stories and education videos. Also, we have submitted our focus group paper for publication in the European Journal of Pain and have facilitated another 4 groups. Our website project is slow but progressing (mainly due to slow pace of NHS IT departments!). It is also important to note that winning the Grünenthal Pain Awards enables you to be eligible to develop a portfolio study, so you not only receive the funding from the Award and recognition for your team, but you can get additional funding for patient recruitment which is a fantastic bonus. We cannot more highly recommend this unique national recognition of patient centered pain initiatives, which provides only modest funding, however provides opportunities even we did not foresee!" Professor Tara Renton



2015

Overall Award Winner

Dr Hannah Twiddy and team, The Walton Centre NHS Foundation Trust Liverpool

"Young adults need to be able to link the information we're giving them to manage their pain within their values, so we use materials that are accessible to this population." Dr Hannah Twiddy, Clinical Psychologist

Summary of entry

Supporting young adults with chronic pain: a multimedia based specialised pain management programme

The Walton Centre Pain Management Programme improves care provision for young adults (aged 18-30 years) with chronic pain by providing focused and specialised services and interventions through accessible and engaging multimedia modalities.

What impact has this Award had?

"One of the main positive impacts of winning the award is the Trust then decided to invest in two brand new virtual reality exercise bikes for use by the young adult groups. It has raised the profile of the young adult intervention group we run and meant that we have started to receive enquiries and referrals from additional sources, neighbouring and less specialised pain clinics. It has been so important to have the work we have done for our young adults recognised and expanded." Dr Hannah Twiddy



2016

Overall Award Winner

Dr Bianca Kuehler, Susan Childs and team, Chelsea and Westminster Hospital NHS Foundation Trust Hospital

"Patients who have been exposed to human cruelty and torture need a specially planned service. The unique feature of this service is its multi-disciplinary input, with doctor, nursing, psychology and physiotherapy support to bring patients towards their identified values and goals." Dr Bianca Kuehler, Specialty Doctor Pain Anaesthetics

Summary of entry

A one stop multidisciplinary pain clinic for survivors of torture

This clinic offers a single appointment medical, psychological and medication assessment in a safe environment for this vulnerable and poorly understood pain patient population.

What impact has this Award had?

"This award will allow the commencement of measures that investigate post-traumatic stress disorder (PTSD), alongside the development of a specialised compassion-focussed pain management programme for survivors of torture and the provision of a swift access psychiatry clinic."

Our main experience so far is that it raised our profile. We are already seeing an increase of referrals to the specialist service including direct referrals from GP's. This is achieving exactly what we want as we hope to help health care providers to understand this complex patient group better and give them the opportunity to refer patients to us."



This advertorial has been written by Grünenthal Ltd. Its placement in this journal has also been funded by Grünenthal Ltd.

Calling for submissions for 2017

Grünenthal is delighted to announce that it is supporting the Grünenthal Pain Awards for the seventh year in 2017.

There will be three award categories, with a top award for 2017 of £10,000 for the Overall Award Winner.

Grünenthal would like to thank all applicants and judges over the last six years, and welcomes submissions for 2017.

For further information about the Awards, or to request a 2017 entry pack, please contact the organisers, Jango Communications Ltd., by emailing elisia@jangocom.com or calling **01344 860612**.

Awards will only be made available to institutions for the benefit of patients and the NHS and not to the individual healthcare professionals.

These awards and the event ceremony including hospitality have been organised by Grünenthal Ltd. All costs, including catering and judging honoraria have been paid by Grünenthal Ltd.



The Patient Reference Group

Antony Chuter *Chair of the Patient Liaison Committee*

The Patient Reference Group (PRG) was established by the British Pain Society's Patient Liaison Committee (PLC) just over a year ago. Within a very short time and with little publicity, it grew to over 400 members. The Society and the PLC wanted to reach out to people who live with or in pain and to their carers. The PRG has been sent a number of newsletters and is also being used as a survey base. The PRG is very diverse in age, location and other demographics.

We have had an average open rate of 54.2% for emails, which is far higher than the industry average open rate of around 20%. We have also had a slightly above industry click rate of 16.9% when the industry average is 16.5%. This needs to be taken in context that not every email we sent had a survey and some had links back to the British Pain Society. For the surveys we had click rates of about 20%. The group has a significantly higher proportion of women with 371 being women and 40 being men.

The youngest member is 19 years old and the oldest is 88 years, with the group mean age of 45.6 years. The group has 17 people who identify as caring for someone who lives with pain. A total of

355 people identified as a person living with pain and 45 people identified as a person living with pain who is also a carer. In total, 400 people identified as White British or a similar phrasing; 21 people identified as Black and minority ethnic (BME) or similar phrasing.

We would now like to expand the group and grow the online community that the Society connects with. I need your help to do this. I would be delighted if you would please download and print off the poster we have designed to advertise the group to patients and their carers. You can find it here: <https://www.britishpainsociety.org/people-with-pain/patient-liaison-committee/#patient-reference-group>.

Living with or in pain? Caring for someone who lives with or is in pain?

If so the PRG could be just for you. We are looking for people from all areas of the United Kingdom, both people living with pain and their carer and the group seeks to be representative of the wide range of patients living with pain and carers.



Members of the group will be asked to comment on materials such as patient guidance documentation, take part in surveys and questionnaires which in turn help the Society to understand how patients and carers feel.

This is an online email group, so you need access to email.

We will keep your details securely and we won't share them with any organisation outside of the British Pain Society.

To join, please go to <http://eepurl.com/loFwv>

For more information about the British Pain Society and what we do, please visit our website at www.britishpainsociety.org. You can also find more information specifically about the PLC at <https://www.britishpainsociety.org/people-with-pain/patient-liaison-committee/>

Reflections on the first EFIC topical symposium: acute and chronic joint pain, held in Dubrovnik, Croatia, 21–23 September 2016

Neil Betteridge

neil@neilbetteridge.me.uk

Apart from being the first topical symposium held by The European Federation of IASP® Chapters (EFIC), the European Pain Federation, the event also marked the first formal collaboration between EFIC and The European League against Rheumatism (EULAR). I participated in my capacity as International Liaison Officer for EULAR, presenting on Patient Empowerment, and Prof. Maurizio Cutolo, EULAR Past President, gave the opening lecture.

Prof. Cutolo's presentation stimulated great interest, dealing with Circadian pain management in chronic rheumatic inflammatory disease. The evidence presented illustrated how the human body performs a 'reboot' during the night, the immune system sending its 'police officers and firefighters' to attack unhealthy cells in well people and healthy cells in people with rheumatic disease. This was clearly of great interest to an audience comprising predominantly pain doctors, together with some orthopaedic surgeons and representatives of other disciplines.

Other highlights included workshops on surgical pain, led by two of the most renowned leaders in the field, Henrik Kehlet and Winfried Meissner.

Dr Kehlet has been working in Copenhagen for many years and is perhaps the most well-known surgeon among anaesthesiologists around the

world due to his substantial contributions towards the understanding of surgical pathophysiology. In the United Kingdom and many other countries, he is recognised as the founder of the Enhanced Recovery pathway, which has provided 'win-wins' to patients and healthcare systems in many countries now by accelerating the pace of the patient pathway, reducing admission periods (and therefore costs) while delivering patient experience and outcome measures which are as good or better than traditional surgical pathways.

He continues to perform groundbreaking work and, at this meeting, presented new, procedure-specific evidence for optimal analgesia in joint surgery. This included the PROSPECT studies and the use of prospective patient databases. He looked specifically at hip and knee replacement, and his summary of the evidence concluded that there was little or no evidence for the routine use of opioids in these interventions, especially without clear evidence of side effects.

In the United Kingdom, we at the Chronic Pain Policy Coalition are addressing the need for chronic pain patients to have an annual review of their management regime, including use of opioids, and in policy terms this is part of a wider movement to greater opioid sparing' where appropriate.

There are other potential policy implications here, as there is clearly an evidence-based need to develop an approach to surgery which proactively tackles post-surgical pain before the surgery has taken place, the way this is done being variable according to the nature of the specific intervention in each case.

Prof. Meisner, from the Jena University Hospital, Germany, is well known for the Pain Out initiative (see www.paineurope.com). Here, he illustrated how to optimise the organisation of perioperative pain management.

My own presentation had the objectives of challenging some common perceptions of 'Patient Empowerment'. This is a term sometimes more used in the breach than the observance, I find, as commitments to Shared Decision Making rub shoulders with more traditional approaches to care, based on clinician led direction. So my aim was to better define our terms: for example, is 'patient' really the right word for someone with a long-term condition such as chronic pain, who manages that condition 24/7 but is only in a clinic a tiny amount of their life?

But more than that I wanted to offer concrete examples of what patient empowerment means in practice. To this end, I drew on examples from my work with National Health Service (NHS)

Reflections on the first EFIC topical symposium: acute and chronic joint pain, held in Dubrovnik, Croatia, 21–23 September 2016

England, developing a patient booklet on Enhanced Recovery in close consultation with patients and carers; from EULAR's work in building a strong patient network via PARE (Patients with Arthritis and Rheumatism Europe), to collaborate with clinicians and health professionals and to provide an authoritative patient voice in its own right; and from public affairs/political work carried out by the Chronic Pain Policy Coalition in the United Kingdom, and EULAR at European Union (EU) level.

I hope these initiatives and achievements generated by these projects and organisations demonstrate that when patient empowerment is done well, it delivers better patient experience, better patient outcomes and better

public policy for both patients and healthcare professionals.

I would be very happy to share my slides and/or hear from anyone interested in discussing this matter further.

As EULAR PARE reminds people who are discussing issues that affect the lives of patients, 'Nothing about us without us!'

It's a demand, but a very reasonable one.

Personal conclusions

- High attendance and mixed audience reflects strong interest in Joint Pain, with many expressing interest in a meeting on this topic to be held regularly.

- Fast developing interest in seeking to change practice, doing more pre-operatively to optimise/minimise post-operative pain.
- Ongoing interest in use of opioids: better targeting of their use, to avoid over-prescribing (a major policy issue) and the personal consequences which can follow.
- Growing recognition that a multidisciplinary approach (MDT) approach is the only way to handle the surgical pathway effectively.
- The patient is the most important member of the MDT and needs to be appropriately empowered to play an active part in that pathway.



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



Veterans in pain: new resources

Pain News

2016, Vol 14(4) 151

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SAGE

Pain concern

Thousands of British ex-servicemen and women live with chronic pain. Dr Alan Barrett, the Clinical Lead at the Pennine Care Military Veteran Service for Greater Manchester and Lancashire, says that chronic pain is the most common health complaint among his service users. Long-term musculoskeletal problems, which are typically accompanied by pain, are the most common reason for discharge from the British armed forces. Studies in the United States, meanwhile, found that between 40% and 50% of US veterans who saw active service in Iraq and Afghanistan have developed chronic pain compared to 29% of the general population.

Recognising the scale of the problem of chronic pain among veterans and the difficulties many face in accessing pain management services, Pain Concern have produced resources designed to support veterans and their families, as well as, we hope, proving invaluable for healthcare professionals faced with the often complex needs of this patient group. With the support of the Forces in Mind and MacRobert trusts, we have produced a miniseries of three *Airing Pain* podcasts focusing on veterans' experiences and the support available. These are still available to listen to and download and are hosted on a newly developed page

of our website: painconcern.org.uk/veterans.

Topics discussed in the programmes include the transition from military to civilian healthcare, rehabilitation after limb amputation and the interaction between post-combat psychological distress and chronic pain. Our evaluation from the programmes found that as well as being helpful for veterans, they were valued by healthcare professionals with all those we spoke to saying they would recommend the resources to colleagues.

Listen to all three programmes and find more information about the services available to veterans on our website: painconcern.org.uk/veterans.

Have your say and contribute to *Pain News* today

Pain News is the Members newsletter and as such we encourage and welcome member contributions to share your news with the wider membership and beyond.

Do you have a news item to share?

Perhaps a professional perspective, or informing practice piece?

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

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

Upcoming submission deadlines:

Issue	Copy deadline
March 2017	2 nd January 2017
June 2017	31 st March 2017
September 2017	30 th June 2017
December 2017	29 th September 2017



Report on current state of the specialised pain Clinical Reference Group

Sarah Love-Jones *Specialised Services Representative BPS, Consultant in Pain Medicine and Anaesthesia, North Bristol NHS Trust*

National Health Service (NHS) England has announced the appointment of chairs for 40 Clinical Reference Groups (CRGs), in addition to the establishment of four cross-CRG working parties, to be focused on research, data and resource, and guidance and value.

Although some CRG chairs are new appointments, others are returning following the implementation of revisions to CRGs which saw a reduction in the number of CRGs. The CRG chairs will, for the first time, hold formal, remunerated positions at NHS England and will serve for 3 years.

The guide for CRG members has yet to be published, despite NHS England's original commitment to produce this by the summer. It is particularly concerning that the guide is unavailable before new CRGs begin their work programmes. Nevertheless, it is expected that the guide will have information on CRG subgroups and external stakeholder engagement.

With regard to the Specialised pain CRG, it is now appointed and in post. John Hughes has been reappointed as chair. There are eight members representing the four regions, two from each, and all from separate senates. There are three Patient and Public Voice (PPV) members. Competition for clinical members was high, and difficult decisions had to be made. The affiliate members are currently being reappointed. The British Pain Society (BPS) is one and highly likely to remain.

The process is that the CRG agrees the affiliates and then approaches the society – I have just this week completed the application form to apply for the BPS.

The role of the CRGs is to provide *specialty-specific clinical advice and leadership* for Specialised Commissioning. CRGs lead the development of clinical commissioning policy, service specifications and quality dashboards; advise on service reviews; conduct horizon scanning and make recommendations on innovation; identify and explore opportunities to reduce clinical variation in healthcare and deliver value; and provide specialty-specific clinical advice where required.

Background

NHS England is responsible for commissioning £15.6 billion of specialised services to meet a wide range of health and care needs. These include a range of services from renal dialysis and secure inpatient mental health services, through to treatments for rare cancers and life-threatening genetic disorders. Clinical advice and leadership is vital to the success of improving the commissioning of specialised services across the NHS.

CRGs are an integral part of this and bring together groups of clinicians, commissioners, public health experts, patients and carers. They use their specific knowledge and expertise to advise NHS England on the best

ways that specialised services should be provided.

CRGs lead on the development of clinical commissioning policies, service specifications and quality dashboards. They also provide advice on innovation, conduct horizon scanning, advice on service reviews, identify areas of unexplained clinical variation and guide work to reduce variation and deliver value.

CRGs, through their PPV members, also help to ensure that any changes to the commissioning of specialised services are co-produced with and involve patients and the public.

All the CRGs, with the exception of the cross-cutting medicines management CRG, are grouped around and report into, one of six National Programme of Care (NPoC). Further details on the current arrangements for CRGs and the NPoCs they are aligned to can be found on the NHS England website.

CRG membership currently consists of a chair who is a senior clinician in the relevant specialty, up to 14 specialty members from 'Senate' areas, four PPV members and four members from affiliated organisation (such as colleges and societies).

CRG chairs and members do not currently receive additional NHS England honoraria or payments for their work, but are supported by their employers to participate in CRGs.

NHS England has listened to feedback from CRG members and wider stakeholders

on how the current system is working through workshops for chairs and PPV members held over the past 18 months. They also listened to feedback from CRG members and wider stakeholders through the Investing in Specialised Services public consultation in 2015.

The purpose of revising the specialised commissioning CRG structure was to respond to this feedback and also to ensure that this clinical advisory mechanism aligns with the priorities of NHS England as set out within the NHS Mandate, the strategic way forward within the Five-Year Forward View, the need to ensure best value for patients and appropriate clinical advances and innovations.

The revisions

In January 2016, NHS England agreed to engage on proposals to streamline CRGs and enhance the support they get so as to expand their impact.

The following guiding principles have underpinned the revisions:

1. *Delivering clinically led commissioning that is consistent with NHS England principles and priorities.* A competency framework and development programme for CRGs will be created with engagement of the CRG membership, for a more streamlined, fully engaged group.
 2. *CRGs' chairs to be a formal NHS England appointment – with remuneration at one Programmed Activity (PA) per week (4 hours) – to bring recognition and accountability.* In clinical areas that do not have a National Clinical Director or associate director, CRG chairs may take a specialty 'National Clinical Lead' role where NHS England requires this.
 3. *Maintaining the CRG working model.* There is a consensus that improving the current model rather than developing a new one is more likely to deliver constructive outputs in the timescales required.
 4. *Providing comprehensive coverage of the specialised commissioning portfolio.* In the proposal to reduce the number of CRGs from 67 to 44, those CRGs not providing specific support to areas that are a responsibility of specialised service commissioning are removed, and those that currently cover related commissioned clinical services are combined.
 5. *Simplifying the operation of the CRGs.* The previously agreed proposal (prior to consultation) reduces and refreshes the CRG membership, for a more streamlined, fully engaged group.
- During member recruitment, the following was taken into consideration:
1. The two regional representatives will come from different senate areas within each region.
 2. CRGs will, where necessary, have appointment requirements applied to ensure there is a mix of expertise.
 3. One of the regional members is defined as data, information and pricing lead, who will take up a place on the relevant Health and Social Care Information Centre (HSCIC) Reference Group and NHS Improvement.
 4. One of the regional members is defined as a research lead, who will take up a role in the developing partnership work with National Institute for Health Research (NIHR) and other potential research opportunities from the CRGs' work.
 5. One of the regional members is defined as a commissioning for value lead, who will join the commissioning for value work stream.
 6. One of the regional members is defined as a National Institute for Health and Care Excellence (NICE) liaison lead providing advice to NICE.

New perspectives on the placebo response: why does giving nothing work so much better than doing nothing?

Paul Dieppe *Emeritus Professor of Health and Wellbeing, University of Exeter Medical School*

This article is a transcript of a presentation at Philosophy and Ethics meeting in 2016



Although I have recently learnt a good deal from my reading of the book *Cure a Journey into the Science of Mind over*

Body by Jo Marchant and a very recent article *Telecebo: Beyond placebo to an expanded concept of healing* by Larry Dossey (Explore, 2016),ⁱ the influences on my thinking on the subject go back many years, in fact, to a single experience in the 1960s when I was a student at a London teaching hospital. I was sitting in a clinic with Dr Barham, and one of his longstanding patients with rheumatoid arthritis (RA) came in. She was much improved but instead of discharging her after a perfunctory examination, he took a few minutes to inquire about her dysfunctional family and to tell her how well she was looking after herself and how much better her hands looked. I vividly remember the conversation at the end of the consultation:

Patient: When can I come back, Dr Barham?

Doctor: What's the point? I don't do anything for you – I don't give you any medicine

Patient: I need you, Dr Barham. You're my medicine.

Doctor: Oh all right Doris come back in three months then.

Exit Doris

Doctor: That, lad, is the art of medicine!

That was a moment in my life that changed me from a cynical medical student who thought that psychiatry was the only way to go because everything else was so uncaring and led me into understanding that you could actually be a caring doctor even in a teaching hospital environment. That man became my mentor.

The placebo 'effect'

This completely artificial concept was derived from the randomised trial paradigm. We measure the effect of a drug in a predetermined way which means that we've decided what the effect is going to be and what to measure rather than seeing what really happens. And then to see how much of it is anything to do with the drug, we give a dummy drug alongside and see a response. The only bit that really interests us is the difference between this and the drug response, which in general is about 25%.

All our subsequent effort goes into trying to enhance that 25%, and we

completely ignore the other 75%, or regard it as a nuisance, and, until relatively recently, this was generally dismissed as just regression to the mean and something we don't have to worry about.

However, if you put in a third group of people that you just observe and do nothing at all with, you do see some effect of natural change, but it's much smaller than what you get with your dummy pill. For instance, in studies of interventions for pain and depression comparing observation only, dummy and real interventions, the effect size of the dummy is around 0.5 to 0.7, which is a good deal bigger than most of the conventional interventions that we use. Recently, there have been some attempts to calculate the more difficult problem of effectiveness (the effect in real-world situations), and the estimate is that about 75% of the effect of both analgesics and antidepressants is the placebo effect. In other words, about 75% of the pain relief you achieve with whatever you do has nothing to do with the specific intervention. So, why don't we worry about the 75% instead of the 25%?

It beats me as to why the placebo effects this wow! factor – isn't taken more seriously and given more attention. It does mean that giving nothing can be a very effective intervention, and, as I will try to explain, I think it's the *giving* of nothing that is the point.

New perspectives on the placebo response: why does giving nothing work so much better than doing nothing?

**How does placebo work?**

The importance of meaning in this context has been championed by Dan Moerman, an American anthropologist in his lovely book *Meaning, Medicine and the 'Placebo Effect'* (Cambridge Studies). He feels that it is all about finding new meaning for suffering, often through symbolism or metaphor, and that it is the reformation and the reconceptualising of the story that allows you to improve. But conventional theories are predominantly about the power of the mind and almost all mean the power of the patients mind: psychological theories about expectation and conditioning and neurophysiological theories about activation of descending inhibitory pathways of pain control and release of natural endorphins or neurotransmitters. Most of the recent research concentrates on the brain using scans which seem to me like 21st-century phrenology and don't explain anything. It all misses a critical point. The patients' brain is clearly an important effector of the change, but something else needs to happen to activate that change. That is about the interactions between individuals and the contexts in which they take place and within that the space between them: their words, emotions and behaviours. Recent research suggests that the response depends on the giver as much as the receiver. Concentration on the patient goes back to the old idea that some people are perhaps genetically

determined to be susceptible to suggestion. But we now know that some people are better at producing a placebo response than others. Trials by Suarez-Almazor et al. and Kapchuk et al. comparing responses produced by different care-givers giving sham and real interventions, with no-treatment or observation control groups, show that you can train people to be really empathic and optimistic, and sure enough that results in better responses on average. But some people can get a great response even if they are being surly and negative, and some people can't get a good response even if they are trying to do it properly.

It also seems that the good intention of the person who is giving the treatment is absolutely critical. So intentionality of us as interventionists matters. There are good examples in the literature of experiments that have been done by a sceptic or a believer in exactly the same conditions, and the believer gets a good result and the sceptic gets no result. So we can't believe evidence if it depends on the intentionality of the person doing it. I think that probably screws the whole evidence base of medicine.

Maddie Greville-Harris has highlighted the importance of safety in the patient and professional interaction. Both giver and receiver must feel safe, which is rarely the case at first encounter. Being safe is about activating the nurturing response, which is the exact opposite of the fight or flight response. So no wonder when you tell people that they have cancer, they don't hear anything else, because they are immediately in fight or flight mode, and then they don't hear things properly and you can't communicate with them. Similarly, validation is the key to a good placebo response and invalidation, a powerful way of invoking a nocebo effect. Validation is about the patient knowing that the other person really understands and cares for them. Invalidation can occur if the patient thinks that you do not

really understand or care and can occur inadvertently when you think you are being very empathic and reassuring, for example, when you say something like 'Oh don't worry, I don't think there is anything much going on here to worry about'. That gets interpreted as he does not believe me, he thinks there is nothing wrong with me. And that can produce a tremendous nocebo response, is very damaging and is probably happening all the time in routine consultations. Greville-Harris research suggests that nocebo is five times more powerful than placebo.

Placebo effects curiouser and curiouser!

Placebos do amazing things. They work on animals, and good intention works on plants as well as cells in culture. Placebo treatment can cure cows of mastitis. In a trial of high fat diet in rabbits, the animals whose handler cuddled them got no atheroma and the others did. Not all of these experiments have been able to be repeated, but as some people can do these things and some cant, to expect them to be generalisable misses the point. It has been well-documented that healing intention can allow seeds to germinate better, seedlings to grow more and cellular enzymes to behave differently, and the effect is actually bigger in plants and cells than in humans. Stranger still, there is strong evidence in the extrasensory perception (ESP) literature, from human interactions with animals, near-death experience and brain-scanning experiments that the healing response in one living organism can be induced through the good intentions of another at a distance. The odds against these being chance findings in some ESP experiments are huge, but scientists find them hard to accept. (Like Richard Dawkins who said in a radio interview about this subject a few years ago, 'I don't care how much evidence you give me I'm never going to believe it!')

New perspectives on the placebo response: why does giving nothing work so much better than doing nothing?

There is loads of stuff about animals knowing when their owners are about to come home or mystic mogs who know when people are about to die. A palliative care doctor who is a friend of mine told me that if they didn't know who was going to die soon, they just looked to see whose bed the cat was sitting on, and it was always right. Of course it might be the smell, but it also might be something to do with the weird phenomenology that I am suggesting.

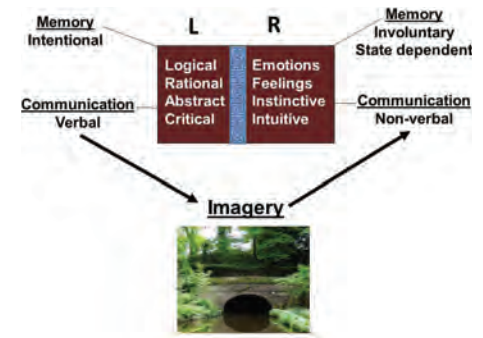
Distant synchronisation of activity in brain scans has been demonstrated in the subjects of Hawaiian traditional healers who were sending healing intentions from the opposite side of the island; this has been repeated by the so-called hyper-scanning techniques. But this sort of stuff isn't talked about because it doesn't fit conventional science.

Explanatory frameworks

One of the proposed explanatory frameworks involves quantum mechanics and entanglement, which I don't claim to understand. Apparently electrons can be in two different places at once and react in exactly the same way at exactly the same time. Another involves consciousness research and the concept of the non-local mind. So we seem to have three strands coming together: quantum mechanics telling us that it is all as it probably should be, distant healing which has always seemed a bit weird

and consciousness research. Regarding the non-local mind: within the biomedical model, we believe that consciousness is generated by the brain, but there is little or no evidence to support that hypothesis, and quite a lot of evidence against it. Many former scholars like Jung didn't believe in it. Nor indeed do the quantum mechanics people, and several of them share Max Planks belief that matter is derived from consciousness and that there is no matter without consciousness. I have no idea what that means, but I think that the idea of the non-local mind makes a lot of the phenomena we see in medicine like placebos that we have been talking about today easier to cope with than our current materialistic, positivist hypotheses. So the idea is that consciousness is out there, and our individual brains are receivers and filters of consciousness, and of course because our brains are different and have developed differently, our experiences are all different, and our contributions back and forth are different with different people. But we are all trying to connect it in to the bigger picture.

The schematic below reminds us that, whereby as humans on this earth, we are body and mind and that dominates because it's about survival, sex and tribalism, we also have our soul, our spiritual side which is the bit that is connected with the greater



consciousness out there. And that bit is about connectedness.

So the question remains: why does *giving* nothing work so much better than doing nothing, and the answer is this: because we can connect with each other. And I just think that's wonderful.

Acknowledgements

This article is a transcript from a lecture given by the author at 2016 Philosophy and Ethics SIG Meeting.

Note

- i. [http://www.explorejournal.com/article/S1550-8307\(15\)00166-4/pdf](http://www.explorejournal.com/article/S1550-8307(15)00166-4/pdf)

To heal or not to heal: the *Hamlet* effect

Sarah Goldingay Senior Lecturer, Department of Drama, University of Exeter;
Presenter, *The Problem of Pain*, BBC Radio 4 (<http://www.bbc.co.uk/programmes/b061t68w>)

This article is a transcript of a presentation at Philosophy and Ethics meeting in 2016

The enactment of the clinical encounter is a key factor determining a person's response to any medical intervention. I'm a performance ethnographer, a humanities specialist who draws on methodological approaches and literature from performance studies. Performance studies (PS) is a discipline that takes a whole systems approach to understanding human-to-human interactions by considering the material and immaterial processes at work in an encounter. Underpinned by the so-called anthropological 'turn', PS was developed out of the work of researcher-practitioners such as Schechner¹ and Turner² and has its roots in Aristotelian and Platonic questions about what it is to be human. Combined with a semiotics of theatre and everyday life,^{3,4} it analyses the performances of the church, or the street, or the courtroom through interpretation of costumes, scripts, sets, embodied and emotional experiences and knowledge, rituals and narrative structures.⁵ Medical practice, too, readily lends itself to analysis in these terms. The theatre in which a surgeon performs is analogous to that in which an actor performs. Elsewhere in the hospital or



the surgery, the doctor carries props and wears costumes that signify purity, knowledge and power. The semiotically rich stethoscope and white coat are less common now, but scrubs and lanyards offer alternative, if more ambiguous, signifiers of a person's role and associated hierarchy. Once in role, the healthcare professional asks questions that follow a pre-existing script or score shaped by Medicine's well-established system and method of 'taking a patient history'. The *mise-en-scène* of many of these encounters is a consulting room, with desk, computer and sink in plain sight, and couch half-hidden behind a curtain. Both actors (doctor and patient) play roles that are societally prescribed and take part in joint rituals, such as the clinical examination, in a place with special significance, set apart in space and time, where acts of healing are performed. These rituals also seep out and extend into the patient's life through the issuing of a pharmaceutical prescription – a set of stage directions which generate a new ritual to be embodied three-times-daily through ingestion or application. So, what might, taking this viewpoint, tell us about the

doctor–patient encounter from the perspective of the physician, and more importantly, how might it help us understand the prevalence of 'burn out'?

I'm part of a transdisciplinary team whose members work in medicine, psychology and the humanities. We take a holistic approach to try and understand how context shapes a person's healing response both positively and negatively.⁶ Our 5-year collaboration has led us to identify four key concepts: (1) human-to-human interactions matter, (2) context matters, (3) the whole person and their community matters and (4) communication, reception and interpretation matters. We believe that interactions, predominantly human-to-human, enable the Healing Response, the intrinsic ability of the human organism to self-heal following physical, emotional, spiritual or social disruption and regain homeostasis. In this article, I want to focus on the physician and respond to some of the conversations I've had with healthcare professionals about the pressure they are under to ensure reproducibility and consistency in every patient encounter. I reflect on the impossibility of delivering this imagined perfection and how that might make a practitioner feel. To do this, I'm going to turn to the narrative surrounding Shakespeare's play, *Hamlet*. I'm not asserting here that the reality of the rehearsal room is equal to that of the consulting room, nor concluding that what happens as we explore an imaginary illness in the one space, is the 'same' as that which happens when we explore a real illness in another. And yet,



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the majority of research into the mind/body implications of the placebo effect (e.g. Benedetti⁷ and Dieppe⁸) and into the well-established healing powers of shamanic medicine (e.g. see Levi-Strauss,⁹ Schechner¹ and Kaptchuk¹⁰) suggests, counter-instinctively perhaps, that the intangible, the imaginative and the performative call into question some of our assumptions about what constitutes ‘reality’:

Though this be madness, yet there is method in’t.

Reproducibility matters in the theatre, just as it matters in medicine. But each profession’s relationship with the idea of reproducibility is rather different. The delight of *The Journal of Irreproducible Results*, and the discussion following so-called ‘crisis’ of reproducibility in biomedicine that came to the fore this summer, shows that reproducibility is understood by medics to be contextual and part of the ‘messiness’ of scientific study. Yet, there is another, more subtle story in play, not directly told but implied through cultural-norms, training and practice.¹¹ This story suggests that, just like a gold standard randomised controlled trial (RCT), the medical consultation should be reproducible, that every encounter could be optimum, every interaction similar and comparable, and, if it isn’t, either the doctor or the patient is at fault. This perceived fault is because either person is failing to follow procedure or to fulfil their normalised roles. And yet, because of our own

personal experience of the ‘messiness’ of life, we know that human-to-human interactions are unpredictable, changeable and surprising, even when guided by the script of taking the patient’s history or the performance score of a physical examination. There is therefore, a tension then at the heart of the doctor–patient consultation. The implied reproducibility is not achievable; what is said is overturned by what is done. While in the acute model, the RCT is the idealised form for all encounters whether at the bench or bedside, with this unspoken measure of reproducibility, the doctor will, on occasion, not meet their own expectations of meeting this unarticulated, but nevertheless, real standard. In some way, they will feel a failure.

Theatre sees reproducibility differently. It asserts that reproducibility is undesirable because it prevents the conditions for the engagement of this particular audience in this particular space and time. Good theatre, even though it knows it will fail, sets out to meet the audience where they are to hold open space where someone watching might re-evaluate their understanding of the world and even change their behaviour. The dominant narrative argues that the best theatre is always responsive. Its subtle story suggests finding a way of making interactions uniform night after night makes for a ‘Deadly Theatre’. In 1968, theatre director Peter Brook wrote a now classic book, *The Empty Space*, about the need for a careful re-evaluation, or even revolution, of the ways that theatre was written, taught, theorised and made. He coined the term ‘deadly theatre’ to describe successful, commercial, but ultimately unsatisfying, theatre. In this model, deadly theatre does not change its audiences’ understanding of the world. Instead it ‘approaches the classics from the viewpoint that somewhere, someone has found out and defined how the play should be done ... imitating its

memories of them, skimping some details, exaggerating the showy passages, forgetting the meaning’.¹² In reading this passage again, I was reminded of medical students telling me that they often mirrored the practices of physicians they observed as part of their training. They copied their tone of voice, their approach to patients and, because this was ‘real’, tended to prioritise this over their ‘classroom’ learning in their professional practice because ‘somewhere, someone has found out and defined how the play should be done ... imitating its memories of them, skimping some details, exaggerating the showy passages, forgetting the meaning’. In part then, this is a theatre of reproduction but not a reproduction of clinical guidelines, but rather of cultural practices:

There is nothing either good or bad, but thinking makes it so.

While I can’t declare the eradication of deadly theatre, Brook’s idealistic perspective of theatre’s need to encounter an audience anew for each performance has become a central strand of theatre production and actor training over the last 40 years. So, how might inverting the idea of reproducibility help us better understand the lack of reproducibility in a doctor–patient interaction? A play like *Hamlet* is repeatedly performed always using the same script. What is accepted, cherished even in theatre, is that while the script, its words and stage directions remain the same on the page, no two performances are ever identical, even if they are performed by the same company on the same day, as with a matinee and evening performance. The performance blueprint – the text – remains the same, as do the settings and the costume, the ensemble and the building, but its subtle interpretation is a matter of individual and collective interaction and experience. This

experience then is akin to that of the physician, but the way that reproducibility is understood, valued and articulated varies. Actors are trained to look for variation, nuance, opportunities to create new avenues of interpretation and understanding. In this training, self-care is paramount and embodied, and emotional knowledge is deemed as valuable as reason and cognition. Although taught, not to encourage navel gazing, of course, that does happen. Self-reflection, taken from a wider perspective, aims to help the actor understand their cultural predispositions and assumptions to help them reconsider the bias they might bring to the encounter. In a more specific way, they are also taught to include self-reflection as part of the warm-up routine that precedes each performance to help the actor understand their present state and what they bring to this particular performance by acknowledging their 'here, today, now'.¹³ Actors are encouraged to reflect on how they feel about each session of training rehearsal and performance, to reflect, respond, adjust their practice and honour their feelings. In the time-pressured environments of surgeries and hospitals, I can see how such a moment of reflection seems a self-indulgent luxury. As one of our research group explained,

*In our business, we Doctors don't pay attention to what an encounter makes us feel. We sit in an analytical frame of mind, trying to figure out what the diagnosis might be, which drug to give, etc., while the patient weeps quietly in the other corner of the room. We may worry about what they are feeling, but we never stop to consider what we are feeling ourselves.*¹⁴

But having permission, either culturally or temporally, to take a moment to reflect on each encounter might give a little relief

to an overworked clinician. This space to notice what didn't work so well, might be time to return to the guidelines to look for ways to refine the next encounter, but it also might be an opportunity to consider not only the expectations the patient brought but also the expectations that the physician has about failing to meet an idealised consultation. Noticing the pressure to 'catch' everything, observing the desire to 'fix' the patient, even if, with a chronic condition, all that can be offered is care.

Actors take their training with them into the rehearsal room, like medical students take their training into their practice. For actors, rehearsals are another sort of testing ground, experimental and full of failure, where the slow building of the world of the play and repetitious explorations of scenes and characters investigate the multiple ways that things might happen in the play. This environment is where the apparent absolute of the play text is interpretation through human-to-human interaction. What happens in the rehearsal room is analogous to the martial arts dojo, where daily repetition of *katas* prepares the body and mind for the improvisation of the fight. For the actor, the repeated scenes provide a portfolio of responses, helping them deal with the improvisational demands of each live performance. And this is true too, in a way, for the consultation room. Doctors have medical training that both prepares them as individuals and provides real-life experience. However, what is different is the expectation of reproducibility because while different healthcare consultations may appear very similar, in particular, if each component is considered in a reductionist way, conducted on the same day, in the same room, by the same practitioners, the interaction of ritualised performance produces different experiences and outcomes.

This model set out in this talk offers a binary of the absolute of reproducibility

versus the absolute of unpredictability. And, as a binary it is, of course, flawed; each encounter is unique, some are closer to the text book or script or rehearsal room than others, while some might begin predictably but by the end have entered new and unexplored territory. Much of theatre is carefully structured, planned, executed time and again with precision, but what it offered is an acknowledgement of the limits of reproducibility and recognises the need for variability. This approach invites a different sort of skill set from its practitioner, one that champions self-care through self-reflection. An actor's training enables engagement in deep-listening with audiences. They seek out the unexpected to shape their responses with profound empathy. This deep-listening is not only aural but also spatial and embodied. Actors are trained to be reflexive about their work, to take their physical and emotional care seriously, to prepare before every encounter and to learn through experience.

So far, medical research has been unable to explain why interpersonal communication and caring is efficacious and how human interactions heal. Perhaps, by acknowledging the way the variability in doctor-patient interactions make the physician feel, this can help us understand how real-time culturally dependent complex interactions can be shaped to create a positive experience for both patient and practitioner.

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Brief psychological and hypnotic interventions in the management of pain – giving control back to the patient

Dr Ann Williamson

This article is a transcript of a presentation at Philosophy and Ethics meeting in 2016



Often, when someone has chronic pain, it tends to be their main focus of attention; their life and their identity

defined by their pain. They may be focused on their pain by hating it, feeling angry about it, wanting to deny it exists, expending energy trying to ‘fight’ their symptoms or simply accept it, feeling helpless and hopeless. This article will demonstrate ways that I use to engage the patient in helping themselves to be as fit as they can be and to be more in control of how they feel; they may not be able to ‘cure’ the pain but they can find that they are more than their ‘pain’ and that they can ‘suffer’ less as a result of it.

Another problem is that often the health professional cannot determine the actual physical cause of the pain, and the patient may feel that they are disbelieved. This may obviously lead to anger and resentment on the patient’s side and leave the health professional with a feeling of helplessness (often masked as irritation). Helping patients tolerate uncertainty is often a major goal of the therapeutic intervention.

The first thing I want to do with patients with chronic pain is to teach them ways to change their focus of attention and help them to become more relaxed. I teach them self-hypnotic techniques but, first, I have to explain what hypnosis is and isn’t. A useful diagram that I use is featured below. I explain that this is a model to help understanding, not the truth.

The brain has two cerebral hemispheres and while in our normal waking state the left tends to be more dominant and could be likened to our ‘conscious mind’. This communicates verbally and is the more intellectual, rational part of ourselves. When we relax or become deeply involved in some activity, our right brain becomes more dominant. The right brain could be seen to be the more emotional, creative part of ourselves that communicates with symbols and images, and could be seen as our ‘unconscious mind’. There is always a difficulty in telling ourselves not

to be upset or anxious because words are not the language of the right brain. But one can paint a word picture using guided imagery or metaphor. All the great teachers of the past have used metaphor or stories because they are such an effective means of communication – they communicate to both types of our processing, left and right brain, intellectual and emotional processing.

We shift into different levels of consciousness at different times every day, and hypnosis is just a label for a way of doing this deliberately in a similar way as meditation. Everyday trance states are common such as getting lost in a good book or driving down a familiar stretch of road with no conscious recollection.

Our conscious awareness of our outer surroundings versus an inner awareness and focus are on a continuum so, when in hypnosis, one’s focus is predominantly internal, but one does not necessarily lose all outer awareness.

Joseph Barber said, ‘Hypnosis is an altered state of consciousness characterised by changes in mood, sensation and perception, and allowing for greater access to unconscious processes’. Hypnosis in itself is not a therapy but it can be a tool that facilitates the delivery of therapy in the same way as a syringe delivers drugs. Hypnosis does not make the impossible possible but can help the patient believe and experience what is possible. Once in



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hypnosis, imagery and suggestion can be used with good effect.

To enter the hypnotic state, one needs to focus attention (induction), and this can be done in many ways. A visual focus could be a candle flame or a computer screen. An auditory focus could be music, chanting or using mantras. Some inductions are mainly kinaesthetic such as progressive muscular relaxation (PMR) or using 'involuntary' (or ideomotor) movement. One of the easiest is to engage the patient's imagination using revivification (or re-experiencing) of an experience, a daydream or fantasy. Hypnosis can be used formally in sessions or informally in conversation by directing the patient's focus and engaging their imagination.

A balance needs to be kept between validating the patient's problem and focusing on their goals. Sometimes it is necessary to break into the flow of negative, problem talk from a patient, and this can be done, without breaking rapport, by interrupting with a cough or a sneeze, or by dropping your pen and moving position, then within the next second or two, focusing the conversation towards more positive aspects.

Health professionals often do not realise the power of the words they use, especially when a patient is feeling anxious. In this state, the patient is already in a semi-hypnotic state where the right brain or emotional processing is predominant and therefore any words may be taken as hypnotic suggestion and act more powerfully (and literally) than expected. Unfortunately the negative is our default position, emotion makes us more suggestible and adrenaline 'fixes' memories especially negative ones.

The meaning may not be what you intended, such as in the story of the patient who was failing to recover as expected after an Australian Doctor had said post operatively, 'You are going home to die!!'

The 'unconscious' does not process negatives, so phrases such as 'Don't worry about it!', 'This won't hurt!' are experienced negatively in the same way

as you cannot not think of a 'pink banana' once it has been mentioned. We need to learn to phrase things in a positive manner.

Therefore, the therapeutic interventions for a patient with chronic pain are to facilitate a different perspective, engage the imagination, focus attention and access a 'being' state where suggestion and imagery is more effective.

Numerous controlled studies demonstrate physiological responses associated with hypnosis, which are not demonstrated with role playing and suggestion/expectancy alone. Research has shown that using imagery in the 'hypnotic state' triggers similar brain changes to the 'real' experience.

Kosslyn et al.¹ in 2000 gave identical mental imagery suggestions to two groups, one in hypnosis and one not. Only the hypnosis group showed activation in the colour areas of right and left hemispheres when asked to perceive colour. Similar studies have been made with auditory and olfactory stimuli.

Derbyshire et al.² in 2004 demonstrated this same effect with pain from a heat probe and hypnotically imagined pain as shown below.



Imagery is not just visual; it can be auditory, kinaesthetic, olfactory/gustatory, spatial or simply an 'awareness'. It is important to mention this to patients who are not very skilled with visual imagery as working with 'just knowing it's there' can

also be effective. It is also useful to point out the differences between associated and dissociated imagery. In associated imagery, one is 'in' the image not merely looking at it; this increases the emotional impact and is used for giving positive suggestion. Being removed from the image and looking at it from a distance (dissociated) reduces the emotional impact and is used when working with negative scenarios.

I find it useful to teach patients to use imagery to help themselves let go of negative feelings and to access their strengths and also to construct a special, calm place, where they can go in their imagination to 'recharge their batteries' and get in touch with their inner strength. The patient is reminded to explore their imagery using all the senses, to really 'be there'. Useful questions can be 'What do you get absorbed in? What helps already? What comes to mind as I say the words calm, relaxing, tranquil?'

Our internal thoughts and ideas about ourselves determine how we feel and behave. 'If we change what we "see" then we change what we feel – we are whatever we think we are'. By changing the imagery, we can start to regain control.

Using imagery, one can help patients change how they see themselves; from a 'victim' to someone who can cope and who has greater control over how they feel.

It can be used to change how patients see others, or a procedure, from threatening and fear-provoking to something that they can cope with calmly. Positive mental rehearsal is often helpful – getting the patient to imagine (associate) with the desired outcome. For example, feeling calm while having a procedure done. This can also often be achieved by suggesting they imagine themselves somewhere else, maybe in their special place.

Imagery can be used with some patients to reduce the intensity of pain and most can be helped to feel less distress. I find client-generated imagery is often very effective. I ask them to close

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their eyes and look at their pain 'out there'. If they could paint a picture of it, what would it look like? By asking various questions about its texture, colour, motion, size, sound and so on, they are encouraged to really visualise it (hence entering a hypnotic state). I then ask what change can they make that would be helpful; that might help it feel easier? As they describe it, I ask them to start seeing that change happen and they feed back to me as the process continues. Some quite marked changes can occur in a short period of time, and before they alert, I suggest that they can keep the comfort they have achieved and successfully repeat the process at home whenever they wish.

There are many other hypnotic techniques that can be used but an example of guided imagery that I sometimes use, especially for headache, is to ask the patient if they have ever played with copper sulphate crystals as a child and watched them dissolve when

you add water. If they reply in the affirmative, I suggest that they close their eyes and imagine their pain gathered up into a crystal. I ask them to tell me what colour it is so that I can ensure that they are doing this. I then ask them to imagine pouring healing fluid over the crystal and watch it dissolve. Once it has dissolved, I ask them to rate how comfortable they feel out of 10 and suggest that they can keep this level of comfort when they re-alert.

Much anxiety and distress is driven by negative internal dialogue which can be changed by using auditory imagery, imagining the dialogue in a cartoon voice or in the voice of someone who has inhaled helium, and it becomes much less believable.

Although much can be done with simple suggestion and use of imagery in the hypnotic state, many patients have underlying difficulties that need resolution. It is beyond the scope of this article to elaborate much on these but, in my experience, many patients with chronic pain, especially those with conditions such as fibromyalgia, will not get a lot better unless these are addressed.

Underlying 'causes' may often be operating at an unconscious level, and hypnosis can often be the way to help the patient resolve these issues. They may include internal conflict; organ language – where the patient's unconscious is trying to tell them something; serving a purpose

or secondary gain; a past traumatic experience; identification – where the patient 'takes on' the problem of someone close to them, often deceased; imprint – where a negative suggestion, something someone said to them, has been internalised and become their truth; and self-punishment – where the patient unconsciously punishes themselves for something that they feel guilty about, whether appropriate or not.

As John Hartland said, 'Few patients will abandon their symptoms until they feel strong enough to do without them'. But by teaching self-hypnosis and showing the patient how to use imagery and give themselves positive suggestion, much can be achieved and no harm is done.

Further useful information can be found at

<http://www.annwilliamson.co.uk>

<http://www.bscah.com>

<http://www.scimednet.org>

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Revivification – changes focus of attention – uses client-generated imagery

Ask the patient to decide on a physical activity such as swimming, skiing, running, horse-riding, cycling, preferably a specific time when they really enjoyed this activity. Ask them to let their eyes close and re-experience it.

Ensure they use all their senses – seeing, hearing, feeling and possibly smelling.

After a few minutes, when they have finished, they should open their eyes and you can get feedback on how they felt. Most notice that they begin to relax.

Alternatively ask the patient to start imagining the activity (swimming) very fast and ask them to gradually slow it down as they feel ready to until they are resting (floating). This matches a high adrenalin state and is often easier to do if the patient suffers from chronic anxiety.

Breathing focus

Observe the breath rather than trying to change it.

Notice the rise and fall of the chest.

Follow the flow of air in and out.

Become aware of slight temperature difference between the air breathed in and that breathed out – as the breath is warmed by its passage through the lungs

Re-focus if mind wanders (which of course it tends to).

Give a positive suggestion for the future (each time you try this, it will become easier and easier to do; as you practise this you may find yourself becoming calmer and more able to deal with things.

Silent Abreaction – Safe release of strong negative emotion

Close your eyes and go in your imagination to a rocky place, miles away from anywhere ...

There, find a suitable rock to be the anger that you wish to be rid of.

And project this anger into the rock, marking it in some way so that you know what it represents ...

Look around for something that you can use to smash the rock into tiny pieces, maybe a pickaxe, a pneumatic drill ...

Enjoy smashing the rock up ...

Decide what you would like to do with the dusty bits left?

Then take yourself to a peaceful place and enjoy the feelings of calmness.

Re-alert.

Suffering as a guiding call towards transformative change: the movie of pain in the cinema of the mind

David Reilly *Senior Lecturer in Medicine at Glasgow University and Visiting Professor of Medicine at Maryland University, USA.*

This article is a transcript of a presentation at Philosophy and Ethics meeting in 2016



It is impossible to create a world that differs from our unquestioned inner maps of the world.

David Reilly

The call for transformation

Unresolved predicaments are the starting point for change. Suffering is not an enemy. It is a guiding call towards needed transformation. Don't turn away.

Pain and the epidemics

When we find ourselves lost, as an individual, a therapist, a system of care, it behoves us to admit it and question the maps we used to arrive there.

And we are at a point in history when we may be ready to admit we are lost – lost in an era of unprecedented spreading epidemics and pandemics of long-term conditions: like obesity and diabetes, and depression – and so much more, including chronic pain. Over 40% of the population in my native Scotland have a long-term condition – a critical impairment of contemporary human wellbeing. This picture is repeated across the industrialised world. And when you have one such condition, you will likely develop more than one. The United Kingdom adults are living longer, but

millions are finding their later years blighted by poor health, and on average, people can expect to spend their last 10 years suffering from health problems. The burden on people and healthcare is enormous, and this cannot be blithely dismissed as a product of medicine's success 'because we are living longer' – as most are diagnosed under 65 years of age, and the ages of onset of many degenerative diseases is getting younger. Lifestyle diabetes is now even appearing in children. These epidemics are linked to the way we live, the way we treat ourselves and the conditions we are subject to. The person suffering with chronic pain does so in this shaping context.

Dehumanising conditions: the conversations of a thousand hands

When we seek professional help with these diseases of modernity, we meet a second equally dense predicament. I call this 'The Conversations of a Thousand Hands' to honour the seas of hands raised when I have asked audience in a number of countries if they agree that the human side of care is under unacceptable strain in today's care systems. We have at least now started to admit this predicament – a significant step forward – because feeling and acknowledging suffering is often the prerequisite to invoking a call for change, rather than just working harder with our

old maps. In this dehumanisation, as in the epidemics, we find that our old ways are not working well. They palliate, they don't transform. We watch, feeling almost helpless, as the tide rises of stress and poorer wellbeing in our staff, battering the shore of our therapeutic spaces and hopes.

The fifth wave: changing responses to changing suffering

As circumstances change, so must our response. If our current ways were the answers to these predicaments, we would have resolved them, as we have with many infectious diseases epidemics. These contemporary challenges are not yielding to the power of the medical and expert 'fix-it' maps. We need a different way, we need to change. And for that, we need to tune our compass in a fresh direction and generate different maps. We need to first create the conditions to create, before we can create. This process is scale independent – it applies in the suffering of a single life, as it does to a culture. We turn to ask, 'What maps are driving this suffering, and what is this suffering calling for?'

The 'Fifth Wave' is one dialogue model of value in considering our change process. It characterises the great health gains through the eras of the industrial revolution as arising from four prodigious waves of public health, each standing on the shoulders of its predecessors: The first wave was that of great public works

and municipalism in the 1800s. Then the second wave, building from the early 1900s, accompanied the refinement of the scientific approach, including the germ theory of disease, the pharmacological explosion, the growth of hospitals and the introduction of new healthcare professions. The third wave after World War II (WWII) saw the restructuring of institutions, welfare reforms, new housing, social security and the birth of the National Health Services (NHSs). This was followed by the fourth and current wave with a focus on the risk theory of disease and lifestyle advice (like smoking, diet and physical activity).

The continuing spread of new forms of long-term non-infectious conditions evidences the diminishing returns from these four waves – and forces us to seek ‘the Fifth Wave’. This must move us beyond managing our predicament – to actually *transforming* it. Take the transformation of another epidemic from another era – and consider the parallels to our predicaments. In 18th century Glasgow, thousands would die in those years when cholera hit. People struggled to manage, calling for more vital resources and care for the sick. Comments of the time included saying such trouble was just the way it is, an inevitable part of modern life, part of the human condition. Transformation had to wait until someone dreamed a new vision, navigated by a fresh map. Arguments that the new way was not feasible, not affordable and would fail took 25 years to overcome. When Loch Katrine’s clean water supply was finally channelled to the city, it cut the deaths to just double figures when the next cholera epidemic swept the United Kingdom.

Our shift of vision – inner life, innate strengths

What will our equivalents be to Loch Katrine’s water for today’s epidemics? What will transform this suffering for ourselves, through our care for others, in

our systems and in our cultures? What do we do when the fix-it model fails?

The conclusion adopted in The Fifth Wave report, chimed with from my own work in ‘the healing shift enquiry’. This new wave will build on, *not reject*, the establish four waves and their core question: ‘What can we do help this situation?’ This is not either/or. The new wave’s core question will be along the lines of: ‘What can be done to release capacity – within this person, this community, this situation?’ This shift of compass immediately shifts the journey and the outcome. The shift moves us from an orientation of seeking, or acting as, an external expert to intervene (a ‘cure’ for suffering, obesity, despair, lifestyle diabetes, loss of meaning etc.), to a path of helping ourselves and others release our innate capacities, and foster a sustainable developing nurturing relationship with this. This could sound like so much idealism or grand theory. It is actually focussed, practical and potent. Later, I’ll aim to bring this to life a little with a person’s account of their own transformation and offer some comments on the catalysts to such change.

Becoming students of suffering and release

Let us now consider this needed shift in relation to chronic pain. The four waves’ models work well in acute pain and tissue damage, but in chronic pain, they show diminishing returns; way too often tipping over into a negative long-term impact. To our disappointment, and sometimes shame, we have learned painfully slowly that pain killers are not the answer to chronic pain. One core reason for this failure is that we have been attempting to apply the fix-it model of pain to the domain of suffering. That map leads us astray. I consider the call now is for us to also become students of suffering and its release, rather than only pain. Most of us were not trained for this. We have been learning it ‘on the job’.

Let’s distinguish suffering from pain. Pain is a trigger for suffering of course, but suffering is a mental state. Mental states are internal. They are always up for change. To say that nothing can be done for a human in suffering is forever nonsense, even if ‘the pain’ itself cannot be directly modified. But of course, alter suffering and *en passant* pain alters. At start, it’s us, not suffering that has to shift. Our suffering must cease to be the enemy to be eliminated. Rather, it presents a guiding call for change: indeed, the spot-on signpost towards our *transformation* and eventual flourishing. In a storm, sailors do not get far arguing with the wind, the change their relationship to it, by turn into it. This theme of shifting thinking, and so perception, is one that I would like to explore further together.

Relationship: the crucible of change

In all this, safe compassionate relationship is a crucible of healing change: relationship with yourself and your own life and humanity, and, critically for us as professional carers, the relationship with a trusted other. At our best, the relationship and safe space we create are catalysts for healing change.

Transformation

Subjective
Change
Within
The Inner World
Of
Consciousness

At some deep level, when someone comes to sit with us, they are hoping for transformation. Our job is to hold the candle of knowing this potential lies dormant; then grow an understanding of the maps that are shaping their journey and the perceptual shifts and so changes of heart that lie waiting.

Such transformative change is very

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concrete in the end; it's not some esoteric concept. Human beings and their biology have built-in capacities for remarkable shifts. Based on my clinical learning, I *know* that that person in front of me has the capacity for improvement in their experience of life and their wellbeing, even for transformation. The fact I hold that view is already a catalysing condition. To meet someone who recognises your potential to get free is impactful in itself.

The puzzle becomes quite different from the mechanised medical model, which remains invaluable in its place (if it works, use it). The puzzle becomes the releasing of potentials and establishing self-sustaining growth of change.

The potential for change in peoples' mental state – in their inner world – can be illustrated by twice looking at the same identical short video of a taxi ride round New York. The first time it is accompanied by fast spiky discordant jazz. This filmic journey induces a sensation of tension and anxiety; the passers-by appear somehow threatening, the place one tries to escape from. The second show, to soothing classical music, induces a feeling of calm and happiness and the very same people appear reassuringly friendly, the city one to explore. So we experience and recall two quite different New Yorks. Watching it, you experience a dramatic shift in your mental state, your experience, your emotion, your physiology, your perception, your processing and how you are going to perceive and engage with the world. So what soundtrack are you running in your head, or your patient or client in theirs? Say you are out walking in long grass and you stand on a big snake. You stagger back in terror. Then, as you look down, only then do you notice that it was a rope! Your fear reaction dissipates. What caused that fear? – not the object on the ground but the perception and the movie in your mind it created. What if 'the snakes' of your life are actually

ropes? What then? I can hear your mind arguing with this idea already, 'of course they are snakes' it says. 'How could anyone with this pain view it and life differently? My New York is the real one'.

We can interact with these processes in ways that shift suffering. We can question our mind's perception and its mental maps of the world. Evolution has created mechanisms to generate mind and its product of ego. It generates thought-images all day long, it does this by itself, it doesn't need us. It scans below conscious level, drawing its conclusions and spotting its snakes. This mind is stronger than us, and we cannot command mind to not react. But, we can deepen a capacity to come to awareness of the fact that we are in mind's soundtrack, immersed in the hypnotic movies of the mind. And a whole culture can be so immersed. This awareness is the beginning of the shift. The mind doesn't want you to get this. 'Leave it to me' it says, 'I've got reflex brain mechanisms that evolved over millions of years to deal with the threat, I'll keep you safe'. These brain mechanisms don't need what we think of as 'me' (in fact, when activated, they suppress 'top down' frontal cortex activity). They are also ever powerful and present in a person's consultation with you. We don't have to just be the mind's slave, following its voice.

Our inner world

We've all got a voice in our heads – a running commentary. But who is listening to it? Pause on that for a moment. See what your vocabulary and models are when considering this. Words are inadequate here, and mine may not match yours; a description of our direct conscious experiences is always inadequate. However, you know the universe only through the content and process of your own consciousness; you live in a movie representation of the world, playing in the 'cinema of your

mind', be it transmitted from your senses by electro-chemical processes and filters, and/or, just as powerfully, projected from your internal movie projector and its scripts, its soundtracks – its network of maps.

A little exercise:

enter reflection for a moment and consider your true identity by completing this sentence: *I am ...* What did you get – a name, a role, a gender, achievements? Now, close your eyes for a few minutes and just be with the two-worded sentence: 'I am'. Let there be a firm full stop at the end. Sit with it, gently repeating it when you realise your mind has wandered. This can induce a sense of stillness as the voice in your head ceases for a moment. In this silence, you realise that that is who you really *are*, and what you are, is *alive*. You are consciousness, all the rest is a story – sweet and sour, rich and poor, pain-filled or free and so on, but don't think you are the story of yourself, your identity or the state of your mind or your body; or else, *welcome to suffering*. Peace ... I am ... That's what everyone longs for. Deep happiness, peace, release. It's there, waiting, always. It goes with the bricks of being alive, it can't be removed from a person, only obscured.

But mind doesn't want you to find this, because the egoic structure, in that moment of 'I am', considers that as a moment of annihilation, like a death, and it has to keep you in the story – to keep itself alive.

We are alive in our inner world, and yet must navigate and 'live' in the story of the outer world. To quote one Wisdom tradition, to 'be in the world but not of it'; to know the mind and its business, its drives and needs, the things it calls success and achievement and satisfaction and safety, and eventually to be able to say to it, as to a little child: 'Sweetheart, come here!' I have found that establishing a nurturing relationship to life, to our body, to our mind is a key for success in releasing suffering, in

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fostering flourishing. The way out of suffering is not a war, it is way of a nurturing peace.

Over the centuries of scientific growth, how much have we been studying this inner world and its ways (rather than just describing its derangement) in our medical and healthcare system? Let me go back before the customary quoting of Descartes to Galileo:

... if the perceiving creatures are removed, all of these qualities (tastes, odours, colours etc) would be annihilated and abolished from existence. (Galileo 1623)

This centrality of consciousness is *not* the reductionist materialism that followed and came to dominate what we have called science – and science's active discarding of subjectivity. We have an impoverished method. The overriding third person objective view has little time for the first person subjective, never mind the deep listen and consideration of a hardly spoken of 'second person' perspective.

As an aside, Galileo's quote might have guided us into enquiry of what the spiritual traditions would call emptiness. (The ego is terrified of that, of that silent 'I am'.) We have sure avoided that. And in the same century and from another tradition:

What counts is 'the heaven of the interior life', not 'external devotions'. The important thing is learning 'the spiritual philosophy. Others may study natural philosophy and learn to know the things of nature but do not learn to know themselves'. St Joseph of Copertino – 17th Century

We may now have some clues on mechanisms and effects of all this, but that said, we don't have a clue what consciousness is:

Nobody has the slightest idea how anything material could be conscious.

Nobody even knows what it would be like to have the slightest idea about how anything material could be conscious. (Jerry Fodor, Philosopher, 1992)

Consciousness manifest, in the deepest sense, is who we are, but trying to explain or analyse it is well-nigh impossible. There are two models: the first and dominant model, the emergent view, postulates that the brain produces consciousness as an epiphenomenon. The second model, the non-emergent view, suggests that the brain transmits consciousness – which is '*latent in the deep structure of nature: before brain, mind was*' (William James. 1898). It has been suggested that the effects on functioning from damage to or stimulation of parts of the brain support the former, but this is tantamount to saying that because cutting some wires in a TV affects its function, it must be the origin of the things occurring on it. The non-emergent view suggests that there must be a mechanism for transmission of consciousness pre-existing the biological apparatus which only acts as a filter. Fascinating speculation, but as Bob Dylan might have said if he had thought about it, *We are matter, the stars are matter, but it doesn't matter*. From our point of view, our engagement is practical, empirical, seeking what works in the relief of suffering. And suffering lives in the inner world – or do you have another view where it is?

Can you see any links in all this stuff to the maps that we have used to navigate 'pain management' and maybe hints of others we could use?

I have found these themes to be central in my work with patients whom the pain clinic has failed to help. That was my training ground and much of my clinical practice – sitting with people stuck in chronic pain and suffering. It felt like I started from a place of uncharted territory:

Imagine ... we had four hundred years of research on the inner world, the mysteries of mind, soul, and consciousness ... instead of researching the science of matter ... (Henri Bergson)

And that was written in 1913, so now it's 500 years. We continue to approach human suffering in a fix-it manner; by external objectification. This can be a wonderful thing and it's not a question of either/or, but there are a lot of people for whom the toolkit is inadequate. We are grateful for the former ways of the external expert coming up with a solution: the clean water supply, new structures, drugs and so on, but so often in the modern epidemics that's not working. We need to see the strength within the individual and how it can be released. I don't know what makes plants grow, but I can begin to understand the conditions that affect it and can get quite expert at gardening. But that doesn't solve the mystery of what life is and why seeds germinate. A plant knows how to grow, and we don't have to know (but crawling on our scientific hands and knees we, forever, can try and inch forward). The key thing for us is to set up the right conditions and then we see it unfold in front of us like a mystery. I find this a very releasing image of what we are doing when we sit with that individual and drop that god complex – or that sense of failure when we are hitting the problem with a hammer and it's not going in.

It is impossible to create a world that differs from your inner unquestioned map of the world. You are up against evolution and biology. Functional magnetic resonance imaging (fMRI) scans show that the same brain areas are activated by the world 'out there' and the world 'in here'. If your deep belief is that your New York remains a place of threat, or your ropes are all snakes, then despite therapies, you will still be living in hell. But this invites the response: 'what does this

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man know about *my* life? – in *my* case it's a *real* snake!' To achieve transformation, we have to get to some of these maps and mechanisms and be part of the processes that facilitate the shift. There is a physiological mechanism involved: the more you think a thought, the more it becomes 'hard wired'; myelin is laid down on initially small connections, increasing the rate of transmission thousands of times, so that the thoughts are now *embodied*. So the journey may be long, difficult and relapsing as the old soundtracks keep reasserting themselves, as we work to try to re-myelinate, to strengthen, to grow and to re-model our minds – and thus brains. The brain is a dynamic living organ responding to how it is used and who is using it. You have the virtual-self of the mind – the stories and movies that are using it all the time, but there is a deeper self that can look at it with gentleness and patience and kindness and understanding. Shouting at it won't change it. Sheer willpower won't re-myelinate it or re-model it. So we all live with the experience of snakes in our lives. Your ego is always central in the movies of your mind. This is the world of the person sitting in front of you – the New York they are in. *Just like me*. I use that as a very important and humbling mantra in my work.

Many people come to a pain clinic with direct iatrogenesis ... 'things are fine, a wee line on your X-ray ... your spine is crumbling. you will need long-term drugs' and other snake-invoking litanies, evoking the first New York reaction. And that is a biological mechanism. The person may be reluctant to acknowledge this and emphasise that they are positive, but in the back of their mind a voice is saying '*it's a snake ... it's snake*'. And unless you try to unlock that situation, you will be wasting your time. Occasionally you encounter what I have nicknamed 'sentinel side-effects', where a person has an adverse reaction to *everything* you give them. I think this is a

phenomenon where the body is rejecting the attempt to turn off what it sees as the protective fire alarm and saying 'you need this pain because it is your safety signal because you are in danger; they've missed something, your spine *is* crumbling ...'. So any prescription is a threat. An fMRI study¹ of 'hallucinated' pain suggested under hypnosis showed activity in the same areas as with physically induced pain. But when subjects were asked to just 'imagine' pain, there was only minimal activation. Of course there is no such thing as imagined pain because that is a subjective experience. But we can be trapped within the movie. It is possible to experience pain in the absence of direct stimulation, and there is evidence of possible direct cortical involvement in some clinical functional pain disorders, but it is nonsense to suggest that people suffering these are weak or manipulative.

So conditions must be created that make it safe for the person to discover and reveal their current maps and movies. In fact a rule: Unless this 'old story' is honoured, there will be no seeding of a 'new story'. Around all that therefore is what we have been learning about creating what I've thought of as 'therapeutic encounter'. I have to explore this elsewhere, for example, <http://www.thehealingshift.org>, where you can download an iteration of my six part Student BMJ series. In the limited space here, I will now rely towards the end of this article on a first person witness account of a healing shift and a transformative change. I see such experiences as the core substance of our study of what I've seen as the human healing response.

Transformation in practice Transforming story

So we are talking about being change agents, involved in the issue of suffering and release, and so necessarily involved in the question of the transformative

journey. What is that? Through our struggle, as our better hidden self is rediscovered, our inner resources are found and mobilised.

The teenage explosion of brain growth is more of a pruning: cutting back what hadn't been brought out. If not taken into imaginative stories or given visions of hope, these circuits will atrophy, and those of threat-survival will be strengthened, as the brain adapts to the sort of jungle it finds itself in. However, its plasticity allows for later change as we begin to live differently, by different values, by re-emphasising a fresh compass. It is often fresh stories that shift our understanding and inspire us to act differently.

I maintained a focus over 20 years of one-to-one encounters as a doctor of a conscious enquiry into learning about human healing capacity, and what blocks it and releases it. Then in 2004, I began to research if I could apply the principles I had learned into a group setting, using a model of TheWEL programme and later the StaffWEL. The results show rich gains for people in wellbeing measures and, in subgroup observations, correlated objective shifts. This will be reflected in 'Carol's' story that follows. As a StaffWEL group participant (once a week for four half days, with home-study materials supplied) she would be guided into a journey of change, beginning from where she was, how she view the world, what is important to her, what her values are, using universally accessible language, until she is in a place safe enough to shift off her usual maps. This is done with all the delicacy of a therapeutic encounter. She was then offered a fresh story, metaphor and vision, backed up with support practices, aimed primarily at triggering her self-compassion as a foundation for a change in her self-care.

A story of transformation

'Carol' had suffered bouts of depression every year for the last 36 years, which

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were as troughs in an overall pretty miserable existence. She had used anti-depressants on a seasonal basis. She had experienced periods when she was unable to leave the house for months. She was anxious all the time, and 'fear' is a central theme in her life. She had suffered panic attacks that could involve urinary incontinence and vomiting. She was subject to paranoia and self-loathing. Not many people knew how much she had suffered as she could 'put on a face'. Re-interviewed 3 months after TheWEL, her manner and bearing was upbeat and she spoke of a deep transformation in herself as a person in the world. Her life had changed: her work and relationships with colleagues, her family life and her attitude towards food. She was off anti-depressants. But what was most apparent was her changed awareness and ways of being with herself. In her own words,

It's totally different. The whole way I look and see things and feel things ... I keep pinching myself that I'm not dreaming all this... I'm not afraid anymore ... this confidence is coming from inside it's not just a phase ... When I'm myself now, I'm quite happy with who I am.

I'm healing, I see myself as healing. This is just a personal thing, I've seen myself with like an open wound that's never healing, and now I can see it's closing down you know it's like, you know how if you've got a scar it's open, so now this is closing in, its healing, that's how I feel. It's not open anymore.

Note her language and the inner world working with image and metaphor. That's why arts work. She generated, from the depths of herself, this image of a wound that is closing, an image of what she naturally called healing. The more you attune to these spontaneous languages, the deeper the communication.

Her transformation has been maintained at 9 and 12 month follow-ups. This transformation has lifted her out of the medical models of the four waves and went well beyond the horizon we currently work to too often. She, like the majority of participants (including many with chronic pain), also improved on a range of subjective and objective measures, backing up their core narratives of healing change. Some fuller details of the evaluation results can be followed from the references.

The nature of transformation

A portent or miracle 'does not occur contrary to nature, but contrary to what is known about nature'.
(St Augustine's City of God, 5th century)

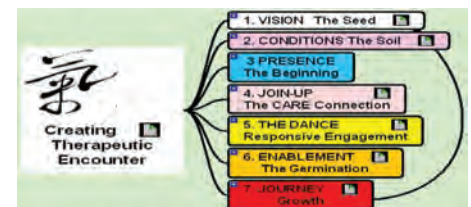
It's hard to understand such transformations, never mind mechanisms and the complex system of cause and effect. It seems wise for now to root into empirical study, working with the phenomena of direct accounts of healing change and practice, avoiding premature or over-inclusive theory and explanation.

The conditions for transformation – creating therapeutic encounter

At a practical level we can begin to chart the key ingredients needed for such shifts to occur. Here is a sketch of key elements as I currently understand them:

1. *Vision*: Holding a vision of the person's power and release.
2. *Conditions*: We set the conditions to optimise the coming encounter and change process (e.g. your inner state, and theirs, the external environment).
3. *Beginnings & Presence*: We aim to begin well – with aware alertness in the opening moments, building from there, coming gradually to presence.
4. *Join-Up*: Our aim is to creating 'join-up' – through opening safe space, working towards a tangible human connection (which brings its own shifts).

5. *The Dance*: Honouring their old story, we work together to seed the new story. A core aim is to achieve an activation of compassion-based self-care.
6. *The Germination*: We hold awareness of the shift processes, flowing through all these steps, as the seed begins to grow.
7. *The Journey*: Now in the subsequent (hero's) journey, we chart together the states, but especially the stages, of the change, and tune our interval support and re-activation as need be, as their journey skills grow.



This is an alive complex self-organising system of changing process. The conditions matter often more than the actions. In the dance, there is no single correct thing to do. We each will have different gifts and skills to offer. Monitor this closely, however, and you'll feel when you have stood on their foot – and need to make a correction. Touch well one good domino and others tend to fall. Its growth is shaped by context and care: your intentionality, your authenticity, your presence, your focus, your caring, your listening, your building of the empathy, of safety, the opening of compassion.

As we listen to the old soundtrack, the old story it helps validate, honour their experience – but often this only at the start of the encounter process, and you don't have to get all the details of past traumas. Sufficient for them to hear their story and know you have too. Repetition without new perspective risks myelinating their old story, re-traumatising.

At the pivot point when new story is seeded, I find metaphors of nature powerful (likely preverbal domains are activated). For example, you might ask,

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'Would you treat a dog the way treat yourself? Would you say that to a child? If you were a plant, what shape are you in? What does this plant need? How is your self-gardening?' Such images would be rebuffed as trite in ordinary encounter, but in therapeutic safe space, they become myths – non-literal stories bearing deeper truth.

Healing and wholeness

Returning to Carol's use of the word healing, it's time to reclaim this term, not leave it side-lined to esoteric ideas or non-local effects. As she shows, it is needed to discuss powerful everyday experiences – you cut yourself and it heals, you break your heart and it works towards healing. This is a natural profound capacity lying within each individual, because it is inherent in life itself.

We started with stuck predicaments suffering and a search for a new wave of health creation. This took us into the mysteries of inner life, of consciousness, of healing relationship and encounter, of change and transformation. Then we listened to Carol and her release. I find myself wondering if some of Carol's experiences and new ways of being correspond to the goal of many of the traditional spiritual paths to finding peace. It's interesting that these altered states, these hard won spiritual paths, correspond to that state of being when 'psychological functions like thinking, sensing, feeling and intuiting become "unified," complementary and mutually enhancing; a movement towards psychosynthesis – this oneness of being rooted in consciousness' (Grosso, 2016). This state is one which probably all of us are privileged to have at some moments in our lives, and many have described to me as arising during an effective therapeutic encounter together. It's a good compass point.

Acknowledgements

My thanks to the Philosophy & Ethics Special Interest Group of the British Pain

Society for inviting me to speak at their 2016 Annual Meeting: The Power of the Mind in Pain, and thanks to Dr Peter Wemyss-Gorman for transcribing that talk and so allowing it to be shaped into this article. 'Carol's' case was one of many studied by my research colleagues who evaluated TheWEL: Maria Higgins, Patrick Quinn, Desiree Cox and Fiona Smith, supported by the Scottish Government and TheWEL Charity. I wish to express my gratitude to the many patients from whom I learned in my 38 years as a doctor and to the NHS Centre for Integrative Care in Glasgow for acting as an inspiring centre of care and learning.

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The misuse of gabapentinoids

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



In 2013, the general practitioner (GP) and medical writer Dr Des Spence,¹ writing in the BMJ, raised concerns regarding

pregabalin and gabapentin. He noted that in just 5 years, prescriptions of pregabalin had increased by 350% and of gabapentin by 150%. He highlighted the psychotropic effects of these drugs and the growing black market for them, including through online pharmacies. Dr Spence cautioned that pain and anxiety symptoms are subjective, and though the use of gabapentinoids is backed by 'gold plated evidence of benefit' in neuropathic pain, many prescribers have taken the National Institute for Health and Clinical Excellence (NICE) and Cochrane endorsements as *carte blanche* to prescribe these medications freely. Presciently, he asked whether it was time to tackle 'the rise and rise of gabapentin and pregabalin prescribing'.¹

Seized of the issue, Public Health England and National Health Service (NHS) England jointly issued a document in December 2014 entitled 'Advice for prescribers on the risk of the misuse of pregabalin and gabapentin'. The document stated,

Patients should be told about the potential for pregabalin and

gabapentin to lead to abuse or dependence. It is important for prescribers to have a complete list of medications (including any over-the-counter products or illicit drugs) that patients are taking so that hazardous drug interactions can be minimised or avoided.

If there are features in the patient's history that increase the likelihood of pregabalin and gabapentin being misused, these should be discussed openly with the patient and the rationale for prescribing suggestions and decisions should be discussed fully and documented.²

In January 2016, following a review of gabapentin and pregabalin by the Advisory Council on the Misuse of Drugs (ACMD), Prof. Leslie Iversen – Chair of the ACMD – wrote to the Home Office highlighting their concerns about the potential for misuse of these drugs.³ Quoting data from the Office for National statistics (ONS) that, in 2014, 26 deaths were attributed to gabapentin and 38 to pregabalin on the deceased's death certificate, Prof. Iversen stated,



Pregabalin may have a higher abuse potential than gabapentin due to its rapid absorption and faster onset of action and higher potency. Pregabalin causes a 'high' or elevated mood in users; the side effects may include chest pain, wheezing, vision changes and less commonly, hallucinations. Gabapentin can produce feelings of relaxation, calmness and euphoria. Some users have reported that the 'high' from snorted gabapentin can be similar to taking a stimulant. When used in combination with other depressants, they can cause drowsiness, sedation, respiratory failure and death.

Noting that pregabalin and gabapentin's potential for abuse is similar to that of tramadol, the ACMD recommended that both these drugs be controlled as Class C substances and listed as schedule 3 drugs 'so as not to preclude legitimate use on prescription'. Prof. Iversen's letter also recommended, 'It should be an obligation of the prescriber to undertake a proportionate risk benefit assessment prior to the prescribing and repeat prescription of either drug'.³

Dr Des Spence, in September 2016, wrote again on the issue in the GP journal 'Pulse'. In a piece titled 'Gabapentinoids-the new diazepam?', he stated,

Do we have a problem with gabapentinoid abuse? If it quacks like a duck and looks like a duck, then it's a ducking duck. Pregabalin

The misuse of gabapentinoids

is already a controlled medication in the US and there is debate about controls in the UK. The research base for the benefits of gabapentinoids is of short duration and in a small, defined population where as few as one in 10 benefits. We need to change our prescribing policy now and limit the use of gabapentinoids.⁴

Which brings us to our responsibilities as pain specialists: is a modicum of soul searching in order? Have the increased concerns about opioids and nonsteroidal anti-inflammatory drugs (NSAIDs) led to an undue reliance on gabapentinoids? In my view, it's high time to rein in the prescribing of pregabalin and gabapentin and I, for one, will be taking a good, hard look at my own clinical practice.

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Apps, Bots and Wearables: the future is here at present

Dr Stephen Humble *Consultant Pain Medicine & Anaesthesia, Charing Cross Hospital, Imperial College Healthcare NHS Trust, London*

Dr Damien Smith *Consultant Pain Medicine & Anaesthesia, The Hillingdon Hospitals NHS Foundation Trust, Middlesex*

Dr Arun Bhaskar *Consultant Pain Medicine & Anaesthesia, Chair, Communications Committee, Elected Council Member, The British Pain Society*

Introduction

William Shatner and more recently Chris Pine has immortalised Captain James T Kirk of the USS Enterprise from the sci-fi series *Star Trek*, which has a cult following of at least three generations. Some of the 'senior' readers may remember that it started as a small television show which debuted in 1966 and ran for only three seasons before being axed in 1969 due to low ratings. The pioneering original show went boldly into the galaxy of the 23rd century, using an array of space-age technology to explore strange new worlds and seek out new civilisations. We were witness to Kirk and his crew benefitting from numerous futuristic devices including mobile communicators, voice recognition, universal translators, videoconferencing, automatic doors, handheld computers and of course laser beams. Later, scientists and engineers adopted these ideas enabling contemporary society to benefit from these state-of-the-art devices that are now often taken for granted. Apps, Bots and Wearables are integral to many of these technological devices.

Apps

An App (or Application) is a computer programme or a piece of software that has been designed for a specific purpose. Apps will be immediately

familiar to all smartphone users, the use of which are undertaken for a variety of everyday purposes including messaging, ordering a taxi, reading the news as well as more bizarre ones such as the Human to Cat Translator and the Sheep Counter. Health-related Apps are becoming increasingly popular and have been utilised to provide daily reminders and prompts for medications or appointments and/or to monitor diet and exercise (Vardeh and Eccleston, 2013). Notable examples include the *Couch to 5K*, which helps the so-called couch potatoes to become runners over approximately a 2-month period through voice commands and a graduated exercise regime. *Strava* is an App used to log users' activity including; route, elevation, speed, time and energy. Users can share their data with friends and compare their performance with others online.

Of specific relevance to pain medicine, Apps for pain patients have started to emerge such as the *Pain Toolkit*, developed by our own Pete Moore alongside health professionals. The *Pain Toolkit* helps patients engage with active management strategies such as pacing, goal setting, relaxation and building a support team in order to eventually move away from being a patient and to become a regular citizen again. *My Pain Diary* is a pain 'tracker' including calendar and the ability to describe

intensity, location and type of pain. It also produces a PDF file, which the patient can share with their physician.

FibroMapp is an App designed for people with Fibromyalgia and monitors pain, activity levels, sleep, flare-ups, medication and mood. It is easy to see how large amounts of contemporaneous data could be potentially obtained in a relatively painless, timely and cost-effective manner, and this could be used for assessing clinical outcomes for clinical research trials.

Apps are also being used to improve healthcare provision both in the United Kingdom and all over the world. While far from being a panacea, telemedicine has almost certainly improved access to healthcare and specialist opinions for patients living in remote areas such as parts of the Highlands and Islands of Scotland. Separately, telemedicine can also be used to share world-class expertise with countries experiencing severe shortages of trained health workers. *VirtualDoctors.org* provides a sophisticated, yet easy to use telemedicine service to rural Zambia via smartphone Apps. This enables healthcare workers in Zambia to send electronic clinical data to volunteer doctors in the United Kingdom for advice regarding diagnosis and treatment. With reference to evidence-based medicine, studies are still underway to determine the best way to utilise Apps for health

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management. The limited evidence available currently suggests that Apps may be a useful adjunct for both monitoring symptoms and delivering interactive pain management approaches in a responsive and cost-effective manner (Anderson et al., 2016; Dahlberg et al., 2016; Vardeh and Eccleston, 2013).

Bots

Bots are Internet robots and have been described as the next frontier (The Economist, 2016). They are software programmes that perform automated tasks via the worldwide web. Bots are used typically for simple repetitive tasks that, via automation, can be carried out at a far higher rate than it would be possible to achieve by a human. A common example of a Bot is a Chatbot. Chatbots simulate conversation with people using artificial intelligence and can alter the way users interact with the Internet to make it a more conversational approach. Most of us with a modern iPhone will be aware of Siri, the in-built voice-controlled personal assistant. Rather than typing into a search engine, users simply speak into the phone and the personal assistant does the rest. This may not immediately be everyone's preference, but is in fact a big improvement over listening to *muzak* (piped instrumental music played) while on hold on the telephone 10 minutes after *Pressing 1* to speak to a customer service agent. Indeed, many companies are developing user-friendly Bots to help with standard queries or to assist consumers shop for specific items via interactive websites (BBC). Separately, Bot-based messaging Apps are becoming increasingly popular and potentially used more than social media sites such as Twitter and Facebook.

Some of us have read or heard about the famous, or perhaps infamous, Bot *DoNotPay*. It was created by a second-year Stanford University student to help



people contest parking tickets. The programme asks a series of questions to decide whether an appeal is possible and then guides the user through the appeals process. This artificial intelligence Chatbot lawyer has taken on 250,000 cases (in London and New York) and won 160,000 of them (~US\$4 million worth of parking tickets). An example of more relevance to healthcare is *HealthTap*, which uses Facebook Messenger Bots in order to provide expert answers from physicians directly to patients within a social network model. Users can obtain the answers to specific questions about medical symptoms they may have and whether or not they merit medical attention as well as checking on

appropriate medication dosages. For a subscription fee, members may also access live videoconferencing with clinicians of various disciplines. This approach is part of a growing trend in the United States and a number of other Telemedicine providers currently exist around the world. However, this approach is not without controversy, and concerns have been raised by some regarding safety, privacy, accountability and quality of care (American Medical Association). It seems that Bots have yet to find their optimum position within healthcare, but it is likely that they will be adopted increasingly in relation to marketing, and this is likely to involve the realm of Independent practice. However, Bots and Wearables may also be vital to the realisation of virtual reality (CNBC), which has the potential to lead to the development of ever-more immersive therapeutic experiences (Chen, 2016; Li et al., 2011). Firsthand and scientists from the University of Washington developed SnowWorld, a virtual reality experience for managing procedural pain. *The New York Times* thus wrote about the technology:



SnowWorld puts Pixar-like animation to medical use in a virtual video game that relieves the pain of burn victims. Try it. It is completely absorbing to pelt woolly mammoths and penguins with snowballs while your ears are filled with the irresistible strains of (Paul Simon's) Graceland.

Wearables

Wearable technology refers to devices that are worn on the body, which may take the form of electronics, transmitters, software and sensors. Early examples include hearing aids and calculator watches, while a more recent development is the contentious Google Glass optical head-mounted display, which have been used during surgery and interventional radiology (Nosta, 2013; Haslam and Mafield 2013) and may be controlled by voice-activation. Smart clothes are also in development, and early examples of these include T-shirts, bras and shorts that can collect biometric data such as heart rate, stride length, pelvic rotation and contact time with the ground (Edwards, 2016) and sync with mobile devices. Separately, the Apple Watch allows users to make telephone calls in a way that is highly reminiscent of the wrist-based communication device that Captain Kirk employed in Gene Roddenberry's epic series, which was first broadcast 50 years ago. It also has numerous other features including activity tracking and Apps to assist with specific fitness goals.

Similar wrist-based fitness-oriented devices include FitBit, Jawbone, Garmin and NikeFuel. These Wearables allow owners to record steps walked, distance covered, calories burned, heart rate and sleep pattern. Data such as these are of course of interest to large business and health insurance companies. Indeed, some users may be able to receive discounts on health insurance bills. Controversially, some large employers have taken the concept a step further by



using Wearable technology to monitor the fitness of their employees and rewarding or penalising them based on whether or not they met their fitness targets (McGee, 2015). Nevertheless, Wearables can be an excellent way to stimulate people that would not normally exercise regularly to engage with more healthy behaviours.

The underlying basis for these devices is nanotechnology, which refers to the manipulation of matter sized between 1 and 100 nm. An early proponent of this field was the Nobel Prize-winning physicist Richard Feynman who discussed the concept in his 1959 lecture at Caltech: *There's plenty of Room at the Bottom*. Inspired by Feynman, Eric Drexler expanded and popularised the field (Drexler, 1986), encouraging the development of smaller and smaller systems. The rate of progress in this area over the last few decades has been staggering and has impacted dramatically on daily life, leading to the casual use of technologies that were considered, previously, to be unobtainable until significantly later in human development. These developments have huge implications for the future of healthcare, diagnostics and disease management.

Conclusion

So what does this mean for Pain Medicine? The combination of Apps, Bots and Wearables has the potential to promote the type of personalised,

structured and graded exercise and rehabilitation programmes to optimise function in novel ways, which would be extremely relevant to the management of many chronic pain patients. This information could potentially be shared with clinicians or peers in a support group and would facilitate active management with ongoing support and encouragement. This technology is available now and, if used appropriately, could be beneficial for many of our patients as an adjunct to face-to-face care at a time when the National Health Service (NHS) continues to explore strange new world's beset by uncompromising enemies and a flagging engine. In the words immortalised by Scotty, chief engineer of the USS Enterprise, '*She cannae take any more, Captain! She's gonna blow!*'

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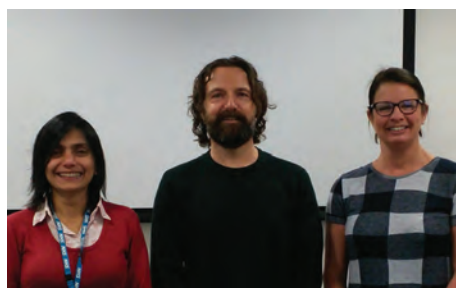
Experience of managing patients in a joint pain and substance misuse clinic

Dr Nilu Bhadra *Consultant in Pain Management and Anaesthetics Blackpool Teaching Hospitals NHS Trust Foundation Trust*

Dr Susie White *Specialist Clinical Psychologist in Chronic Pain*

Dr. Ashutosh Kaushal *Consultant Psychiatrist Early Intervention Service (Central and West Lancs) Lancashire Care NHS Foundation Trust*

Dr John Richmond *Clinical Lead Delphi Medical Ltd*



A Laughton (Sister in Delphi),
S Melrose (Sister in Delphi)

Chronic pain affects between 8% and 60% of the population.¹ High-risk drug misuse is estimated to affect approximately 1% of the population.² Chronic pain is common in patients with substance misuse problems but undertreated because of lack of evidence, lack of expertise, poor communication between different health professionals and preconceived negative attitudes towards these patients.

While chronic pain and addiction are different syndrome complexes, several comparisons can be drawn between them. Both addiction and pain are influenced by biological, social, psychological and environmental factors. Drugs of abuse evoke reward pathways, which adapt and develop tolerance and result in the phenomenon of withdrawal on cessation. Withdrawal produces fear leading to behaviours to gain relief. Chronic pain is an emotional experience, which acts as a strong motivational driver

for change. It harbours fear leading to behaviours to gain relief. The presence of both conditions can result in a reorganisation of neural pathways in the brain with possible effect of wind-up phenomenon and sensitisation, both of which may result in increased pain perception. Chronic use of addictive drugs may also affect the processing of pain stimuli through sympathetic stimulation, hypothalamic–pituitary–adrenal axis dysregulation and opioid tolerance. In pain medicine, a prevailing assumption is that ‘the pain is what the patient says it is’; in addicted individuals, the situation is potentially more complex as there are two pathways at play. The interdependence between addiction and chronic pain symptoms, biopsychosocial aspects and various neurobiological pathways of both syndrome complexes suggests that both of them need to be treated and addressed together as trying to address just one or another would not be effective.

Several guidelines suggest joint management of patients suffering from addiction as well as chronic pain. Their main recommendations include a full joint assessment and investigation, a jointly agreed treatment plan, non-pharmacological and pharmacological interventions, adequate dosing of replacement opioid, a single prescriber with regular reviews, urine drug screening as needed, adequate social support, financial advice, housing advice and a



plan for responding to non-compliance or if outcomes are not met.

Liaison between the addiction and the pain service is recommended to provide the best care for this group of patients. Addicted patients in pain tend not to recognise that their addiction disorder has a bearing on their experience of pain and may be more likely to expect drugs to be the main, and possibly only, solution. They may also have a prejudice that the clinic may be limiting their access to analgesia specifically because of their addiction disorder, which can interfere with the educative process around pain management. They may well not want to attend the addiction service if they see their primary problem as pain, and at the same time, previous poor experience while in hospital may stop the patients from fully buying in to what the pain service has to offer. Joint working

Table 1. Outcomes for selected patients managed in a joint pain and substance misuse clinic at the Blackpool Victoria Hospital

Measures	Sleep quality	Hours of sleep	Sensory pain	Affective pain	Total pain score	Pain self-efficacy	Anxiety	Depression	Psychological health (TOPs)	Physical health (TOPs)	Quality of life (TOPs)
Number of patients who improved	2	2	4	3	5	5	3	4	3	3	3
Number of patients who declined	1	0	2	1	1	1	3	0	1	1	0
No change	4	4	0	2	0	1	1	3	0	0	1
No data	1	2	2	2	2	1	1	1	4	4	4

TOPs: treatment outcome profiles.

between the addiction and pain teams helps to circumvent some of the issues and helps in better comprehension and hence acceptance of what is on offer. This hopefully leads to a more rehabilitative, functional approach, with less reliance on medications including opioids. Immediate access to drug screening helps the team with decision-making and removes doubt as to whether the patient is complying with the treatment plan as recommended by the team. A multidisciplinary approach to treat these patients has been recommended.

Blackpool has a high incidence of patients with high-risk drug misuse, significant numbers of which experience chronic pain. Here, we report our use of a multidisciplinary team approach for eight patients who were seen in the clinic and were demonstrating motivation to stop using illicit drugs. Our team consists of Pain and Substance Misuse Consultant, Lead Recovery Nurse, Psychologist and patient's Recovery Key Worker. Our aim is to optimise patient's pain relief while encouraging the patients to stop illicit drug use.

Our Strategy consists of the following:

1. *Comprehensive assessment and treatment* – This includes assessment of pain and substance misuse problems, led by pain and substance misuse consultants, and assessment

of various social factors. All pain treatments, non-pharmacological as well pharmacological, are optimised. Psychological support is offered and is considered a necessary part of engagement with the service.

2. *Commitment to stop illicit drugs and, potentially, opioid replacement therapy (ORT) as well, if necessary* – Patients are asked to commit to stop using illicit drugs as with continued use it is not possible to measure treatment response and, if ready, are weaned off their opioid maintenance regime if this was not providing adequate pain relief. After optimising all the pain treatment, opioids in much smaller doses were offered if needed, appropriate and necessary but under the ORT pathway.
3. *Relapse prevention strategy* – Combining expertise from the substance misuse and pain to develop a relapse prevention strategy plays a fundamental role for the success of the clinic. As addiction is known to be a chronic relapsing disease, a plan must be there in case of relapse.

Our experience

Eight patients were seen in clinic. The patients ranged in age from 38 to 60 years; two were female and six were

male. Patients visited the clinic on average four times. Of the eight patients, results indicated that five showed improvement in their overall pain. Four had reduced symptoms of depression and increased self-efficacy. Anxiety for three patients increased. Sleep quality and quantity displayed limited change. Of the four patients who completed the treatment outcome profiles (TOPs) at the first and last appointments, three patients noted improvements in their psychological, physical and overall quality of life scores. Two patients were able to come off their ORT successfully. One was able to reduce their buprenorphine dose. Two patients who refrained from illicit drug use relapsed after discharge. One patient had to be discharged from the clinic due to non-attendance (see Table 1).

Discussion

Guidelines have been published regarding managing pain in patients with addiction, but we have found there is no absolute 'right way' of managing these patients.^{3,4} There are issues related to the addiction itself, drug interactions and co-morbidities of the patient. The drug misuser experiences immediate relief of distress when using illicit drugs which leads to an unrealistic expectation that the 'correct' drug for pain will give rapid

and complete pain relief. This expectation is in sharp contrast to the very crux of the pain management mantra. These patients also have impaired control over their drug use and their lives. It may be prudent to include external control (a clear opioid pathway written agreement and the use of illicit drug testing) in the strategy to manage risks in these patients. This group of patients have usually been maintained on ORT for at least 2 years and the evidence base for ORT promotes doses of 60–120mg of methadone to reduce illicit use. Also, the traditional response to pain in this patient group has been to increase the total opioid dose, as a sole response, as they have either been seen separately or not in a site with easy access to the multidisciplinary approach needed.

But long-term data regarding opioid use in patients with chronic pain suggest not only lack of efficacy but also increased risk of harm as well as some evidence of increased mortality.^{5–8} Among various other risks, there is a known risk of opioid-induced hyperalgesia.⁹ There is some evidence that patients addicted to heroin may also suffer from hyperalgesia.¹⁰ There is also a stronger drive from substance misuse services now for the rehabilitation of their patients towards abstinence, trying to avoid leaving people on long-term ORT who may be able to live drug-free lives. A combination of the different approach and strategy in substance misuse services for rehabilitation of this group of patients, as well as a lack of efficacy of opioid medications in long-term management of chronic pain, does suggest that opioids in ever-increasing doses are not the only solution in this group of patients.

Our strategy is trifold: complete assessment of patient, supportive treatment with maximisation of pharmacological and non-pharmacological treatment, and encouragement to stop using illicit drugs including the use of detox facilities and/

or weaning off ORT for suitable patients. With addiction in remission and optimal functioning, the uptake of pain management rehabilitative approach techniques can be appreciated. Opioids are used as a last resort only when needed, exercising the opioid pathway. This approach does need to be supported by relapse prevention which is the third pillar of our strategy. These patients are at high risk of relapse as addiction is a recurring disease. Preventing relapse is most important for effective treatment in patients with substance misuse disorder in remission, and even more when treating these patients' pain with opioids.¹¹ Our relapse strategy consists of various measures bundled together using pain team expertise, substance misuse team expertise and existing community support networks that already exist within both. An important aspect of this is to arm the patients with techniques that include cognitive and behavioural aspects not only to deal with high-risk situations but also to implement positive life style changes to maximise their gain from pain management strategies. We encourage patients to keep a diary of pain, quality of life, sleep and activities. This not only enables patients to reflect on the difference any intervention has made but also allows clinicians to measure effects of the same. If relapse does occur, careful review of the relapse episode can be helpful. Without deep understanding of addiction as a chronic relapsing disease, patients are in danger of being discharged, pushing them back into addictive behaviours. Hence, a relapse management strategy and having addiction expertise or support in place are essential.

Treating chronic pain in patients suffering from substance misuse disorder is challenging. We believe these patients need an individualised, structured and supportive treatment care plan provided by combined expertise from both the pain management and addiction

services. Our data indicate that inter-agency management could be effective in decreasing pain and drug use, alleviating depression and improving confidence. We plan to continue to develop the service, and our aim has been to stop not only illicit drug use but also ORT and facilitate integration back into society. We propose that relapse prevention is an important part of the treatment care plan for these patients, and we intend to develop this further.

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TREATMENT OUTCOMES PROFILE

CLIENT ID

SEX

MALE ☐

FEMALE ☐

DOB

 DD / MM / YYYY

KEYWORKER

TREATMENT STAGE

START ☐

REVIEW ☐

EXIT ☐

POST-TREATMENT ☐

INTERVIEW DATE

 DD / MM / YYYY

Use 'NA' only if the client does not disclose information or does not answer

1 SUBSTANCE USE

Total for
NDTMS return

	WEEK 4	WEEK 3	WEEK 2	WEEK 1	AVERAGE PER DAY	
A. ALCOHOL	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> UNITS	<input type="text"/> 0-28
B. OPIATES/OPIOIDS (ILLICIT) Includes street heroin and any non-prescribed opioid, such as methadone and buprenorphine	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> G	<input type="text"/> 0-28
C. CRACK	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> G	<input type="text"/> 0-28
D. COCAINE	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> G	<input type="text"/> 0-28
E. AMPHETAMINES	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> G	<input type="text"/> 0-28
F. CANNABIS	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> SPLIFFS	<input type="text"/> 0-28
G. OTHER SUBSTANCE. SPECIFY:	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> G	<input type="text"/> 0-28
H. TOBACCO Includes ready-made and hand-rolled cigarettes, cannabis joints with tobacco, cigars, pipe tobacco, shisha/waterpipes, etc	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/>	<input type="text"/> 0-28

2 INJECTING RISK BEHAVIOUR

	WEEK 4	WEEK 3	WEEK 2	WEEK 1	
A. INJECTED	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
B. INJECTED WITH A NEEDLE OR SYRINGE USED BY SOMEBODY ELSE	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
C. INJECTED USING A SPOON, WATER OR FILTER USED BY SOMEBODY ELSE	YES <input type="checkbox"/>	NO <input type="checkbox"/>			<input type="text"/> Y or N (Y if either is yes)

3 CRIME

	WEEK 4	WEEK 3	WEEK 2	WEEK 1	
A. SHOPLIFTING	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
B. SELLING DRUGS	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
C. THEFT FROM OR OF A VEHICLE	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
D. OTHER PROPERTY THEFT OR BURGLARY	YES <input type="checkbox"/>	NO <input type="checkbox"/>			<input type="text"/> Y or N (Y IF EITHER IS YES)
E. FRAUD, FORGERY OR HANDLING STOLEN GOODS	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
F. COMMITTING ASSAULT OR VIOLENCE	YES <input type="checkbox"/>	NO <input type="checkbox"/>			<input type="text"/> Y or N

4 HEALTH & SOCIAL FUNCTIONING

A. CLIENT'S RATING: PSYCHOLOGICAL HEALTH (Anxiety, depression, problem emotions and feelings)	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 POOR GOOD	<input type="text"/> 0-20
B. DAYS IN PAID WORK	WEEK 4 <input type="text"/> 0-7 WEEK 3 <input type="text"/> 0-7 WEEK 2 <input type="text"/> 0-7 WEEK 1 <input type="text"/> 0-7	<input type="text"/> 0-28
C. DAYS ATTENDED COLLEGE OR SCHOOL	WEEK 4 <input type="text"/> 0-7 WEEK 3 <input type="text"/> 0-7 WEEK 2 <input type="text"/> 0-7 WEEK 1 <input type="text"/> 0-7	<input type="text"/> 0-28
D. CLIENT'S RATING: PHYSICAL HEALTH (Extent of physical symptoms and bothered by illness)	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 POOR GOOD	<input type="text"/> 0-20
E. ACUTE HOUSING PROBLEM	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="text"/> Y or N
F. AT RISK OF EVICTION	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="text"/> Y or N
G. CLIENT'S RATING: OVERALL QUALITY OF LIFE (Able to enjoy life, gets on with family and partner, etc)	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 POOR GOOD	<input type="text"/> 0-20

TREATMENT OUTCOMES PROFILE

ABOUT THE TOP

The Treatment Outcomes Profile (TOP) is the national outcome monitoring tool for substance misuse services. It is a simple set of questions that can aid improvements in clinical practice by enhancing assessment and care plan reviews. It can also help to ensure that each service user's recovery care plan identifies and addresses his or her needs and treatment goals.

Outcome reports are compiled centrally within Public Health England (PHE) via the National Drug Treatment Monitoring System (NDTMS).

Keyworkers should complete the TOP within two weeks either side (+/- two weeks) of the first modality start date at the beginning of each service user's treatment journey. This provides a baseline record of behaviour in the month leading up to starting a new treatment journey. If the treatment start TOP is completed after the first modality start date, it should focus on the 28 days before this date.

It is good practice to review a service user's recovery care plan every 12 weeks, and it is recommended that the TOP is completed at these reviews. However, this may be more or less frequent depending on individual need.

Also complete the TOP at treatment exit. Some services may want to use the TOP to measure post treatment exit outcomes.

HOW TO COMPLETE THE TOP

START BY ENTERING:

- Client ID, date of birth and gender
- Completion date
- Keyworker name
- Date of assessment
- Treatment stage – treatment start, review, treatment exit, or post-treatment exit.

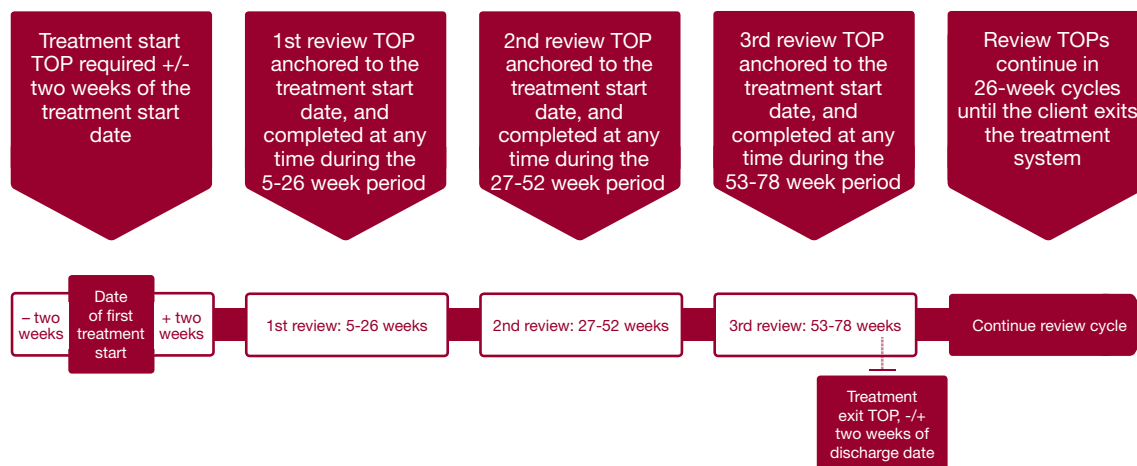
TYPES OF RESPONSES:

- Timeline – invite the client to recall the number of days in each of the past four weeks on which they did something, for example, the number of days they used heroin. You then add these to create a total for the past four weeks in the red NDTMS box
- Yes and no – a simple tick for yes or no, then a 'Y' or 'N' in the red NDTMS box
- Rating scale – a 21-point scale from poor to good. Together with the client, mark the scale in an appropriate place and then write the equivalent score in the red NDTMS box.

A FEW THINGS TO REMEMBER

- The red shaded boxes are the only information that gets sent to PHE
- Week 4 is the most recent week; week 1 is the least recent
- The Treatment Start TOP should always capture pre-treatment drug use, so it is important that the recall period is the 28 days before the treatment start date. Not doing this will skew outcomes as there is likely to be a lower baseline.

THE PROTOCOL FOR TOP REPORTING



Alcohol units converter

Drink	%ABV	Units
Pint ordinary strength lager, beer or cider	3.5	2
Pint strong lager, beer or cider	5	3
440ml can ordinary strength lager	3.5	1.5
440ml can strong lager, beer or cider	5	2
440ml can super strength lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9

Drink	%ABV	Units
Glass of wine (175ml)	12	2
Large glass of wine (250ml)	12	3
Bottle of wine (750ml)	12	10
Single measure of spirits (25ml)	40	1
Bottle of spirits (750ml)	40	30
275ml bottle alcopops	5	1.5

THANK YOU FOR USING THE TOP AND CONTRIBUTING TO NDTMS

Why should fear lead to suffering for 80% of the world's population?

Dr Chris Ford *Clinical Director*

Sebastian Saville *Executive Director*

<http://www.idhdp.com>



It is recognised that controlled substances such as morphine are indispensable for the relief of pain and suffering.

International Doctors for Healthier Drug Policies ('IDHDP') launched a campaign earlier this year, 'Striving for equity in the treatment of pain' (<http://idhdp.com/en/campaigns/pain.aspx>), with the purpose of highlighting the dreadful inequity that allows 80% of the world's population to suffer unspeakable pain while dying from painful conditions such as cancer and end-stage AIDS, suffering during labour or after enduring serious injuries. This, while the richest 20% take it for granted that these controlled medicines will be readily available in such circumstances.

The idea for the campaign came largely from our realisation of how few people knew that the vast majority of the world's population are denied pain medication that the richest countries take for granted. Although only anecdotal we would ask at conferences and other events what percentage of the population had access to proper pain management and there was always



shock when they heard the figure of 20%. Even among doctors this information is sadly lacking. At a specific study day at the Royal

College of General Practitioners (RCGP) about pain, where the campaign had a soft launch, less than 2% of the delegates had any knowledge of this appalling situation. We felt that if more people knew about this inequity, it would help a great deal in changing the situation.

Regulations (<http://idhdp.com/en/resources/news/pain/fear-and-confusion.aspx>) to prevent the use of drugs like heroin have unnecessarily created an atmosphere of fear when it comes to prescribing what are in essence similar drugs for the treatment of pain. There should be no reason why it is not possible to reduce the harm created by the misuse of drugs like heroin, while ensuring that drugs like morphine are readily available for the treatment of pain irrespective of which country the patient lives.

As part of the campaign IDHDP put on a side session about the campaign at Commission on Narcotic Drugs (CND), which occurs annually and is the central drug policy-making body within the

United Nations system. It was the event that was going to draft proposals for United Nations General Assembly Special Session on Drugs (UNGASS), to which we had been working towards for the past 3 years.

For the first time 'access to controlled medications for medical use' was added to the consensus document between all the nations. Many palliative care and pain organisations had been striving for this for many years and we had focused on this in our campaign leading up to UNGASS.

The campaign recognises how information and training are needed in many countries. Even those where effort has been made to address the excessive red tape to prescribe controlled medicines, there are still significant training needs for medical staff, particularly in the area of effective palliative care and treatment of pain. Kenya is one country that has made great strides with organisations like Kenya Hospice and Palliative Care Association (KEHPRA; <http://kehpc.org/>). Organisations like Worldwide Hospice Palliative Care Alliance (WHPCA; <http://thewhpc.org/>) have been working tirelessly for years and have achieved a great deal recently co-hosting with African Palliative Care Association (<https://www.africanpalliativecare.org/>) the 5th International African Palliative Care Conference in August titled 'Differentiated care for diverse

Why should fear lead to suffering for 80% of the world's population?

communities' (<https://africanpalliativecare.org/conference2016/index.php>).

Perhaps of greatest importance is a global public information programme on the basic human right of access to medicine to alleviate otherwise intolerable pain. IDHDP created a short film (<http://idhdp.com/en/campaigns/pain.aspx>) to highlight the current inequity. For people who have had a loved one dying from a painful condition mitigated by the use of medicines like morphine, it is unimaginable what it would have been like without. The campaign wants these people to ask why it is that a highly effective and cheap medicine is denied to so many.

'Fear rules us. It robs us of our reason', says Dr MR Rajagopal, chairman of the Pallium India charitable trust:

Doctors, drug regulators and legislators are in shocked fear when they think of the possibility of their offspring getting addicted to a drug. Because they do not stop to learn enough, they put in unrealistic restrictions. The result – failure of the purpose, and needless pain and suffering, the extent of which is beyond our power of imagination.

'I hate to imagine what cancer pain is like, I have not experienced it', adds Dr Zipporah Ali, Executive Director of

Kenya Hospices and Palliative Care Association:

However, I have witnessed cancer patients who have no access to appropriate pain medication. We are living in a time where we talk about best standards of care, of human rights, equal opportunities. Let us join our efforts to ensure opioids are available to relieve pain not just in the developed world, but globally. Pain relief is a human right.

The UN General Assembly Special Session ('UNGASS') on the 'World Drug Problem' took place in April 2016, the first for nearly 20 years. Some weeks before, IDHDP co-hosted a side session on the inequity of pain relief at the Commission Narcotic Drugs in Vienna. Another side session (<http://idhdp.com/en/resources/news/march-2016/side-event-at-59th-session-of-the-commission-on-narcotic-drugs-vienna-march-2016.aspx>) focusing on the same issue was hosted by IAHP. After years of campaigning by WHPCA and other organisations, access to controlled medications was supported by all countries and added to the outcome document endorsed at UNGASS.

What is now essential is that we help ensure this becomes reality on the ground.

Policymakers must be made aware that doctors from all over the world want to see access to pain medications for all and health becomes much more prominent in future drug policies. Using the IDHDP newsletter (<http://idhdp.com/en/resources/newsletter.aspx>) to disseminate stories about the interface between practice and policy, we attract doctors to the website where there is a great deal of information on the importance of doctors advocating for change.

IDHDP is launching phase 2 of its campaign in the next few months 'Striving for equity in access to controlled drugs in the treatment of dependence'.

Medicines like methadone and buprenorphine are on the World Health Organization (WHO) essential medicines list to treat drug dependency. The evidence for their use in preventing drug-related deaths, reducing HIV transmission and improving the physical and mental health of dependent opioid users is overwhelming. However, even though injecting drug use takes place in over 150 countries (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>), only 80 countries provide Opioid Substitution Treatment (OST).

Your role in both phase 1 and 2 is crucial to the success of this campaign – so please support the campaigns and join IDHDP (<http://idhdp.com/en/support-us/join-now.aspx>) now.

Educating secondary school students about paediatric chronic pain

Polly Louise Langdon *PhD Candidate, University of Southampton*

Cynthia Graham *Professor of Sexual and Reproductive Health, University of Southampton*

Christina Liossi *Professor of Paediatric Psychology, University of Southampton; Honorary Consultant Paediatric Psychologist, Great Ormond Street Hospital Foundation Trust*



Paediatric pain and school functioning

Paediatric chronic or recurrent pain is a significant public health issue.¹ Up to 88% of children and adolescents experience, often debilitating, chronic pain² which can have a profound, negative impact on all aspects of life.³ Data from a large representative sample of Flemish school children and adolescents ($n = 10,650$; aged 10–21 years) found that headache (47.6%), abdominal (47.5), back (38.6%) and musculoskeletal pain (38.6%) were the most commonly reported chronic pain locations within this age group.⁴ Children with chronic headache, abdominal, limb and back pain have reported limitations to hobby engagement, social interactions with peers, sleep and school attendance.⁵

From a young age, children spend a significant amount of time at school – a time which is important for a young person's cognitive, social and psychological development.³ The importance of these school experiences and the high prevalence of, often

debilitating, paediatric chronic pain highlight the need to fully understand the impact of chronic pain on school functioning. It is

important to consider not only school attendance and performance but also how school personnel, teachers and other students respond to pain problems. Interactions with both school staff and peers can have a considerable influence on pain behaviours, including school avoidance.⁶

The inverse relationship between paediatric chronic pain and academic performance is well documented. Evidence suggests that this association is due to a combination of various factors including absenteeism; pain-related impairments in cognitive functions such as attention, concentration and memory; and sleep disturbance. Chronic pain has a significant impact on children and adolescents' cognitive function,¹ academic performance (decline in grades) and school attendance.^{5–7} Pain-related school absences are highly prevalent,⁶ with over half (51%) of a clinical sample of Dutch children (8–18 years) reporting short-term absences (1–3 days per month) and 14% reporting long-term absenteeism of more than 3 months.⁸ In addition to the

difficulty of experiencing chronic pain, re-starting full-time education can be tiring and stressful following periods of frequent or long-term absences.³ Children often have to 'catch up' with their peers, and common triggers of pain include the school environment (e.g. heavy school bags), school work and lack of sleep.⁹ In addition, chronic pain can be all-consuming. Research suggests that children with chronic pain display an attentional bias towards pain-related words¹⁰ and that pain-related information is more easily remembered than neutral information.¹¹

School functioning, however, is not limited to attendance and academic achievement. Social interactions with other students and participation in extracurricular activities are also often negatively impacted by chronic pain.³ For example, 71% of children in one particular pain clinic sample were unable to take part in physical education (PE) because of their pain.¹² Considering the high prevalence of school absences, decline in academic performance and limitations to school activities, it is not surprising that peer relationships can also suffer.³ A systematic review of 33 studies investigating peer relationships of children and adolescents with chronic pain showed that overall, children and adolescents with pain reported feeling misunderstood and isolated.¹³ The reactions of significant others to youth



with chronic pain can have an important influence on their pain experience and how they cope with it.¹⁴ For example, school avoidance has the potential to be impacted by the involvement of significant others in the life of the child including family members, peers, school personnel, and the medical team and their responses to the child's pain.¹⁵ In a group of Canadian school students (aged 12–15), peers influenced how adolescents communicated about pain. Interestingly, adolescents were not tolerant of peers' pain behaviours when they did not perceive the cause of the pain as severe. Adolescents discussed their peers' pain experiences in terms of whether or not the pain was perceived as 'real',¹⁶ a finding that further helps to explain why adolescents with chronic pain conditions report having fewer friends.¹³ An understanding of childhood/adolescent pain should include the way in which the family, teachers and peers respond to that situation. How peers communicate attitudes and perceptions of pain, analgesics and management influences the adolescents with pain.¹⁶

Adults with a significance within a child's life (parents, teachers) are also important in helping children to manage their pain effectively.¹⁷

Pain education

Previous research has emphasised the importance of teachers' knowledge about their students' chronic pain conditions and ability to manage it effectively in reducing pain-related absenteeism.¹⁸ Teachers themselves have reported a need for more knowledge and guidance from healthcare professionals regarding how to manage their students' pain symptoms and pain-related behaviour in school.¹⁹ School personnel asked for (a) definitions, descriptions and knowledge of what to expect; (b) increased communication with medical professionals; (c) guidance/directives from the medical team; and (d) a more collaborative approach to dealing with their students' pain in the school setting. Teachers also reported a sense of isolation, confusion and uncertainty including how to respond when their students report pain. Participants also expressed concerns about the effects of a student with chronic pain on classmates. They reported confusion about how to provide other students with correct and helpful information and how to manage any emotional reactions (e.g. if classmates become distressed or worried about the child in pain). These findings, along with those showing children's feelings of being misunderstood and isolated by peers and the importance of pain-related social interactions, highlight the need for increased education about chronic pain in schools. One way that we have attempted to disseminate information about chronic pain to UK secondary school students is through one of us, Polly Langdon, becoming a PhD Tutor with the Brilliant Club.

The Brilliant Club

The Brilliant Club (<http://www.thebrilliantclub.org/>) is a (UK) national charity set up to challenge the difference between children from low and high socio-economic status (SES) obtaining places at prestigious, Russell Group, universities. Almost half (48%) of private school educated children gain a place at a highly selective university, compared to just 2% of children eligible for free school meals. Considering that university fees are now approximately £9,000 per year, it is particularly important to challenge this disparity and encourage high-achieving pupils from state schools in low SES areas to consider higher education. The Brilliant Club aims to address this issue by working with schools and universities all over England, from Cornwall to Newcastle. PhD tutors from highly selective universities, including the University of Southampton, are recruited and trained to develop and deliver modules based on their PhD research.

Chronic pain in childhood and adolescence

My (Polly Langdon) module, titled 'chronic pain in childhood and adolescence', aimed to provide students with detailed understandings of the following: (a) pain across childhood and adolescence, (b) the importance of researching pain within these age groups, (c) how chronic pain impacts all aspects of life for young people and their families and (d) how researchers can develop interventions to improve the quality of life (QoL) for children and adolescents living with pain. Each tutorial, lasting approximately 60 minutes, gave students a brief overview of pain in childhood/adolescence including activities and class discussions. Students were also directed to further information sources at the end of each tutorial to encourage independent reading.

Box 1. Tutorial 3 – pain in childhood (0–11 years).

Today's key question(s):

- How do children understand health and illness?
- What conditions are associated with chronic pain in childhood?
- How does childhood chronic pain impact on children's quality of life?
- How does childhood chronic pain impact on the child's family?

Learning outcome(s):

By the end of this session, you will be able to

- Consider how developmental theory helps us to better understand children's understanding of pain
- Identify various common conditions that are associated with childhood chronic pain
- Think about childhood pain from a biopsychosocial perspective
- Identify various ways in which childhood chronic pain could interfere with a child's quality of life
- Identify various ways in which childhood chronic pain could impact on their family's life
- Compare and contrast how chronic pain impacts differently the lives of children and adolescents

My module comprised five learning tutorials, a final assignment and a feedback tutorial. Tutorial title, key questions and learning outcomes are detailed for Tutorial 3 in Box 1.

All students provided positive feedback about the course, often reporting that they found the topic interesting and thought-provoking. As a tutor, I found that students engaged well with the course content and produced excellent group discussions surrounding pain-related topics and assignments. As a researcher, I also benefited from hearing adolescents' views about chronic pain as students had a personal insight into how a chronic pain condition might affect someone of their age.

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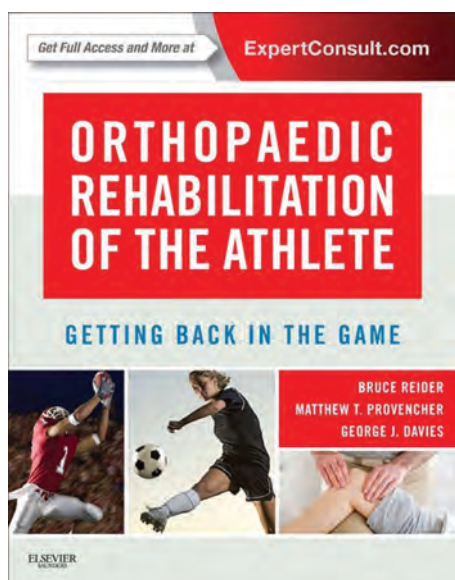
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Book review



Pain News
2016, Vol 14(4) 187–188
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SAGE



Bruce Reider, George Davies and Matthew Provencher. Orthopaedic Rehabilitation of the Athlete: Getting Back in the Game, Elsevier, Philadelphia, PA, 2015. ISBN: 9781455727803

Reviewed by Rebecca Pardoe, Lead Physiotherapist Pain Management, City Hospital, Birmingham, UK

When I was asked to review this book, I was slightly nervous to say the least; I was not a book connoisseur and had never been asked to review a book before.

Even more daunting was that this book was about athletes – I have worked in the area of pain management within the National Health Service (NHS) for last 20 years, so have come across very few athletes in this period; with an increasing feeling of trepidation, I realised I would have to try and recollect my time as a

Junior Physiotherapist when I regularly saw patients post-surgery or in the gym at the old General Hospital in Birmingham.

Luckily for me I also work along a fantastic team of physiotherapists who also were able to give me some constructive feedback and whom have vastly more experience than me working within the world of sport; so here goes ...

The title of the book is '*Orthopaedic Rehabilitation of The Athlete-Getting Back in the Game*' and in essence it does exactly what it says on the tin.

Be warned; it is a rather large and heavy piece of the literature and wouldn't feel out of place next to your Grey's Anatomy on the book shelf. It would be excellent to keep in the department as a reference tool but using it as a portable handbook wouldn't be realistic. However, modern technology does allow us access via eBook format.

The authors of the book are Bruce Reider (a Professor of Orthopaedic Surgery in Chicago), George Davies (a Professor at the Department of Rehabilitative Sciences Programme in Physical Therapy in Georgia) and Matthew Provencher (Chief of Sports Medicine and Surgery at Massachusetts Hospital). All three authors have a significant amount of experience within the area of sports team medical management.

There is additional reference to a huge number of contributors including representatives from the medical world as well as the athletic world; the majority based in the United States. These include athletic coaches/occupational therapists and educators.

The preface states that the book 'was designed to be a comprehensive, extensively illustrated textbook about the rehabilitation of common musculoskeletal conditions that effect athletes-from the professional competitor to the occasional participant'. It also claims to be the first of its kind to bring together surgeons, therapists and athletic trainers to address injuries and judging by the extensive list of contributors from varying backgrounds and professions; I'm totally inclined to believe them!

The book is split into chapters depending on the body area. These include Shoulder, Elbow, Forearm, Wrist and Hand, Spine, Hip and Thigh, Knee, Leg, Ankle, Foot.

Within these chapters are sections which cover the main conditions that can affect that particular region, for example, the 'knee' section covers extensor mechanism injuries/meniscus injuries/articular cartilage injuries and ligament injuries and within these sections are subsections where the authors explore both non-operative rehabilitation and post-operative rehabilitation and then go on to describe a 'beyond basic rehabilitation programme'. This involves targeting a particular sport following a specific injury; an example of this is return to skiing after treatment of a tibial shaft fracture. They also explore literature around the area of rehabilitation for this particular injury and finish by asking five multiple choice questions in order to test your new knowledge and understanding (or not!).

For the purposes of this review, I have decided to look more closely at fifth metatarsal fractures as this is an injury that is fairly common in athletic

Book review

individuals. The chapter opens by describing epidemiology and pathophysiology and relates these specifically to particular athletes; it then goes on to describe the clinical presentation including what to expect to find during the physical examination and also gives some x-ray examples demonstrating the different fractures including an acute Jones fracture and a styloid avulsion fracture.

A very useful aspect of the book, especially for more junior clinicians, looks at differential diagnosis. For example, it explains that a fifth metatarsal fracture presentation can also be mimicked by fifth metatarsal apophysis or osperoneum.

The chapter then goes on to explain non-operative treatments as well as exploring the possible surgical indications. Some evidence is referenced throughout; however, some of these references are relatively old (e.g. Clapper et al., 1995) and I am therefore presuming the literature referenced is well known and/or a respected study in the orthopaedic world.

Again, the chapter concludes by asking the reader five multiple choice questions.

Subsequent chapters include more detail on non-operative rehabilitation of fifth metatarsal fractures which includes appropriate advice concerning the management of pain and swelling and adopting a phased approach to

treatment which enables the reader to view clearly the 'direction of travel' for the patient including expected timescales; there are also photographs depicting the exercises/stretchers described.

Post-operative rehabilitation follows a similar phased approach to therapeutic training and gradual return to sport with sections describing the indications for surgical intervention, a brief summary of the surgery and ensuing management.

So what did I like about this book? I felt that it was very user friendly with clear, logical sections and a good selection of pictures to help explain demonstrate various exercises as well as some fascinating pictures of the various surgical procedures (not for the faint hearted!).

In addition, the radiographic photographs also helped to clearly explain the condition/surgery/clinical presentation which I feel is invaluable for the more novice and inexperienced clinicians among us.

I also loved the 'clinical pearls' of wisdom that were scattered throughout the book.

During my journey as 'book reviewer', I also asked a number of my colleagues their professional opinion; all of which reiterated the above positive views.

I see it being most useful for medical and physiotherapy students or newly qualified clinicians. I also see it being used within the field of sports therapy

and personal trainers. Additionally, I am a prime example of how it could be a useful tool to those of us who aren't specialist in sport rehabilitation but need to 'dip-in' from time to time.

What are the possible downsides to this book? In my view the only two downsides to this book were first the occasional use of dated references. However, as with any hard literature, it is virtually impossible to maintain current research once published.

And second, it was possible biased towards the US athlete and medical system (I only spotted a few European contributors) and although we could apply the majority of the principles to the United Kingdom, this may prove difficult with certain procedures within our different health economies.

In conclusion, I felt that his book perfectly achieved what it says it wants to do, that is, the rehabilitation of the athlete back to their sport. The overall writing style and presentation was at a level that provided the reader with a clear management plan with contained enough information for more junior clinicians to feel competent at providing appropriate and effective clinical input.

I have already made reference to it for my daughters' university assignment on quadriceps muscle rehabilitation and it came in very useful following a friends' netball injury during a training session in July so thank-you Dr Reider, Dr Davies and Dr Provencher!

Word Search

Regional Anaesthesia

J I O Z A X I L L A R Y B N D K U T C U
P G Y Z I E L L A Y U A A J I O G S W X
X D U U T P A W I P Y N D C A V J M C Y
J P Y E Y I R U H P D K G I B K S C E A
K D D J B U U O C N S J U P A C L E M D
Q V Y I W C D M A U U U E I F L J V G E
B O T Z P J I H R M P Z B L Q B B K J M
R Y P V I E P Z B F R F C C N R L G J L
S M H H J W E R E U A T Y G A M H K J D
X A R Q C B D E N E C R K V K Y E P H W
B N C G O F F W O I L K K J D K E T C P
T L N N E F I J T P A N F I M R B Y P T
N O W Y B Y H A Q T V B Q O O F C D E S
M V X W X H I R J F I N N N D Q Y Z A A
O Y D C P C F I A K C H E X T W B Z H A
L K K U S K C F J N U A R Z C H D O I E
Z N U O C J A E N E L A C S R E T N I L
O B P D C N T C I P A U Y I N K J D H V
X T R X V M E R K H R P L I A P G A T A
J C V L A W S E N G G X V V C C V V Z N

EPIDURAL
TIBIAL
RADIAL
BRACHIAL

AXILLARY
PERONEAL
SUPRACLAVICULAR

ULNAR
SCIATIC
INTERSCALENE

New Members ratified since September 2016

Name	Current Post	Place of work
Dr Shoma Khan	Counselling Psychologist	National Hospital for Neurology and Neurosurgery
Dr Samantha Owen	Senior Clinical Psychologist	Abergele Hospital
Miss Charlotte Sear	Pain Specialist Nurse	Stoke Mandeville Hospital
Dr Mohamed Eid	ST7 Anaesthesia	Royal Victoria Infirmary
Mr James Odell	PhD student	University Bournemouth
Dr Abigail Olubola Taiwo	Lecturer	University of Wolverhampton
Mrs Kate Thompson	Senior Physiotherapy Lecturer	Leeds Beckett University
Dr Sarah Gibb	Locum Consultant	Sunderland Royal Infirmary
Mrs Wendy Ballington	Pain Specialist Nurse	Frimley Health NHS Trust
Dr Michael Jones	Advanced Pain Trainee/ST7 anaesthetics	Belfast City Hospital

Join our Special Interest Groups (SIGs)

The British Pain Society recognises the importance of providing members who have specific interests with a forum (Special Interest Groups) to discuss their interest in more depth. The Society actively encourages and supports the development of such Special Interest Groups, as they are an important element of our multidisciplinary Society and are a key member benefit. There are currently 14 SIGs;

- Acute Pain
- Clinical Information
- Headache
- Information Communication Technology
- Interventional Pain Medicine
- Medicolegal
- Neuropathic Pain
- Pain Education
- Pain in Children
- Pain in Developing Countries
- Pain in Older People
- Pain Management Programmes
- Philosophy & Ethics
- Primary & Community Care



For more information about any of our SIGs and how to join please visit: <https://www.britishpainsociety.org/for-members/special-interest-groups/>

Philosophy and Ethics Special Interest Group Annual Meeting Rydall Hall, Cumbria

26th – 29th June 2017



Living Well Right to the End

Living Well Right to the Endsounds impossible...

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

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

Can we somehow enable those we care for to achieve a level of wellbeing even as they decline into terminal illness or perhaps face the simple fact of old age and the prospect of death?

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

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

Our speakers include Prof. Karol Sikora, Dean of Buckingham Medical School speaking on 'Living With the Uncertainty of Cancer'. Dr Sara Booth, Lecturer at Cambridge University and at King's College in London who has researched breathlessness and has an interest in the characteristics of wellbeing. Kate Binnie is a music therapist who uses music and song in her work to relieve suffering. Steve Johnson is a Buddhist teacher, mindfulness trainer and healthcare chaplain in hospital and hospice settings. Dr Emmylou Rahtz has a PhD in Psychiatry and is interested in how healing can be achieved. Fr Andy Graydon will speak about the concept of 'deep acceptance' around living and dying and Dr Jeremy Swayne's talk 'Coming Alive at Last' will deal with enrichment and wholeness despite serious or even terminal illness.

**Pain Management Programmes SIG
Biennial Conference
Glasgow Caledonian University, Scotland
14th & 15th September 2017**



“Gonnae no dae that!” – exploring patient and clinician fears

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

Social events:

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



Should you have any queries about the event, or require more information on travel or hotels in Glasgow please contact Scottish.PMP@ggc.scot.nhs.uk

www.britishpainsociety.org/mediacentre/events/