

JUNE 2012 VOLUME 10 ISSUE 2

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



Mask: Mirror: Membrane

Time to listen pain

Books on prescription

PMP self-management

NHS reforms and pain services

Engagement in the new health service



THE BRITISH PAIN SOCIETY

ISSN 2050-4497





THE BRITISH PAIN SOCIETY
An alliance of professionals advancing the understanding
and management of pain for the benefit of patients

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PAIN NEWS is published quarterly.
Circulation 1600. For information on
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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 :
9th July 2012**

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

The cover picture is an image from the article
Mask:Mirror:Membrane (see page 104 in this
issue of our newsletter). This is a photograph
by Deborah Padfield with Alison Glenn from the
series face2face © Deborah Padfield.

THE BRITISH PAIN SOCIETY
PAIN NEWS

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Professional perspectives

Time to listen and explain

86 The threat to pain services and the continuing NHS reforms

Dr Thanthulu Vasu, Editor, Pain News

The threat to pain services and the continuing NHS reforms is a topic that has been discussed in the past. However, it is still a topic that needs to be discussed. The threat to pain services is a real one. The NHS is facing a number of challenges that are threatening the future of pain services. The continuing NHS reforms are a major challenge to the future of pain services. The NHS is facing a number of challenges that are threatening the future of pain services. The continuing NHS reforms are a major challenge to the future of pain services.

Informing practice

Books on Prescription

Country Helme, Lay Member, Patient Liaison Committee, British Pain Society

113 Books on Prescription

The British Pain Society is pleased to announce that it has published a new book, 'Books on Prescription'. This book is a collection of articles that discuss the use of books in the management of pain. The book is a valuable resource for pain management professionals and patients alike. The book is a collection of articles that discuss the use of books in the management of pain. The book is a valuable resource for pain management professionals and patients alike.

Professional perspectives

Outcome of combined injection and physical therapy in managing persistent musculoskeletal pain

Alison Vasey and Shyam Balastran: University Hospitals Coventry & Warwickshire NHS Trust, Coventry

97 Outcome of combined injection and physical therapy in managing persistent musculoskeletal pain

The aim of this study was to evaluate the outcome of combined injection and physical therapy in managing persistent musculoskeletal pain. The study was a retrospective analysis of patients who had undergone combined injection and physical therapy. The results of the study showed that the combination of injection and physical therapy was effective in managing persistent musculoskeletal pain. The study was a retrospective analysis of patients who had undergone combined injection and physical therapy. The results of the study showed that the combination of injection and physical therapy was effective in managing persistent musculoskeletal pain.

Professional perspectives

The users' experience of the Pain Management Plan

Emily Thomas, Laura Costa, Polly Authorn, Frances Cook, Patricia Hild, Sue Archer and Robert Jones

100 The users' experience of the Pain Management Plan

The aim of this study was to evaluate the users' experience of the Pain Management Plan. The study was a qualitative study that involved interviews with patients and healthcare professionals. The results of the study showed that the Pain Management Plan was a valuable resource for patients and healthcare professionals. The study was a qualitative study that involved interviews with patients and healthcare professionals. The results of the study showed that the Pain Management Plan was a valuable resource for patients and healthcare professionals.

British Pain Society

Calendar of Events 2012



Philosophy & Ethics Special Interest Group Conference
Monday 2nd July to Thursday 5th July 2012
Rydal Hall, Ambleside, Cumbria

Commissioning Pain Services (25th Study Day)
Monday 10th September 2012
Churchill House, London

Interventional Pain Management SIG Conference
Friday 28th September 2012
Radisson Blu Manchester Airport, Manchester

Patient Liaison Committee Seminar
Monday 5th November 2012
Churchill House, London

Psychological therapies in the management of pain (26th Study Day)
Friday 23rd November 2012
Churchill House, London

Pain Education SIG – One Day Seminar
Thursday 29th November 2012
Churchill House, London

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

<p>Date for your diary: 2013 Annual Scientific Meeting 16th – 19th April 2013 Bournemouth International Centre, Bournemouth</p>
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Why does it still need saying?



THE BRITISH PAIN SOCIETY

Pain News
10(2) 63–65

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The opposite of a correct statement is a false statement; but the opposite of a profound truth may well be another profound truth!

Neil Bohr, Nobel prize winner for Physics (1885–1962)

The Annual Scientific Meeting (ASM) of the British Pain Society (BPS) in Liverpool was once again a big success. The main reason for this was your kind support and participation. On behalf of the members, I thank the Secretariat who have worked hard for this occasion and the Scientific Programme Committee or Organising Committee for the excellent programme. Our ASM for next year will be held on 16–19 April 2013 at Bournemouth and please note the dates in your diaries.

I had lots of positive feedback about the new format of *Pain News* since we moved to SAGE publishers. SAGE has done excellent work and has raised the quality of the publication. Please keep

writing to us about how we could further improve our newsletter.

'Why Does it Still Need Saying?'

*I find you want me to furnish you with arguments and intellects both.
No, Sir, there I protest you are too hard for me.*

Oliver Goldsmith
(*The Vicar of Wakefield*), 1766

In *Pain News*, my task with debates is made easier (or should I say, made possible) by Rajesh Munglani; not only does he arrange the intellects, but he also takes part in the excellent arguments for these controversial topics. His debate on 'Does a diagnosis in pain medicine promote disability?' in our last issue has stimulated significant thought-provoking discussions; we have learned a lot from these debates.¹

However, Peter Wemyss-Gorman exclaims with sadness: 'Why does it *still need* saying after all these years?' (see Letters to Editor at end of this issue). I can understand his frustration: after working more than three decades in the specialty, he comments that we still need to raise our voice to change the dualistic mindset. It is a truth, as he mentions, that it is appealing to both professionals and patients to hold still relatively simple concepts of mind–body dualism.

Biopsychosocial Model of Pain Management

George Engel presented the biopsychosocial model of illness first in 1977.² More than three decades on, still we find it difficult to persuade few health

care professionals, let alone patients, to understand this concept. Waddell's *The Back Pain Revolution* changed our understanding of this complex phenomenon and we have come a long way, including detailed descriptions of yellow, orange, black and blue flags.^{3,4} We have proven the effect of beliefs and coping strategies, explained fear avoidance and catastrophising phenomenon. The International Association for the Study of Pain (IASP) clearly mentions that 'the critical elements of an interdisciplinary treatment approach (based on this biopsychosocial model) are the most clinically effective and cost-effective approach to use in patients with chronic pain.'⁵ In the field of family medicine, Borrell-Carrio et al. defended the biopsychosocial model; the authors clarify that the relation between the psychological and physical aspects is complex, subjective and not reducible to laws of physiology.⁶ They conclude that the value of this model is in guiding parsimonious application of medical knowledge to the needs of each patient. In our field of pain management, most of us would agree with this fact as there are lots yet to be explored and researched.

Has the Biopsychosocial Model Achieved its Potential?

A recent study has shown that British pain clinic practitioners have readily embraced the cognitive behavioural therapy (CBT) approach, but relatively little consideration has been given to the social factors; it concluded that the multidisciplinary pain clinics espousing a biopsychosocial model may not be achieving their maximum potential.⁷

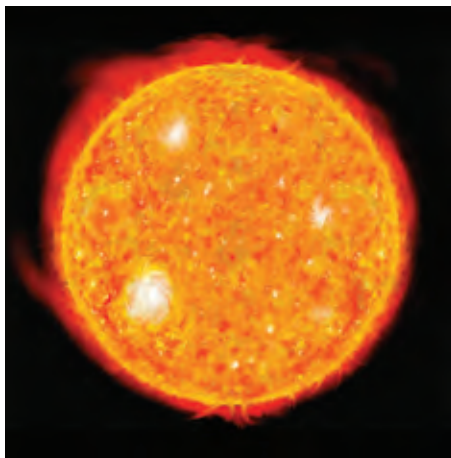
Why does it still need saying?

However, this qualitative study has its own limitations as it interviewed the clinicians involved and researched their beliefs.

There are critics of the biopsychosocial model, especially when it comes to spinal pain. Gatchel and Turk (2008), while doing a point-by-point refutation to a previous review, argue that the misuse of the biopsychosocial model by *inappropriately* trained health care specialists decreases its maximum utility and validity.⁸ They stress that this model underscores the important interactive contribution of factors in each of these defining domains and suggest that they require individual assessments.

Science fulfils its purpose, not when it explains the reasons for the dark spots on the sun, but when it understands and explains the laws of our own life ...

John Ruskin (1819–1900)



Bio – Psycho – Social: Each Component is Important

The IASP clarifies that the biological, psychological and social factors must all be simultaneously addressed.⁵ However, in some cases, the biological factors are bypassed and this is when problems in diagnosis and management can get complicated. Further, the policy makers

find the cost-effectiveness an attractive strategy to reduce or stop few interventions. This was seen to happen in recent past with National Institute for Health and Clinical Excellence (NICE) guidelines CG88.⁹

Have We Forgotten 'Bio' – or Are We Tired Now?

In the last issue of our newsletter, when I published Yellowlees's article on the cost-effectiveness of pain clinics, I expected lots of feedback.¹⁰ He comments in the last few lines: "Maybe managers should say: 'We're cutting all of you by 20% because there isn't really much to choose between you.' Maybe we should consider ourselves lucky if we're not shut down." Contrary to my expectations, there was only one comment. Is this because my colleagues consider this as true and is the fiscal climate so bad? A friend of mine asked me an interesting question: 'Why have many of the general practitioners not raised the voice against reduction of pain services? Don't they see us as a valuable service?' We have to remember that they see the majority of the bulk of the chronic pain problems in the community and we see only the tip of the iceberg.

When I was young, I thought that money was the most important thing in life; now that I am old, I know it is.

Oscar Wilde (1854–1900)

Economic and Financial Pressures

Or is it just the change in economical and financial conditions that has caused more pressure on the pain clinics? Until now, the National Health Service (NHS) has been outperforming other developed countries despite spending much less than most of them; the UK has the least expensive health system among 14 high-income countries analysed by a Commonwealth Fund study.¹⁴ We should be proud to know

that our country had the lowest percentage of patients who had experienced medical or other errors, as well as the highest percentage whose prescriptions were kept under review. Is this all going to change with the proposals set by the new Health and Social Care Bill? Interesting arguments are made in this issue by Rajesh Munglani with regards to the threat to pain services. Andrew Baranowski explains more about the specialised commissioning services and how this could affect the pain services. Also in this issue, Sam Eldabe discusses the variation in commissioning for spinal cord stimulation services. But these cuts can affect every service under our multidisciplinary umbrella; we have to fight *together* for the benefit of our patients, whether it is intervention, psychology or other services. We have to convince the policy makers that we work in the multidisciplinary model to do the best and help our patients.

Talking about financial pressures, we all agree that we need to look at ways of delivering our services cheaper, preferably aiming at self-management by patients. In this issue of *Pain News*, Frances Cole describes the patient-led, CBT manual-based self-management pain management programme (PMP). I have requested another elite specialist team to write about internet-based PMP education in a future issue. Innovative ways of looking at self-management are inevitable if we are to survive in these tides.

Coming to research, again, the chronic pain specialty suffers due to lack of funding and interested clinicians. The clinicians are busy with the number of patients seen, policy makers want to save money in this difficult financial climate and patients want to have a quick fix – each has their own priorities. As Loeser comments on the research funding in America: 'By far, the most common neurologic disorder in the American public is chronic pain, and they



do virtually nothing in the realm of chronic pain research – it is a fraction of a percent of their funds.’¹⁵

American biologist Edward Osborne Wilson, twice winner of the Pulitzer Prize, uses the term ‘consilience’ to describe the synthesis of knowledge from different specialised fields. He believes that in future, science will uncover the unifying principles at all levels, from molecular to societal, and create connections between the fields that are currently separate.^{6,16} He describes that single synthesis traverses the scales of space, time and complexity to unite the disparate facts of disciplines, which is a perception of a seamless web of cause and effect. When I read this, I have the optimistic hope that in future, chronic pain mysteries will be solved by innovations like consilience. We have already made theories on environmental and genetic causes of pain; can we not progress to just find the complex link now? Until that

time comes, we will keep working hard to help our patients.

I will conclude now with Wilson’s closing remarks in *Consilience*:

To the extent that we depend on prosthetic devices to keep ourselves and the biosphere alive, we will render everything fragile And if we should surrender our genetic nature to machine-aided ratiocination, and our ethics and art and our very meaning to a habit of careless discursion in the name of progress, imagining ourselves godlike and absolved from our ancient heritage, we will become nothing!¹⁶

I hope you enjoy reading this issue of our newsletter. Keep writing in.

Thanthullu Vasu
Bangor, North Wales

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Professor Richard Langford



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Pain News
10(2) 66–67

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I am writing this just a few days after the Annual Scientific Meeting (ASM) in the superbly renovated Liverpool docklands, and reflecting on the pleasure of the many renewed acquaintances and programme highlights. Gary Macfarlane in his first year as Chair, and his fellow members of the Scientific Programme Committee, supported by Leila Taleb (our Event Organiser) and the other members of the Secretariat (Jenny Nicholas, Secretariat Manager, and Ken Obbard, Events and Membership Officer), excelled in presenting such a varied and stimulating agenda. This year we had the privilege of a most distinguished opening lecturer, Professor Gerald Gebhart, past President of the International Association for the Study of Pain (IASP) to present an outstanding 'Pat Wall Lecture' on visceral pain. The following three days were packed with high-quality plenaries, workshops, poster sessions and special interest group (SIG) meetings. In fact, the number of active participants is quite remarkable and it has become quite a

juggling act to fit in so many activities, especially with the increased number of SIGs. The ASM culminated in a wonderfully delivered and thoughtful 'British Pain Society Lecture' on 'A Normal Psychology of Pain' by Professor Chris Eccleston. Gary is already under way with plans for next year's ASM in the Bournemouth International Centre, so remember to save the dates: 16–19 April 2013.

Annual General Meeting

As you know, we traditionally hold the annual general meeting (AGM) on the Thursday afternoon during the ASM, and it marks the beginning and end of our year. We owe considerable thanks to two elected members who completed their three-year terms on council:

- Dr Ted Lin, who was previously Chair of the Education Committee
- Dr Thanthullu Vasu, who will stay on council, co-opted as our excellent Editor of *Pain News*

We also congratulate Dr Sam Eldabe as he commences his second term and welcome three newly elected council members:

- Dr Heather Cameron, who will also continue to represent the Physiotherapy Pain Association
- Mr Paul Cameron
- Dr Ollie Hart

This year we also announce, with our congratulations, the appointment of the new executives, who will commence in their actual roles in a year's time:

- President Elect:
Dr William Campbell

- Honorary Secretary Elect:
Dr Martin Johnson
- Honorary Treasurer Elect:
Dr Andrew Baranowski

With this announcement, I would like to especially acknowledge the major contribution of our first ever Vice-President, Dr William Campbell, for his great support over the past year, and congratulate him on becoming the President Elect.

I would also like to take this opportunity to thank two outgoing SIG chairs:

- Mike Basler – Developing Countries SIG
- Val Conway – Primary and Community Care SIG

Both were the founders of their respective SIGs and have done so much to launch and establish their respective activities.

One of the most important and pleasurable aspects of the AGM is the presentation of Honorary Membership. This year, we recognised the major contributions to pain medicine of two notable British academics. Professor Chris Eccleston kindly delivered the citation for Stephen Morley, Professor of Clinical Psychology at the University of Leeds, noting his remarkable contribution to the field of pain medicine. Stephen has also served the British Pain Society (BPS) as a council member and was Chair of the Science and Research Committee. I then presented the citation in support of Professor Andrew Moore, who has made a huge contribution to clinical pain research and its methodology throughout his time in the Pain Research

Department of the Nuffield Department of Anaesthetics in Oxford, including his leadership of Bandler and his role in the Pain, Palliative and Supportive Care Review Group in the Cochrane Collaboration.

Library of Quality Standards

The proposed Library of Quality Standards was confirmed in the spring, after the consultation period by the Department of Health, and as you will be aware, included pain as a topic. This was an important moment for both pain medicine and our patients, as it is the first time that pain has made it in its own right on to the Department of Health Quality and Standards agenda, and follows a sustained effort by the BPS, the Faculty of Pain Medicine (FPM) and the Chronic Pain Policy Coalition (CPPC). It will ensure our place in the commissioning agenda.

Pain Patient Pathways

A Quality Standard requires underpinning guidelines, and we expect that these comprehensive care pathways will be developed by the National Institute for Clinical and Health Excellence (NICE) in the next year or two. The BPS and the FPM will be offering their support in this process, and we would hope that our members will be actively involved, which we have witnessed has occurred in other specialty areas. The development of our

own BPS Pain Patient Pathways is nearly complete, and many of you will have seen the demonstrations in the opening ceremony and during other sessions at the ASM.

The next phase of this project is named 'Implementation and Dissemination', in which we plan many activities including publishing these pathways in the more traditional form of a review/guideline in a peer-reviewed journal, and further developing the material in the form of educational modules. Dr Andy Nicolaou has kindly agreed to accept the overall leadership of these parallel 'Implementation and Dissemination' work streams, comprising the following themes and leaders:

- Primary care: Dr Martin Johnson
- Commissioning: Dr Ollie Hart
- Members: Nick Allcock
- Patients: Douglas Smallwood and Ann Taylor

Mindful of the commissioning consortia and clusters going live in 2013, we are preparing supporting materials for our members to assist in their local engagement with commissioners and we are collaborating with the FPM.

National Pain Audit

This important project for the BPS, which was originally proposed in the CMO's report, and subsequently funded by the Healthcare Quality Improvement Partnership (HQIP) to enable our

collaboration with Dr Foster, is well into its second phase, in which we are collecting patient-reported outcomes. Special thanks are owed to Dr Stephen Ward, Cathy Price and Stephanie Stokes (a member of our PLC) for their leadership and immense contributions in this work.

We are aware that the case-mix data from the recruited patients are still to be collected from some of your departments. If you have data outstanding, please would you kindly inform Robert Douce at Dr Foster on 020 7332 8907. I am also very pleased to announce that we have been successful in a bid for a one-year extension for further work in this study, and I will keep you posted on this in future messages.

E-Learning in Pain

As you will recall, just as 2011 drew to a close, we learned that the joint BPS/FPM bid for an e-learning in pain project had been allocated £170,000 by the Department of Health. Since then, Dr Ian Goodall has kindly agreed to lead on the work, for which preparations are now under way. We (both the FPM and the BPS) would welcome expressions of interest from you if you are interested in making a contribution to this exciting project.

With kindest regards,



Professor Pat Schofield



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I am writing my article for *Pain News* while travelling back from Liverpool to London on the train; I am taking this opportunity to reflect on another successful Annual Scientific Meeting (ASM). The venue was excellent, as always – Liverpool provided a good location with plenty of opportunity to experience the culture that it has to offer and the wonderful choice of restaurants within easy walking distance of the conference centre. What a shame about the weather, but any threat of a hose pipe ban must now be surely passed. There is always a great buzz at the ASM and the mixture of plenary speakers and

workshops contributed to the excellent atmosphere. I was thrilled to introduce my plenary, Dr Gisele Pickering, as apart from being an excellent speaker, she was presenting on a topic so dear to my heart – ‘Pain in Older Adults’ – and she is also a very dear friend. I was also particularly excited this year as the *Pain Guidelines for Older Adults* were launched, which represents three years of very hard work by me and the rest of the team. Please watch the British Pain Society (BPS) website for them to be posted.

The AGM is always an opportunity for me to reflect upon the rest of the great work that is ongoing within the society.

There are seven *committees* within the BPS, with growing membership and activities within the work of the Society – for example, the Communications Committee, which approves publications or our active Patient Liaison Committee, which is becomingly increasingly involved in the work of the Society.

We have nine *working parties* – for example, Drugs beyond Licence and Pain in Older People, along with the working group on Pain Pathways, which is subdivided into five working groups covering specific aspects of the pathways work.

We have twelve *special interest groups* (SIGs), all of which are represented in the programme of the ASM. These groups are involved in various activities of the Society, including facilitating study days or leading on publications.

Study Days

The Education Committee has a programme of study days planned for 2012/13, which will include:

- Update on the Treatment of Low Back Pain (June 2012)
- Commissioning Pain Services (September 2012)
- Psychological Therapies (November 2012)
- Pain Management in Older People (Spring 2013)

Publications

The *Pain Management Guidelines* are due to be published this week and will be published as a supplement in *Pain and Ageing* later in the year. There are several publications due to be reviewed including *Drugs beyond Licence*, *Pain Management Programmes* and *Pain & Substance Misuse*. Two interventional pain medicine publications have been recently approved: *Percutaneous Spinal Intervention* and *Medial Branch Blocks*. The Pain in Older People SIG has submitted two publication proposals, which are going through the approval process.

Membership Figures

We have 1,536 members, represented by 726 anaesthetists, 267 nurses, 97 psychologists, 88 physiotherapists and other disciplines accounting for 358 members. So there is plenty going on and plenty to look forward to.

PAIN?

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10(2) 72

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BPS Honorary Membership citation for Professor Robert Andrew Moore

Citation provided by Professor Richard Langford



It is with great pleasure that I provide this citation to support the award of Honorary Membership of the British Pain Society (BPS) to Professor Andrew Moore. Andrew's odyssey, for it has been a varied and unconventional journey, began at the University of Oxford, with which he has been linked ever since.

Andrew read biochemistry at Balliol College, was awarded a BA in 1970, and went on to achieve his MA and DPhil by 1976. He then spent a decade as consultant biochemist at the Radcliffe Infirmary in Oxford, during which period his enduring collaborations began with pain and anaesthesia, initially with Dr John Lloyd who established the Oxford Regional Pain Relief Unit, and continued with Professor Henry McQuay. The steady stream of papers on opioid pharmacokinetics, new immunoassays for drugs like fentanyl, buprenorphine as well as morphine and its active and inactive glucuronide metabolites, and

pain clinical trials had begun. They highlighted the importance of renal function in morphine-6-glucuronide excretion, and the accumulation of the active metabolite in renal failure. It was therefore no surprise that Andrew retained an academic role in Oxford as honorary senior research fellow in the Nuffield Department of Anaesthetics during eight years as managing director of a company in the diagnostics industry. From the early 1990s, the focus of this research collaboration evolved into evidence-based medicine predominantly (but not exclusively) in pain medicine, and Andrew returned to Oxford as editor in chief of *Bandolier* in 1994. He is also honorary professor at the School of Health Sciences at University of Wales, Swansea.

The use of systematic review and meta-analytic techniques was applied to pain studies and by 1997 had led to the production of tables of relative efficacy of

analgesics in acute and chronic pain and the concept of Numbers Needed to Treat. It was in that same year that Andrew was awarded his DSc. These activities also led to the founding of the Pain, Palliative and Supportive Care review group in the Cochrane Collaboration and also the International Collaboration of Evidence-based Critical Care, Anaesthesia and Pain (ICECAP), which has now had three international meetings.

Andrew's contribution to our knowledge and literature in pain medicine is prodigious, and is exemplified by his astonishing list of journal publications, at last count numbering 455, not to mention numerous book chapters, and of course his *Bandolier's Little Book of Pain*, which has sold over 30,000 copies.

Andrew is listed in the top 30 authors in the Lab Times Publication Analysis of Pain Research publications for 1998–2009.

His H-index (named after Jorge E. Hirsch), a measure of research impact based on publications and citations, is over 45, which is commensurate with the highly prestigious membership of the United States National Academy of Sciences.

It is therefore difficult to reconcile Andrew's international renown in the field of pain medicine with the fact that he has never actually been a member of the BPS, as the membership was exclusively medical in the 1980s when he originally applied and hence he was deemed ineligible.

I am pleased to say that this richly deserved award therefore rectifies this anomaly, as well as marking the esteem in which he is held by the Society. I commend him to you for Honorary Membership of the BPS.



BPS Honorary Membership citation for Professor Stephen Morley

Citation provided by Professor Chris Eccleston



It is my great pleasure to give this citation in support of Professor Stephen Morley for Honorary Membership of the British Pain Society (BPS).

Stephen graduated from University College London in psychology in 1971, gaining his Mphil in clinical psychology from the Institute of Psychiatry in 1975, and his PhD from the Institute of Psychiatry also, in 1982. He trained and worked with luminaries of British psychology, including Monty Shapiro and Jack Rachman, and their influence is often to be sampled in his work. Clinical academics are required not only to be excellent clinicians, teachers, researchers and administrators; they are

also required to have that rare quality of being a 'good colleague'. Stephen has been an excellent colleague, friend and teacher to many over the years, and served his time running, improving, rescuing and steering from the brink of self-destruction, many departments (and individuals). He has continuously supported the work of the BPS and the British Psychological Society. He was editor of the *British Journal of Clinical Psychology* and chair of the BPS Journals Board. He is currently psychology section editor for the *European Journal of Pain*. Stephen is a man with that most valuable and rare of attributes: he 'gives a good opinion'.

Despite being busy shaping and influencing the careers of others, Stephen has also led from the front with over 150 peer-reviewed scientific publications. Reviewing his contribution to date shows its remarkable depth. A number of themes emerge. First, Stephen has always had a concern for methodological innovation, rigour and accuracy. Second, he has always been 'critical' of the canon. Third, he is almost an academic gardener. The seeds he plants sometimes take time to grow, but grow they do. For one example, his early work on selective bias is much cited in the current industry of research on attention. For a second example, his work on evidence for cognitive behavioural therapy (CBT) is now amongst the most highly cited papers in pain research. His work on memory and identity has largely gone unnoticed but sits ready to be 're'-discovered.

All of the above might inadvertently give the wrong impression that Professor Morley is only a serious man. It is important to communicate that his patrician sensibilities include a healthy disregard for pomposity. He has been influenced by that other great psychologist Monty Python and is never far away from a Goon showing. His sense of humour, wisdom, insatiable curiosity and his generosity have meant that the Society has benefited tremendously from his membership and support. We are grateful for his friendship and expert guidance. For these reasons I am pleased to give you Professor Stephen Morley as deserving of Honorary Membership of the BPS.



Engagement in the New Health Service

Andrew P Baranowski and Martin Johnson

Since the instigation of the National Health Service (NHS) in 1948, controversy has abounded and clinicians have been forced to respond to the changes imposed on them by the government or sink; then how could they serve their patients? In many ways the situation has not changed; currently many clinical services feel threatened and impotent by the latest of the government plans aimed at improving the NHS. Several of our friends have resigned and left the NHS to work abroad and many consider early retirement. We frequently hear: 'What should we do to maintain our pain management service?'; 'How do we ensure that the patients have the best and most appropriate pain management service, which is their right?' As British

Pain Society (BPS) Council members, we are often challenged with: 'And what are you doing about this...?'

It is not the purpose of this article to defend or condemn the changes that the NHS is currently experiencing, but rather to look at some of what the BPS Council is currently engaged in on your behalf – and to suggest how you, your team and patients may also take matters forward to ensure that we are in a position to provide world-class pain management services that are the envy of others across the world, despite these difficult times. With apologies to the rest of the UK, this article relates to the changes happening in England.

You may not be aware, but currently there are three levels of commissioning:

national, regional and local. Most of us will be familiar with local commissioning involving the primary care trusts (being abolished in 2013). However, services are also commissioned at a regional level by the specialised commissioning groups (SSG), currently 10 for 10 regions, as well as by the more specialised commissioning at the national level undertaken by the National Specialised Team (NST). The plan is to reduce the number of agencies involved in commissioning down to two groups: clinical commissioning groups (CCG) at the local level and the NHS Commissioning Board (NHS CB) at the national level.

With the final vote in parliament now having taken place, CCGs are now a reality. Their basic function is to plan, agree and monitor services, improve and maintain quality in primary care and to ensure that the commissioning budget expenditure is not exceeded. In October 2012, the NHS CB will be established as an independent statutory body, initially only having limited functions – in particular, establishing and authorising CCGs. CCGs should in theory have their full 'powers' established by 1 April 2013; however, we are aware from personal communications that a high percentage of the CCGs will not be ready/allowed to commission from this date and will be looking for guidance from the NHS CB. Indeed, even those CCGs that are granted this privilege may well be given guidance from the top down. Therefore, the Department of Health is looking for guidance itself on clinical areas –



including issues relating to pain management. It is very keen to have advice on the commissioning of pain services (some of which will come from the final pain summit report). The Royal College of General Practitioners (RCGP) and the BPS are coordinating, on your behalf and through a variety of routes, the implementation of the Pain Patient Pathway Maps – this will include relevant advice from the BPS in a commissioning document for non-specialised pain services (tiers 1 and 2). However, local services, in some areas, are already making plans around pain services (some apparently ignoring them!) so it is *vital* that you seek local advice regarding engaging with your CCGs.

The NHS CB will commission at the national level and will take on responsibility for those services currently commissioned at the national level by the NST, as well as some of those services currently commissioned at the regional level. Other regional services will be devolved to the CCGs. It is generally accepted that very rare conditions and/or treatments will remain under the auspices of national commissioning by the NHS CB. The problem has been how to decide which services currently commissioned at a regional level should be passed to the CCGs and which to the NHS CB.

The NHS has recently set up clinical reference groups (CRG) for around 60 services, including pain medicine. The exact remit of the CRGs is still being developed as it is early days. Andrew Baranowski was appointed, following a national advertisement, to chair the CRG-Pain with an executive committee that includes a public health consultant and a senior commissioner. The membership of the group is complex due to the principle aim to ensure equity of representation geographically across England, as well as appropriate representations from the various

disciplines, societies and public patient engagement (PPE) agencies. It is still too early for us to know what impact CRG-Pain will have on the commissioning of specialised services, but to date the group has been involved in two projects: (1) advice on specialised clinical networks (SCN); and (2) drawing up a scope and specification for a specialised pain management service (SPMS).

The plan is that there will be NHS CB-prescribed networks called SCNs. The aim is that these will bring primary, secondary and tertiary care clinicians together, with partners from social care, the third sector and patients to define evidence-based best practice pathways, which are implemented and assured through network relationships with commissioners and providers. It is expected that there will be approximately 15 geographical patches in England. The number and size of each prescribed SCN will be based on patient flows, with SCNs aligned to and operating within an overarching 'umbrella' network structure at the national level.

So what has the CRG-Pain recommended around SCNs for pain? First, that pain services already have the infrastructure for setting up such networks under the auspices of the BPS, the Faculty of Pain Medicine (FPM) and the Chronic Pain Policy Coalition. We have pointed out that following on from the 2008 Chief Medical Officer's report, the BPS has developed and is in the process of publishing best practice guidelines that cover the management of pain from when a patient presents to health services through to the later more complex stages. There are close links between the BPS and the RCGP Pain Initiative Group. We summarised by stating that the BPS structure, with appropriate support, would form a strong basis for a cost-effective national strategic clinical network meeting the establishment criteria presented to us.

We went on to say that pain is ubiquitous and a fundamental condition; as a consequence there are currently numerous groups involved in management, often with different approaches and supporting evidence. A single national strategic clinical network supporting the management of pain as a well-defined disease process would reduce the current variance in treatment approaches and availability across England (UK) and support cost-effectiveness.

The second task that the CRG-Pain has been involved in is drawing up a scope and specification for what would constitute an SPMS. This is a piece of work in progress. For the scope of an SPMS, we need to have an objective way of differentiating between specialised and non-specialised elements of a pain service. This is proving more difficult than one might expect as this needs to be based around codes. Some work has been done on this before by members of the BPS and the FPM in Annex A of *SSNDS Definition No. 31 Specialised Pain Management Services (adults)* (3rd Edition). However, our group feels that for the best results, complex procedures in particular, but not solely, should *not* be undertaken in isolation without the support of an interdisciplinary team engaged in appropriate assessment and management and this needs to be reflected in the code definition. It is likely that a specialised service will be defined by:

1. *Interdisciplinary and multispecialty* pain assessment, management and rehabilitation by appropriately trained pain specialists.
2. *Patients with complex pain and pain-associated disability.*
3. *A dedicated specialised pain management centre.*
4. *The provision of complex pain interventions.*

Engagement in the New Health Service

All of the above will be delivered from a dedicated centre. Referral would be from secondary care or above, where management has not been successful in a local pain management setting. As we have said, there is a lot of explanatory text around this.

The CRG-Pain is also looking at the possibility of extending the codes to reflect complex interdisciplinary and multispecialty management as an intervention. Specific examples of complex management in their own right may include outpatient, residential or inpatient specific interdisciplinary cognitive behavioural therapy pain management programmes by a comprehensive interdisciplinary/multidisciplinary team for patients with complex pain and pain-associated disability, where the service is specific, highly structured and intensive and as a consequence, the number of patients requiring that service is small and the skills will not be available in less specialised pain management centres – for example, dedicated pain management programmes for sickle-cell disease, facial pain, urogenital pain, hypermobility, children and young people.

Another example might be those treatments involving complex manipulation of medication as an inpatient, especially opioids, where there is multispecialty and interdisciplinary input.

A lot of work has been undertaken by the CRG-Pain on the specification of an SPMS. As a part of this work, we have drawn up a concise definition; however, the explanatory text is lengthy. An SPMS delivers timely interdisciplinary and multispecialty pain assessment, management and rehabilitation by

appropriately trained pain specialists for specialist patients with complex pain and pain-associated disability in a dedicated specialised pain management centre. Such a service is capable of providing complex pain interventions, and works within the context of local pain management services that provide the majority of pain patient assessment and management in England. To provide support for BPS members and to support the services that we provide to our patients, the BPS is currently setting up the Pain Patient Pathway Maps Implementation Task Force. More about this in the next edition of *Pain News*.

Summary

1. Commissioning is a reality and it needs *you* to take proactive steps in

your area to find out what is happening and how to engage with CCGs.

2. CCGs will commission at the local level and the NHS Commissioning Board (NHS CB) at the national level.
3. A clinical reference group for pain is being set up to advise on specialised pain services.
4. Strategic clinical networks will bring all tiers of provision together with partners from social care, the third sector and patients to define evidence-based best practice pathways.
5. Much of the strategic clinical network can draw upon the links that the British Pain Society already has and potentially use the pathways that we are writing at present.

Special Interest Group for Philosophy and Ethics of the British Pain Society

The Ethics of Care

Rydal Hall, near Ambleside, Cumbria, 2nd to 5th July 2012



The BPS website

Rajesh Munglani



THE BRITISH PAIN SOCIETY

Pain News

10(2) 77

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The words 'poisoned chalice' comes to mind ...

The British Pain Society (BPS) council asked me to chair a small group to help consider updating the BPS website.

Very few doubt that the online presence of an organisation is critical to its image and presentation of its values and aims. But more than simple marketing or advertising, veneer is at stake here. The explosion of internet speeds has meant that huge amounts of information can be transmitted directly and quickly to people without the need for paper – just as well considering the price of exorbitant postage and efforts to go green!

We had our first face-to-face meeting on 12th January 2012, in which we discussed many technical and practical problems including website maintenance, cost and other issues like simplification and integration of online membership application, renewal of special interest group (SIG) membership and conference booking. Most importantly, we discussed what we and indeed *you* want from the website in terms of content. Suggestions included the following:

- Downloadable information
- Content – facility to update and upload, increase the use of video and audio on website, including video of lectures given at conferences

Webshot of the BPS website at present



- Discussion groups based around SIG members, making it easier to network and communicate
- Continuing medical education (CME)-accredited modules in pain management

We discussed the specific areas that should be available to members (Vs non-member areas) and some opined that unrestricted, open-access content would be better and would perhaps encourage people to join the BPS.

The group also consisted of Joshua Adedokun, William Campbell, Arun Bhaskar, Nick Allcock, Jenny Nicolas, Mick Serpell and Ken Obbard. Now, we are inviting lay members and website developers to join us for the next meeting.

If you have any thoughts you would like to share with us, please email Ken Obbard in the first instance at kenobbard@britishpainsociety.org.



News from the Pain in Developing Countries (PDC) SIG

Compiled by Clare Roques (PDC SIG Chair)

A World Health Organisation briefing note published in 2009 states: 'The World Health Organisation (WHO) estimates that five billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for moderate to severe pain.' The full version of this briefing note is available from: http://www.who.int/medicines/areas/quality_safety/ACMP_BrNoteGenrl_EN_Feb09.pdf. The aims of the PDCSIG (and to my knowledge the British Pain Society (BPS) is the only International Association for the Study of Pain (IASP) chapter with a SIG aimed specifically at such issues) are focused on improving access to pain management through advocacy, education and liaison with related groups. Following Mike Basler's article in the Winter 2011 edition of *Pain News*, we are aiming to publish a regular news update with a brief outline of events and members' experiences related to pain in developing countries.

The Morphine Manifesto

Many of you will be familiar with the work of the inspiring Dr MR Rajagopal from Kerala, India and will have heard him speak at the PDCSIG workshop in Edinburgh last year. The organisation he leads, Pallium India, has joined up with several other groups throughout the world, including the International Association for Hospice and Palliative Care, the Pain and Policy Studies Group, University of Wisconsin/WHO Collaborating Center for Pain Policy and Palliative Care and the IASP, to launch the The Morphine Manifesto: A Call for Affordable Access to Immediate Release Oral Morphine. Many of the specific issues related to morphine access are outlined in this document, such as the high financial costs as well

as over-stringent regulation often encountered in the developing world. More details and the opportunity to sign the manifesto are available at <http://palliumindia.org/manifesto>

Life Before Death Films

Another project supported by the IASP in conjunction with others, is the award-winning *Life Before Death* film series. Earlier this year a feature-length documentary featuring interviews with key health care professionals as well as patients and their families, narrated by David Suchet, was released. I would encourage you to watch this powerful film, which is both incredibly moving yet surprisingly uplifting. The project also consists of a series of 50 short films

released once a week from May 2011, aimed at improving awareness of the issues related to accessing adequate pain management and palliative care. More information is available at <http://www.lifebeforedeath.com> where the short films are also available to view.

IASP Developing Countries Working Group

As well as funding various projects as outlined above, the IASP has a committee dedicated to pain management in developing countries, chaired by Professor Sir Michael Bond. Through the Developing Countries Working Group, the IASP has supported many projects including fellowships in Bangkok and Cape Town (in conjunction

with the World Federation of Societies of Anaesthesiologists) and also in Bogota. Other supported work has included donations to Kybele, a group focusing on improving conditions of childbirth throughout the world, and to Hospice Africa to support education. The Working Group will be meeting at the IASP congress in Milan later this year.

Members News

Emma Sherriff (SpR in Anaesthetics, North Western Deanery) has recently spent a year working with Medecins Sans Frontieres (MSF). This work took her to several countries including Yemen, Sri Lanka and Pakistan. She writes:

For acute pain I worked along the lines of the WHO analgesia ladder, however the supply of opiate based drugs was often difficult. Supply in an area of conflict is difficult and permission to bring anything into a country stronger than tramadol is often refused. The patients however managed very well on simple analgesia and occasional tramadol. The surgeons I worked with and I became very adept at providing local anaesthetic blocks to cover surgical incisions. The patients rarely complained and were highly motivated to get out of bed and mobilise despite often extensive surgery (laparotomies/thoracotomies).

A big part of working for MSF is education and teaching. I carried out twice weekly teaching during my projects for the nursing staff and local doctors often covering topics such as analgesia, pain scoring and chronic pain. Chronic pain, even among the expat staff I worked with,

is often not a consideration. When there is an influx of war injured patients, nobody has time to treat any chronic conditions. MSF do have protocols and projects aimed at helping these people especially in countries where war has created generations of amputees. In some African countries, this is used by the military as part of their policy of terror; for example in Sierra Leone many people lost their limbs after machete attack. I treated several patients in Yemen with amitriptyline who had suffered from phantom limb pain for many years but had never had the chance to be treated before. One 18 year old girl I worked with [who] had lost her leg during a rocket attack several years before described the pain as "taking over her life". Within a month of starting treatment she had started to sleep properly and was beginning to see a future for herself.

Hopefully we will be able to publish a more extensive article of Emma's experiences in the future.

Senthil Vijayan (ST7 in Anaesthetics, London Deanery and Honorary Secretary of the PDCSIG) writes:

I was recently in India and was having a chat with one of my friends who is a GP in a busy practice. He mentioned that he has got lot of patients with chronic pain in his practice and finding it very difficult to manage them. We thought that I could run a workshop for the GPs in his area and he assured me he can arrange some of his patients to turn up on that day. I was very impressed with his organising skills; he could arrange a workshop within a couple

of days. On the day of [the] workshop nearly 15 GPs turned up. I gave a couple of presentations explaining the concepts of chronic pain, neuropathic pain, fibromyalgia and myofascial pain. In the afternoon he had some patients who clearly had chronic muscular pain and had definite trigger points. I was able to demonstrate trigger point injections and the patients were very happy. The GPs were very surprised that a simple intervention can make such a big difference to the patient's quality of life.

Lou Millington (GP in London and member of the PDCSIG committee) is planning to visit parts of francophone Africa with a charity called Hospice Africa France Soins Palliatifs (which, all being well, will be underway by the time this article is published). Her work will be focused on education and improvement of the palliative care and pain facilities in this under-resourced area. We hope to publish a report of her experiences on her return later this year.

PDCSIG Projects

By the time this article is in print, the SIG will hopefully have circulated a survey to BPS members aiming to detail their experiences of working in developing countries; we aim to publish this in *Pain News*. If this is successful we would like to survey other related groups.

And finally, if you have any items you would like to be included in further PDCSIG news round-ups or you would like to be involved in any of our work, please contact me via the BPS Secretariat.



News from the Acute Pain Special Interest Group

Dr Jane Quinlan *Chair, Acute Pain SIG, The British Pain Society* janequinlan@btopenworld.com

The British Pain Society's (BPS) Acute Pain Special Interest Group (APSIG) consists of nurses, doctors, physiotherapists and psychologists who see inpatients with pain rather than, or as well as, outpatients with pain. Although the name of the SIG – Acute Pain – does not reflect all that we do, acute post-operative pain constitutes much of our workload, both in its treatment and in developing guidelines and educating ward staff in its management. The ever-rotating carousel of foundation doctors and middle-grade doctors, along with constantly shifting ward nurses, means that improving post-surgical analgesia is a Sisyphean task. We optimise epidurals, nerve infusions and patient-controlled analgesias, and we protect patients in pain from junior doctors' sub-homeopathic doses of oramorph, and 80-year-old hypertensive kidneys from their liberal prescription of non-steroidals.

Gone are the days when patients were allowed to languish in our wards until they were healed and pain-free. NHS efficiency now means that patients are sent home earlier, still with pain and, with an out of sight, out of mind mentality, we assume they are fine. But if we struggle to educate hospital staff in safe and effective pain management, why do we expect patients at home to fare any better?

Many studies have shown that pain is poorly controlled at home following surgery. One, carried out by Watt-Watson et al.,¹ found that all patients contacted after day case surgery described their pain at home as being moderate to severe at some point in the first few post-operative days. Despite this, many patients took no painkillers, while those who did described high incidences of adverse events such as constipation, nausea and drowsiness. Only 50% felt that they had received clear instructions on how to take pain medications, but the instructions failed to provide strategies if the medications were ineffective or caused side effects. Some patients volunteered that their medications 'didn't do anything for my pain after day 1, so I stopped them'.

Bisgaard and colleagues² rang cholecystectomy patients at home every evening for seven days following surgery to ask about pain using a visual analogue scale (VAS) from 0 to 100. Predictably, median pain scores decreased as the week progressed, but some patients still had pain scores > 50 at day seven. A cumulative total VAS pain score (TPS-VAS), to reflect pain over the whole week, was then calculated and, when investigators contacted the patients a year later, they found that those with higher TPS-VAS (\geq median) were more likely to have ongoing pain a year later. It has already been recognised that severe acute post-operative pain appears to be associated with chronic post-surgical pain, but the importance of pain scores over the week following surgery, rather than just the day, is sobering. We should, then, be encouraging our patients to take more analgesia at home and provide them with alternative strategies if they encounter unacceptable side effects.

However, a word of caution: patients may underestimate the risks of simple painkillers. There has been recent media coverage of the death of a young mother following a liver transplant necessitated

by paracetamol-induced hepatotoxicity. She had been taking 'a few extra tablets' of paracetamol every day for two weeks after day case surgery. As a result of her death, her family called for paracetamol to be made a prescription-only drug, observing: 'Paracetamol can be fatal. But when you look at the packets, they don't look dangerous.' In 2009, a paper published by German toxicologists came to the same conclusion: that paracetamol and aspirin, both of which can be fatal in overdose, should be made prescription-only, as they pose an unacceptable risk to the general population.³

A review of over 660 patients published earlier this year by the liver unit in Edinburgh⁴ confirmed the dangers of staggered overdose compared to single time point overdose. Despite lower total ingested paracetamol doses, staggered overdose patients (24% of the admissions) were more likely to be encephalopathic on admission and they had higher mortality rates compared with those who took a single large overdose (37% vs 28%, $p = .025$). The reason given for repeatedly taking higher than recommended doses was stated as relief of pain in over half of the cases.

This risk is compounded by over-the-counter (OTC) combination analgesics where it may not be obvious that a formulation contains paracetamol, which may lead to unintentional supratherapeutic ingestion. An American study of patients attending an emergency department found that over 50% of patients were unaware of the maximum daily dose of paracetamol, while 50%–90% were unable to identify which of a list of trade-name compounds contained paracetamol.⁵

The risks are certainly there, but education is needed rather than wholesale withdrawal of access to analgesia. Alison Jones, a professor of toxicology working at the National Poisons Information Service, provided perspective by clarifying that 'less than 0.1% of the estimated 30 million paracetamol users in the UK attend hospital with a paracetamol overdose each year, and approximately 200 people die, most of whom presented late or did not receive antidote, N-acetylcysteine, within 12 hours.'

There is room for improvement in patient information to improve the safety and effectiveness of simple analgesia. APSIG members are well placed to develop the extension of care from hospital to home, and to educate and support patients, just as we do ward staff, in providing good quality analgesia while keeping patients safe. We are always keen to welcome new members to our SIG, so visit our (soon to be updated) page on the British Pain Society (BPS) website, email me or come along to the National Acute Pain Symposium, a wonderfully relaxed, educational and useful meeting.

National Acute Pain Symposium

The National Acute Pain Symposium is due to take place at the Crowne Plaza Hotel in Chester on Thursday 13 and

Friday 14 September 2012. This meeting has been underway for 22 years now and is the premier acute pain forum in the country. It is attended by 200–250 delegates each year, most of whom return time and again. The delegate list reflects the multidisciplinary nature of the symposium, with about half the delegates being anaesthetists of various grades, and the balance being acute pain nurses, recovery room nurses and high dependency unit (HDU)/intensive therapy unit (ITU) nurses. There is even the odd physiotherapist and pharmacist in attendance. The symposium attracts eight Continuing Education and Professional Development (CEPD) points from the Royal College of Anaesthetists. The informal and relaxed nature of the symposium is usually thoroughly enjoyed by all who attend. Chester, a beautiful and historic walled city, has been the home of the symposium for the past 12 years and is a favourite with the delegates. An informal delegate dinner is arranged at a local Brazilian restaurant and makes for a wonderfully relaxed and friendly evening. The Crowne Plaza Hotel is a first-class venue for the event, with delegates rating the venue, refreshments and lunches highly year upon year.

As always, the programme finds a balance between academic/scientific topics presented by the country's top authorities, and everyday pragmatic issues with daily practical application. A case report presentation is part of the programme with animated discussion from the floor. A poster competition attracts about 20 entries each year and provides an opportunity for those who have done innovative work to highlight their efforts. Prizes are on offer for the best three entries and winners are each given 10 minutes to speak about their posters to the delegates.

Topics scheduled for this year's meeting include presentations on: nerve block infusions after amputation; an update on new advances in acute pain

management; extended-release epidural morphine for enhanced recovery in colorectal surgery; an epidural-related case report with evaluation and discussion by a neurosurgeon; a presentation on the pan-European PainOUT benchmarking project; acute pain management in the accident and emergency (A&E) department; functional magnetic resonance imaging (MRI) scanning in acute pain; non-steroidal anti-inflammatory drug (NSAID) update; acute pain in the cognitively impaired patient; co-administration of opioid agonists and antagonists; assessment of pain; and use of nerve blocks in large animal veterinary practice.

Many of these presentations are by speakers of national and international repute – most of whom have spoken before at the meeting and who return to join us every couple of years. There is also a meeting of the APSIG of the BPS. If you would like any further details of the symposium, please contact Georgina Hall who will be delighted to give you any further information that you might need (tel: 0151 522 0259; email: medsymp@btinternet.com).

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News from the Science and Research Committee: Report on Clulow Award 2011

Mick Serpell

There were 11 applications for the biennial Clulow Award in 2011. This is a threefold increase compared to previous rounds. There were many excellent applications and it was a close-run affair. However, the committee is pleased to announce that the winning application was submitted by Prof. Gary Macfarlane

and his team from Aberdeen University, entitled 'The epidemiology of chronic pelvic pain in women'.

We have recently implemented recommendations from the Association of Medical Research Charities (AMRC), which has resulted in an increase in number of committee members from four

to ten. This was done to broaden the 'expertise' of the group and also to enable the exclusion of elected council members in scoring grant applications (on issues of conflict of interest). It is encouraging to see a healthy and competitive interest in the award, and we look forward to future application rounds.

Advanced nursing practice in pain management: Report from Parallel Session

Nurse members of the British Pain Society (BPS) hosted a successful and enjoyable session at the Annual Scientific Meeting (ASM) to explore current trends and barriers related to advanced practice in pain management. Co-hosted by Felicia Cox and Dr Emma Briggs, this parallel session attracted a large audience despite some tough competition from other sessions.

Felicia is Editor of the *British Journal of Pain* and is a co-opted member of the BPS Council because she also

represents the Royal College of Nursing (RCN) as Chair of the RCN Pain and Palliative Care Forum. She is the immediate past chair of the RCN London Pain Interest Group and keenly supports and mentors novice authors to write for publication. She leads a team of specialist nurses in an acute tertiary referral trust and has diverse research and clinical interests.

Emma is a lecturer at the Florence Nightingale School of Nursing & Midwifery, King's College London where

she leads undergraduate and postgraduate modules on pain and research. Emma is the Chair of BPS Pain Education and is the current chair of the RCN London Pain Interest Group.

This SIG session featured two presentations from nurses working at advanced practice level. The first speaker, Dr Gillian Chumbley, spoke about the challenges of the nurse consultant (NC) role and her current experience of undertaking postdoctoral research of post-operative pain as part of a clinical

lectureship supported by the National Institute for Health Research (NIHR) Clinical Academic Training Programme. Gill described the evolution of the NC role in 2000 as a means to try and keep experienced senior nurses within clinical practice.

The expectation was that the NC would have a Master's level qualification and the education should be career long. This role has four core functions:

- Expert practitioner
- Professional leadership and consultancy
- Education, training and development
- Service development and research

The main threat to the NC role at present is a lack of new posts, the loss of current posts and threats of de-banding – all viewed as a means of cost cutting. The lack of a clearly defined career pathway for nurses beyond the NC post or working at that advanced level of practice has led to few nurses applying for clinical or senior clinical academic posts. Other graduate professions such as podiatry and dietetics are encouraged to gain limited postgraduate clinical practice before undertaking postgraduate research qualifications. This contrasts sharply with what happens in nursing at present.

The second speaker, Dr Laserina O'Connor, is an advanced nurse practitioner and prescriber. She is a senior adjunct lecturer at University College Dublin and is the first nurse to be elected as the President (elect) of the Irish Pain Society. In her spare time she is the President of the Irish Pain Nurses and Midwives Society. She designed and coordinated the first MSc in Advanced Pain Management in the Republic of Ireland and outlined that students undertaking this award required 500 hours of supervised practice. She described her experience of undertaking her PhD as a 'double and reciprocal apprenticeship' and that

we should be aspiring to a doctoral-level qualification that fully acknowledges and rewards the groundbreaking work being carried out at the theory–practice interface in nursing and health care. Laserina clearly described that her vision of an advanced practitioner was one who advanced the science of nursing by undertaking research, demonstrated exemplary and autonomous expert practice, while being a pioneer and clinical leader. She also explored the importance of a community of pain practice where people with different experiences (novice, expert) and roles (practitioners, lecturers) worked collaboratively to enhance learning and professional development.

Following inspiration from both speakers, attendees broke into smaller groups to identify the key issues for the future of advanced nursing practice in pain management. A number of key themes emerged from the exciting discussion, including published documents that never translated into an implemented framework, a lack of leadership from the NMC, a plethora of titles for similar roles, coupled with a lack of understanding of specific post-registration qualifications especially from other disciplines. The notes of the meeting will be shared with those



present who provided their contact details. Please contact Emma (emma.briggs@kcl.ac.uk) if you wish to be included in the circulation list and help move the agenda forward in advancing nursing practice in pain management.

Felicia Cox and Emma Briggs

SMSness

Dr Arasu Rayen, Birmingham



My mobile phone contract is due for renewal. I have been discussing with my service provider the details of my next two years of digital detention, I mean contract. Apparently, I will get a free phone, unlimited texts, 500 megabytes of data and 600 voice minutes. Hang on. Did I say unlimited text messages? Who on the earth needs unlimited texts? Definitely not me! Do you need unlimited texts? If you say 'no', you may be surprised to know that in 2010 there were astonishing 6.1 trillion (192,000 per second) text messages sent across world networks. Last year, the networks around the world raked nearly \$114 billion just from SMS messaging mania! OMG!¹

Why does the world love texting? Apparently, texting helps you to perfect the way you communicate a message before you send it. You can also hide your emotions well (if you want to). It also helps a person to communicate from situations where telephone calls are not allowed (e.g. in a meeting). Texting also helps to boost the 'chemical romance' in your brain. It is

believed that the culprit could be dopamine, which causes the desire to text constantly as it is one of the chemicals involved in reward-driven learning. Among all ages, teens are the worst offenders. According to research, teens on an average send up to 60 texts a day.²

Text messaging – aka Short Messaging Service or SMS – is 20 years old. The first SMS was sent on 3 December 1992 over the Vodafone network in the UK. The message was 'Merry Christmas', sent by engineer Neil Papworth of the British technology company Sema. This was sent across wire and cable, not wirelessly.

I recently had a referral from a general practitioner (GP) with some abbreviations like 'pt', 'refrd' and more. Who knows what will happen in 2050? Abbreviation may be the norm in medical correspondence. SMS (or text) language may be accepted as a norm in day-to-day social and medical communication. You are (hopefully) reading this in 2012. Just fast-forward another 38 years ... Read the following letters from a GP and the reply from pain clinic (imaginary, of course).

If you cannot understand the SMS letters of 2050, please turn to page 136 for an ancient version of the same letters (circa 2012 version).

SMS in Medicine

- In the UK, many hospitals send SMS reminders to patients about their hospital appointments.
- In developing-world rural settings, information about drugs and diseases are sent to patients and health professionals in their own languages to help them to cross-check diagnoses and drug information.³ Déglise et al., in their review of SMS usage in the developing world, found

at least 34 applications to help in disease prevention.⁴

- PharmaSecure PAS India Ltd developed a system of printing unique, random codes with a private virtual phone number on each packaging unit of drugs. Consumers, on buying medicine, send the unique code to a virtual private number of PharmaSecure via SMS and receive instant confirmation of the drug's expiration date and authenticity. This is a cost-effective way of fighting counterfeit drugs.⁵
- Frontline SMS is an open-source, free software. Once installed, it helps the user to send and receive SMS to a group of people and collect and analyse data regarding the activity of the SMS usage. This has been used across the globe, but mainly in the developing world, in various projects to change the health of society.⁶
- Text to Change is a similar programme, but it uses the technique of sending health-related questions to patients. If the patients answer correctly, they are rewarded with mobile phones, phone credits and T-shirts. If they answer incorrectly they are sent the correct answer. Patients are also encouraged to visit the clinics.⁷
- Medic Mobile provides various free tools to exploit SMS technology for health services.⁸
- For secured SMS consultation there is TigerText. This gives total protection of the text consultation with your patients.⁹

SMS has come a long way in the last 20 years. The SMS language may take over the way we communicate digitally. Even though SMS had become part of everyday digital life, there are a lot of criticisms about the use of SMS language, especially by young children



THE BRITISH PAIN SOCIETY

Pain News
10(2) 84–85

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SAGE

Sundale 4m Surgery
11, Hellwington Road
Crowbar
Crown CRV1 18X

Dr. AL. V. S Kind, Dr VRY Nice, Dr VRY An Gry,

Dear Dr A Lone, 12/02/2050

Re: Jude Houston (DOB 09/10/1995), 145, Rise Lane, Coverdale, CRE 16C

Thk u 4 ur nput in 2 dis gntl man's care hu iz wel known 2 r practice. He cam 2 me like 3 mnths ago w sudn onst of lw bk pain wile he wz like workin in da grdn. Simpl pain killas nd phystrpy didn't hlp him rite. Nw hz pain hs xtndd 2 his rght butx nd sumtimes rdiatd 2 his rght leg. Evn tho he compls of probs w blada, on qstionin I found out dat it iz driblin rther thn incntence. He iz v much trubled bi dis pain @ nites 2 da xtnt dat he told me dat he hz not slept like 4 nrly fw wks. I lder wethr u cud luk @ him nd let me no ur plns 2 hlp im.

Plz snd dis pt bk 2 r srgery afta 2 vsits unls u blev dat he can't like b mnagd n prmry care clser 2 om.

PCM f u ned ne mo info.

Thanx

Ttyl bro

Dr VRY Nice

Dr A Lone
Da lly Pain Clinic
lly DGH
Da Lonli Place
Loose End LOL17V

Dear Dr Nice 10/12/2050

Re: Jude Houston (DOB 09/10/1995), 145, Rise Lane, Coverdale, CRE 16C

Thk u 4 sndin Houston 2 ma pain clnc. He cam 2 c me w lw bk pain of 6 mnths dration innit. Az u mntiond n ur leta da pain strtd whl he wz wrkin in hz grdn yh. Ther iz like sum radiatn of da pain dwn 2 da rght lg but it's nt asociated wid any pns nd ndles or nmbnss or anything. So 4 he has like trd smpl nd cmplx anlgscs, phystrpy, TENS mchine, chroprectic nd acupnetre widout mch bnfit, k. He nt only strgls wid his actvtes of dly livin rite, but da guy also has prblms wid slp yh. He has trd TCA but had 2 stp it cuz of sde efcts. He's a hyprtnsve nd he's like on ramipril 4 dat. He's rtired nd livs wid his wfe. Thers like no psychosocial ylw flgs in his hstry or anythin :/

Xamntion shwd dat he's wlkin wid a lmp nd stndin wid his rght nee flxd innit. Ther is no pain bhviour but ther is sum feer avoidnc. Flxion, rtation, sde flxion nd xtnsion in da lmbrrgion wre ltd. Plption ws pnful on da rght sde lwr lmbrrgion. Strate Lg raysin tst ws +ve on da rght sde @ 4ty dgres, innit. Ther is mld rduced snsation @ da rght L5 drmatom yh. Rflxs wer like nrml.

Afta da clnc I snt dis gntl man 4 MRI scn of da lmboscal spne wich shwd summat like disc prlps @ L5/S1 area cmpresion on da rght L5 nrv root.

In ma opnion, dis man's pain mai b cuz of da lmbrrgion disc disese wid sciatica. 4 his symptmtic pain relief I hav prscrbd him gbpntin nd bkdd him 4 root elevee injctn.

Thanx

Kk m8

Dr A Lone

Further Information

Web links to learn more about SMS language:

- <http://www.sms-text-guide.com/sms-text-language.html>
- http://en.wikipedia.org/wiki/SMS_language
- http://www.webopedia.com/quick_ref/textmessageabbreviations.asp
- <http://www.ego4u.com/en/chill-out/curiosities/sms-english>
- <http://www.netlingo.com/acronyms.php>
- <http://transl8it.com/>
- <http://www.2u2.co/sms-translator-abbreviation-translator.php>

Please turn to page 136 to understand these letters!

Acknowledgements

The author would like to thank his daughter for proofreading the first part of the clinical letters for correctness of SMSness.

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- 11 Moorhead J. Carol Ann Duffy: 'Poems are a form of texting'. *Guardian* 5 September 2011. Available online at <http://www.guardian.co.uk/education/2011/sep/05/carol-ann-duffy-poetry-texting-competition> (accessed May 2012)

and teenagers,¹⁰ but there are some supporters as well. Carol Ann Duffy, an English poet laureate, believes: 'Poems are a form of texting. It is the original

texting. It prepares the children for a lifetime of poetry.'¹¹ Currently, the use of abbreviations in clinical letters is not an accepted practice.



The threat to pain services and the continuing NHS reforms

Rajesh Munglani, Cambridge

The views expressed in this article are that of the author and do not necessarily represent the views of the British Pain Society or any of the organisations that Dr Munglani is attached to.



There is no doubt that we face a huge challenge as a country; the massive deficit that was calculated recently as £988 billion (63.0% of gross domestic product (GDP)) is unimaginable anyway but has been ballooned further, by the recent interventions in supporting the banks, to an eye-watering £2,311 billion (147% of GDP).¹ In one sense the recent economic/banking crisis has only highlighted what was happening previously. That is, a ballooning deficit that has been occurring over the last decade or so. It was not always the case; in fact national debt fell to 29% of GDP by 2002. It increased from 30% in 2002 to 37% in 2007. This was despite a long period of economic expansion; it was primarily due to the government's

decision to increase spending on health and education.

There has also been a marked rise in spending on social security; since 2008, due to the economic recession, the receipts have fallen while spending on unemployment and so on has arisen. The public sector net borrowing (PSNB) (annual government borrowing) for 2010/11 was £143.2 billion, or 11.7% of GDP. Due to financial stringency, the equivalent forecast for 2011/12 is £122 billion² and the government has indicated that it wants £20 billion worth of efficiency savings from the National Health Service (NHS) by 2015.

Why is the NHS the target for such cuts? In 2005 the Labour Party promised sustained investment in the NHS to deliver its commitments to reduce waiting times, expand the workforce and improve buildings and facilities. It made a specific pledge to triple spending compared to 1997 levels. Looking at the data from the King's Fund and the Department of Health annual reports in 1997/98, £33.5 billion was spent on the NHS, and in 2008/09 the NHS spent £96.4 billion. Taking inflation into account, this represented, according to the King's Fund 'expenditure in real terms by nearly 7% each year between 2000/01 and 2010/11 representing a higher sustained increasing funding since the NHS was established.'

In 2009 NHS spending stood at approximately 8% of GDP compared to the European average of 10%, but with inclusion of the 2% due to private care in the UK, we did approach the European level of expenditure on the NHS. By 2010 the NHS was spending £105 billion a year. The King's Fund further states that unfortunately this increase in expenditure has not led to a matched increase in productivity; in fact it quoted a reduction in productivity of 2.5% per year between 2001 and 2005.³

The coalition government has pledged to keep NHS spending at current levels but demographic changes alone will mean that anything up to £1.4 billion will be required simply to maintain the services. This does not take into account the inflation costs and costs of new treatment, which of course will diminish the ability of the NHS to maintain current services. The lack of productivity of the NHS is also strongly criticised by The Taxpayers' Alliance; a 2008 report, *Wasting Lives: A Statistical Analysis of NHS Performance in a European Context since 1981* by Sinclair and Sikora,⁴ states: 'The United Kingdom caught up with its European peers at a nearly constant rate between 1981 and 2004. ... The massive additional spending since 1999 has had no discernible effect on mortality rates.' The report also states

that the £9.8 billion extra spent during this period 'has largely been wasted'. In fact Professor Sikora mentions that in 2004, the latest year for which data is available, higher rates of mortality amenable to health care in the UK relative to the average of European peers led to (an extra) 17,157 deaths in that year.

According to Professor Sikora, the extra funding made no difference to the outcomes within the NHS, the piecemeal reform that had been going on was not a solution and wholesale radical reorganisation had to take place. In particular, he cited an example of the decentralised model of health care in Switzerland, where health care is managed by an independent sector free of political control and there is no equivalent NHS monopoly. He ends the executive summary section with:

The poor performance of British healthcare is not preordained. It is not a price we pay for ensuring that everyone gets the treatment they need, given that the other European countries this study has examined all look after the unfortunate. Failing to reform leaves British healthcare without the decentralisation competition and professional management that it so urgently needs. Ultimately, failing to reform the NHS costs lives.

Simplistically there are two issues at stake here: (1) *economic* – we need to save money; and (2) *strategic* – NHS spending in the past has not led to a sustained improvement in outcome. So there has to be a reform of the service if we are to manage with an ageing population and incorporate new technology and medical advances into our health care system. So, is the mantra that the NHS is an inefficient cumbersome beast an accurate picture?

Again looking at the data from the King's Fund, some of the extra money was spent on managers rather than front-line services. In 2009 the NHS



employed the full-time equivalent of 1,177,056 staff (1,431,996 headcount), of whom 42,509 were managers or senior managers. While the total number of (clinical) NHS staff increased by around 35% between 1999 and 2009, the number of managers increased by 82% over the same period, from 23,378 to 42,509.⁵ However, further reflection on the data may give rise to alternative conclusions. We have all seen that the capacity of the NHS to treat within a given target of 18 weeks has massively expanded. We do not hear the stories of people waiting years and years for hip replacements or cataract operations. While the target structure has lots of criticisms in terms of distorting clinical priorities including that in pain, I know personally of many people who are very thankful that within a period of a few months, the joint replacement they required was offered to them, bringing with it a massive transformation in their quality of life.

A recent article by Prichard and Wallace (experts in health and social care and economics) presented to the Royal Society of Medicine (RSM) revealed that the NHS is one of the most efficient systems in the world, when compared to other countries using a number of different parameters; it is in fact only second to Ireland. The USA had the example of the decentralised market-led system and had the highest expenditure and the worst mortality.⁶ The USA

spends 15% of GDP on health, while the UK in total spends 10%, as mentioned above. The *Guardian* highlighted this paper and illustrated some of its other facts:

dramatic NHS improvements have led to a situation where there are now 162,000 fewer deaths every year compared with 1980... the US suffers from a relatively huge bureaucratic burden needed to monitor the costs, behaviour and risks of customers, as well as the immense legal costs required to control payment.

Looking at elderly patients, the difference was even starker, with the best performers – Ireland, the UK and New Zealand – having health systems that were three times more effective and efficient than the worst – Switzerland, Portugal and the USA.⁷

While some areas of the NHS may not have improved, the overall conclusion is that the extra funding *has* been translated into an improved quality of life for the majority of the recipients of NHS care. This paper immediately raises the question: if the extra money that has been spent on the NHS has been put to good use, and the NHS really is one of the most efficient systems in the world, then where is the £20 billion of efficiency savings that has been marked for the NHS going to come from? In this context, while fully accepting the financial constraints that we will need to work under, the only way forward then is the rationing of health care or the wholesale removal of some services that were previously provided by the NHS. The RSM paper is significant as it also suggests that moving to a market-based economy may not actually produce savings; in fact it may do exactly the opposite in that more resources will be consumed by monitoring the system and payments, as in the USA.

Thus, we have a system whereby certain efficiency savings might be

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achieved by cutting back on the disproportionate increase in administrative staff such as managers who have been employed over the last decade or so by the NHS, but it does look like a lot of the other money has been spent efficiently on increasing treating capacity, bringing down waiting times and improving the lives of our ageing population. Attempting to achieve £20 billion in efficiency savings by 2015 (which of course is a political decision and has to be set against the amount that we spend, for example, on defence) is therefore going to result in a contraction of NHS services. There is no other solution! *Pain services in my opinion are particularly vulnerable to cutbacks; this is due to a number of factors.*

In an attempt to reduce costs, the new Health and Social Care Bill 2012 allows for 'any willing provider' to provide services to the NHS. Reassurances have been given that the competition will not be based on price, so that the NHS should be able to compete on equal terms with any other provider. But a closer look at the evidence suggests that there is going to be a forcing down of prices paid for services as one of the aims of the bill is a reduction in costs. By opening up the NHS to competition, invariably the pressure will be to provide more for less.^{8,9} Of course, money that goes to a private provider cannot end up in the NHS – but if the patient is being treated and gets the benefit, does it matter?

Due to the tariff system, certain services are seen to be more attractive than others. You will find very little evidence of independent providers willing to come in and take over acute medicine services that invariably make a loss. However, services that seem to attract a desirable tariff for a defined episode of care are likely to be cherry-picked by the independent providers. Unfortunately, it is clear that in hospitals, loss-making areas

such as acute medicine are often kept afloat by the tariff generated by other services such as pain.¹⁰ Indeed, the tariff structure has meant that there has been a massive expansion in pain services, particularly interventional pain services, over the last few years as hospital sought to increase income from the primary care trusts (PCTs).

In turn, the PCTs saw a massive rise in expenditure on pain services and therefore, in attempt to save money, have put up restrictions. This was well described by Dr Jenny Jessop, consultant in pain medicine, in a letter to the *Daily Telegraph* in 2010, with regard to a situation occurring in one area of England.¹¹ The situation has been accentuated by the report of the Audit Commission on Low Clinical Value services, which included, without discussion for consultation, all spinal injections.¹² This has given confidence to some PCTs to reduce expenditure on injection therapies despite the fact that there is a wealth of evidence of them helping a proportion of patients.¹³

The National Institute for Health and Clinical Excellence (NICE) has also got in on the act, by trying to limit the scope of medical activity by the production of quality standards and clinical guidelines; in addition, it has raised the bar at which a treatment is considered cost-effective. Thus, essentially what we are seeing is a reduction in the sort of clinical activities that the NHS will consider funding in the future. As it says on the NICE website: 'Commissioners to be confident that the services they are purchasing are high quality and cost effective.'¹⁴ Further, the Health and Social Care Bill 2012 instructs NICE to develop these standards and in fact to cover the entire range of clinical treatments. The task is huge, but the imperative to save money means that the ability to provide so-called ineffective treatments will be severely limited. Unfortunately the decision to label something as either ineffective or of low



clinical value is likely to be driven more by political expediency rather than clinical decision-making.

One way forward to reduce the risk of cuts to our specialty of pain management (the analogy with the goose that laid the golden egg becomes apparent) may be to reduce the tariff that pain services command so that they appear less attractive for cuts. The costs of outpatient pain clinics are so much more than simple physiotherapy or other services, that cutting pain clinic activity is a very attractive option for managers; for example, the paper by Carnes et al. published in 2008, which concluded an estimate between 4.0% and 5.5% of new patients in rheumatology, orthopaedics, occupational therapy and musculoskeletal physiotherapy and up to 90% in the pain clinic are people living with chronic pain. The cost of this care ranged from £296 for a course of physiotherapy to £1,911 for a patient seen in physiotherapy, orthopaedic and pain clinics.¹⁵ If the higher authorities and powers decided that the pain clinic activity is not clinically effective, particularly if the Audit Commission and NICE have ruled it, then of course why not offer them just physiotherapy rather than the more comprehensive multidisciplinary management?

There is increasing evidence that the PCTs along with private providers, when they take over the physiotherapy and musculoskeletal services (in an attempt to reduce costs and make a profit out of the tariff), then, what is actually provided is often a pale reflection of what was already provided on the NHS. This often means, for example, fewer physiotherapy appointments and/or a hands-off approach. This was highlighted in a recent newspaper article, which commented that due to an overspend, pressure was put on a private provider to reduce services by a PCT:

Patients could not get physiotherapy services unless they had seen their GP twice, with the appointments at least six weeks apart. Even then, they could only see a physiotherapist a maximum of twice and could not receive any hands-on treatment. Patients were only guaranteed one session of assessment, diagnosis and exercise prescription.

For some people in pain, that simply involved being shown how to do exercises or given sheets outlining postures that would best relieve their pain. Under Principia's (the private provider) cost-cutting measures, patients were only to see a physiotherapist for a second time 'if required'.¹⁶ Local general practitioners describe the service as ineffective and associated with very low patient satisfaction. The term 'salami slicing' comes to mind, which offers just a proportion of what is actually required.

The political ideology behind opening up the provision of NHS services as implicit in the Health and Social Care Bill, along with the imperative to save £20 billion by 2015, means that the pressure on 'any willing provider' to present a service that has been slimmed down is immense and of course the clinical risks to patients will inevitably increase. This has already been identified by civil

servants in a report that the current government does not wish to publish; see, for example, what was published in the *Guardian* in February this year:

What these devastating documents reveal is that, even though risks to patient safety have been identified, the NHS has not been able to mitigate them. The reason for this is simple: the government gave the NHS mission impossible when it asked it to save a massive £20bn whilst simultaneously dismantling it.¹⁷

A further way of saving money has been identified, that is by moving care into the community. Hospital care is perceived to be expensive compared to the numbers treated, and community care is perceived to be cheaper. The evidence suggests that patients do like to be treated in the community or at home, but the quality of community services is utterly dependent on the skill base of the staff in the community rather than simply the setting. There are real concerns that in certain situations, what is provided in the community may well simply be a pale reflection of a much more comprehensive service that was previously provided in hospital.¹⁸

The attacks on pain services are going to come from many sides – the simple imperative to save money; the current attractive high tariff that pain clinic treatments command; the questioning of the evidence base for treatment – which will make them an easy target both for cutting by PCTs and cherry-picking by any willing provider. The replacement of specialised pain clinics by (at times) less skilled musculoskeletal services and the moving of pain services into the community is going result in a very painful period for all of us involved in treating patients in pain (in addition to the patients themselves).

While I personally encourage the development of community-based pain

clinics, I strongly support the continued presence of more specialised hospital pain clinics. These multidisciplinary clinics will help manage the ever-ageing population with pain in a more cost-effective manner and to closely scrutinise the evidence base of treatments in an intelligent way. We have to make sure that assessment and treatment skills are effective and multidisciplinary in nature. The temptation to provide a veneer of service without providing effective clinical provision and exposing patients to risk and suffering is a very real possibility in the current climate. This has led to widespread criticism of the current Health and Social Care Bill by the public, the press, the royal colleges and many MPs. See, for example, the following recent quotes, all published in the *Guardian*:

... the Royal College of Nursing, the Royal College of Midwives and the Chartered Society of Physiotherapy joined the British Medical Association and the Royal College of GPs in calling for the entire bill to be thrown out. Dr Peter Carter, chief executive of the RCN, said that carrying out the reforms at a time when the NHS has been told that it must find £20bn in efficiency savings is quite simply the wrong thing to do.¹⁹

The Medical Royal Colleges and Faculties of the Academy of Medical Royal Colleges continue to have significant concerns over a number of aspects of the health bill. The medical bodies say that unless the proposals are modified, the academy believes that the bill may widen rather than lessen health inequalities and that unnecessary competition will undermine the provision of high-quality integrated care to patients:

The Academy and Medical Royal Colleges are not able to support the bill as it currently stands. The

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Academy is deeply concerned that the upheaval caused by the changes in the bill will distract the NHS from the huge task of meeting the current financial challenges.²⁰

In its recent highly critical report, the Health Select Committee said that hospitals were resorting to short-term 'salami slicing' as they tried to find £20 billion in efficiency savings by 2014/15:

The reorganisation process continues to complicate the push for efficiency gains. Although it may have facilitated savings in some cases, we heard that it more often creates disruption and distraction that hinders the ability of organisations to consider truly effective ways of reforming service delivery and releasing savings.²¹

In summary, we are going to go through a time of severe and painful change and pain services, in particular, are very vulnerable. In my opinion, the Health and Social Care Bill will not promote good health; it will bleed money from the NHS into private providers who will cherry-pick those services that are perceived to be profitable, thus fragmenting NHS care. There is real doubt over whether the private providers will be able to provide the quality of care in the long term, as they will need to make their service run at a profit. Lansley's ideological drive for competition will make it more difficult to actually save money without a radical reduction in actual service provision. The services that can be provided will be severely limited through the intervention of the Audit Commission and NICE. The Health and Social Care Bill is a ring that will rule us all!

The views expressed in this article are that of the author and do not

necessarily represent the views of the British Pain Society or any of the organisations that Dr Munglani is attached to.

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Time to listen and explain

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As all pain specialists know, patients attending pain clinics need extra consideration as they often come to us once all other specialists have failed to provide support. Charon, expert on narrative medicine, suggests that pain physicians are professionals who have learned to deal with defeat, but she also highlights that they need 'to exude optimism and hope, recognise the patient's fear that there is nothing more to offer and must realistically hold out at least a promise of accompanying the patient along his or her road of pain.' Our facial pain patients complete a series of pre-assessment questionnaires and one of these asks them to choose from 12 goals that we believe we can deliver on.¹ The most common goals chosen are to be given a diagnosis, to be reassured that they do not have a serious disease and to be given an explanation. Many also highlight improved communication between the doctor and patient. These are significant goals and require time to achieve. Our pre-assessment questionnaire also encourages patients to state their beliefs about their pain, their presumed diagnosis and add other comments. This often highlights entrenched beliefs, for example presence of infection, misaligned jaws, which are then difficult to change without a considerable input of time.

Once diagnoses are made, the clinician can start to provide an explanation and put forward a treatment plan with a prognosis. The British Pain Society (BPS) has suggested that complex patients should be allocated a one-hour appointment. How many clinics do allocate this amount of time? In our facial pain assessment clinic, we have insisted on 45–60-minute appointments

and validated the need for this through a patient satisfaction survey.¹ In answer to the questions 'Did you have enough time with the doctor to talk about what you wanted to? Do you understand the reasons or explanations that were given to you?' on a scale of 0 to 10, the mean to both was 8.5 (SD = 2).

There is a need for sufficient time, as well as a suitable environment, as both factors can have a significant impact on outcomes. We have pictures, some painted by patients, and an array of books and illustrations on our consulting desks in order to give patients the message that we listen and can provide them with more information.

To make a diagnosis and exclude serious disease, the pain physician has to take a careful pain history. Many patients often do not appreciate that a vast amount of information needs to be gathered about their pain, especially as they may never have been asked about it in such detail. The phrase we hear very often is: 'It's like a toothache but just in a different place.' We need to spend time listening to the patient and their description not just of the pain itself but how it affects activities of daily living.

As has been shown by a variety of studies, we interrupt patients' opening statements within a few seconds and often do not allow our patients to return to the topic. In pain consultations, the opening statements can be very long, which can include their previous consultations and the impact of the pain on their lives. We will often find that at the end of the opening statement we have very few facts about the characteristics of the pain but a great deal about the impact, for example 'ruined my whole life'. Some words that

patients use immediately suggest a diagnosis, for example electric shocks on one side of the face invariably end up being trigeminal neuralgia or a variant of that condition.

Listening carefully to the patients' social and family history will provide us with clues as to their beliefs, significant life events and their potential for self-management. The art of history taking is really about storytelling, which is our most basic means of communication. Patients tell stories to become who they are and their stories are addressed to us and therefore we must listen and become involved. As Greenhalgh and Hurwitz² state, narrative provides meaning, context and perspective for the patient's pain. Picking up cues and then reflecting them back to the patient shows that we are listening. This will improve our relationship, increase trust, potentially improve adherence and harness the placebo response. It will also enable us to personalise our explanation.

Giving explanations for pain is difficult. There is often a lack of public awareness about chronic pain and many health care providers have little experience in pain management. As Salmon³ points out, a considerable amount of time is now devoted to teaching communication skills, but techniques for giving the explanations remains largely untaught. Have we ever thought what impact the words such as heart failure or degenerating joints may have on our patients when they hear them for the first time? In order for explanations to be valid Salmon,³ suggests that they should fulfil the requirements listed in Table 1.

To achieve this, we need a range of materials from visuals, anatomical models, PowerPoint presentations, written



THE BRITISH PAIN SOCIETY

Pain News

10(2) 92–96

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Table 1

Requirements for explanations

1. **Should be plausible** – this involves emphasising to the patient that the symptom is real. It does not need to include a diagnosis. Attributions to physical, but non-pathological mechanisms, such as muscle tension can reassure the patients that the pain is not in their mind.
2. **Must be blame free** – we need to dispel any thoughts that patients have that they are to blame due to a weakness on their part, something that they have done or due to outside influences.
3. **Must address the patient's concerns** – this suggests that the clinician has listened, but needs to be individualised and matched to their beliefs and attitudes.
4. **Need to be based on evidence** as far as possible, or if this is lacking patients need to know this so they realise why explanations may change with time.
5. **Avoid controversy** and contradiction of what other doctors have said. This can be very difficult to do when there is a lack of evidence and there are no standardised recommendations. They can be dependent on the experience of the clinician and the speciality.
6. **Must be action driven** so that the patients become empowered and want to take control and manage their condition as far as possible.

Figure 1



information and website addresses. We hope that our detailed post-visit letters reinforce these explanations and GPs are

provided with ideas for further management and can reinforce the message. We use a structured template

to enable easier navigation through the letter.¹ Patients cannot absorb all the information that we provide them during the first visit and this will often need repeating. Providing patients with coping strategies in cases of flare-ups can further reduce fear and impact of pain on their daily living. There is evidence that chronic pain patients can be highly satisfied with their management despite little symptom relief. This relates to the health care provider's attitude in paying high attention to the patients' needs.

Do you have some explanations that work well for you? Here are a couple that we use, one of which was provided to me by Dr Frances Cole, Primary Care Pain GP.

Figure 1 shows a bus trying to negotiate its way through roadworks; in the distance we see the London Eye. The accompanying text could read as follows:

We are all on life's journey and have to drive our buses. Throughout our journey we meet many passengers; some come and go whereas others stay with us. One new passenger that has recently come on board is called

Figure 2



Pain. You did not invite him in. Pain decides to sit next to you. He distracts you, making driving even more difficult and diminishes your chances of getting to the London Eye. You need to ask Pain either to leave or at least move to the back of the bus where he is less distracting in order to reach your goal. How are you going to do this?

Figure 2, created by Deborah Padfield with a patient, is one that I use frequently to explain trigeminal neuralgia and the effect of uninsulated wires touching each other and generating ectopic sparks.

Complex chronic pain patients need patient-centred, evidence-based care that is delivered in a comprehensive consultation visit. If the visit addresses their goals, provides explanation and education about their condition and its management, and provides the necessary

resources in doing so, it will lead to high overall patient satisfaction. Patients need to be motivated to take control and make the most of further resources that can be offered by a multidisciplinary team in future reviews. We believe that the provision of adequate time should result in decreased utilisation of time and health care resources in the future and provide favourable patient outcomes.

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Variation in spinal cord stimulation commissioning: what does the Hospital Episodes Statistics database tell us?

Sam Eldabe, Middlesbrough
Simon Thomson, Basildon
Ganesan Baranidharan, Leeds

Spinal Cord Stimulation (SCS) was approved as a cost-effective treatment option for adults with chronic pain of neuropathic origin by the National Institute of Health and Clinical Excellence (NICE) Technology Appraisal Committee

in October 2008.¹ NICE stated in January 2012 that no new evidence exists to contradict the 2008 guidance, therefore SCS remains a highly cost-effective treatment with a cost per quality adjusted life year (QALY) of £10,480 for failed back

surgery patients (FBSS) compared with conventional medical management (NICE TAG 159).¹

In updated economic evaluations of the data from two landmark clinical trials used in the NICE Technology Appraisal,

Variation in spinal cord stimulation commissioning: what does the Hospital Episodes Statistics database tell us?

the incremental cost-effectiveness of SCS therapy compared with conventional medical management for the following types of chronic neuropathic pain were:

- £5,624 per QALY in FBSS patients²
- £3,562 per QALY in complex regional pain syndrome patients.³

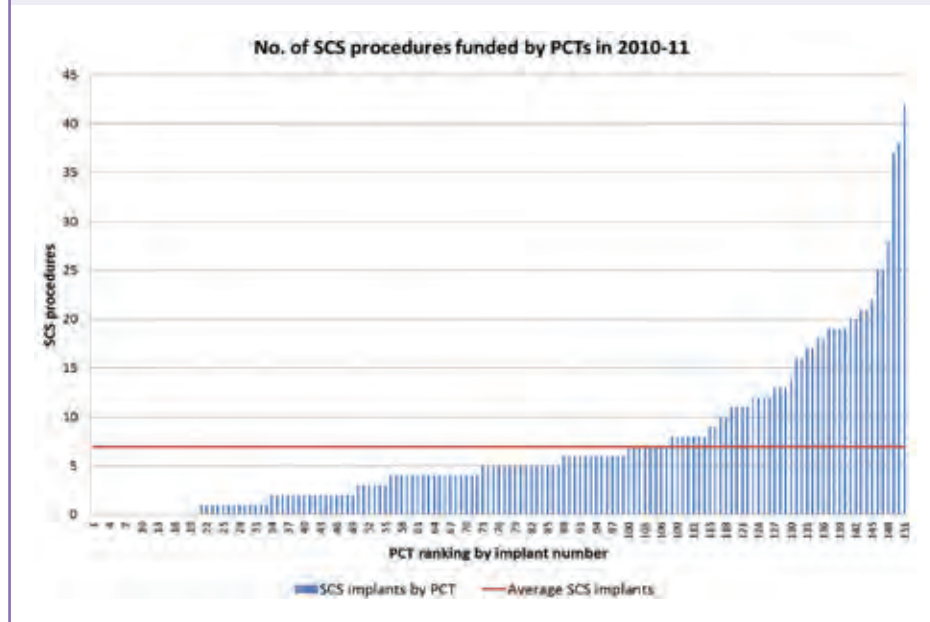
These recent data are comparable to the cost-effectiveness of a simple asthma inhaler, documented at £4,800 per QALY (NICE TA138).⁴ Further, they are substantially below the willingness-to-pay threshold of £20,000 per QALY deemed acceptable by NICE and across Europe, indicating that SCS should be prioritised as a highly efficient use of health care resources. Inconceivably, despite this robust evidence base, SCS was referenced in the Audit Commission's 2011 report on 'Reducing spending on low clinical value treatments' within the Croydon list of ineffective procedures,⁵ demonstrating a lack of understanding of this cost-effective therapy and an uncoordinated approach to SCS commissioning.

The UK prevalence of neuropathic back and leg pain is 5,800 per 100,000 population.⁶ Therefore, approximately 405,115 people in England and Wales suffer from neuropathic back and leg pain, costing approximately £2 billion a year.⁶ According to the Health Technology Assessment that guided the NICE Technology Appraisal for SCS, an estimated 4,051 patients a year would be suitable for SCS treatment if just 1% of the estimated chronic pain population were considered to be suitable for SCS in England and Wales.⁷ With approximately 1,050 SCS-related procedures undertaken annually in NHS England (2010–11),⁸ it can be assumed that only a quarter of the estimated 1% of the chronic pain population is currently being treated with SCS therapy.

In addition to low penetration rates, there remains an unjustified variation in

Figure 1

SCS procedures funded by PCT in 2010–11 (Hospital Episodes Statistics⁸)



implant rates across primary care trusts (PCTs), despite the publication of NICE TAG 159. Unwarranted variation has been defined as: 'Variation in the utilisation of health care services that cannot be explained by variation in patient illness or patient preferences.'⁹ The Department of Health has recently published the 2011 Atlas of Variation, a tool to help the NHS identify unwarranted variation in health care services across England.⁹ The Atlas highlights the amount that each PCT spends on clinical services and links this with the health outcomes of the local population. The Atlas is an invaluable tool enabling clinicians and commissioners to identify and take action against unwanted variation. The Atlas covers only a selection of health care topics, such as the rate of provision for hip replacement and rate of emergency admissions for epilepsy, yet it is pertinent to extend this approach to other areas, particularly where cost-effective treatments such as SCS exist and are underutilised.

The Hospital Statistics Episode (HES) database is a national statistical data warehouse for England of the care provided by NHS hospitals.⁸ The database also stores patient-level information on the specific procedures assigned to each PCT across England. Examination of the number of SCS procedures (including test procedures) undertaken during 2010–11 from the HES database indicates that at the PCT level there is a large variation across England with regard to the number of procedures commissioned (Figure 1).⁸ SCS procedure rates vary from as low as 9 per million in one region compared with 32 per million in another, with the average rate at 21.5 procedures per million across NHS England.⁸ The actual number of new SCS procedures varies from 0 (20 PCTs) to an upper level of 42 procedures per year, compared to an average of seven procedures across all PCTs. Heterogeneous commissioning policies and funding of patients via varying routes including the Individual

Variation in spinal cord stimulation commissioning: what does the Hospital Episodes Statistics database tell us?



Funding Request route may be giving rise to this unjustified variation in procedural activity.

The lack of consistent SCS policy-led commissioning not only leads to inequity of access and an increased administrative workload, it also indicates that in regions where SCS is being underfunded, other less cost-effective treatment options are being used. This promotes an inefficient allocation of resources in the provision of pain management services.

On the provider side, approximately 60 centres are currently offering an SCS service, yet only 35 centres are undertaking more than five procedures per year. This suggests that although access is not a barrier in itself, lack of capacity and low prioritisation of SCS on theatre lists within the existing centres is an important consideration that needs to be redressed. Provider-commissioner contracts that specify appropriate service levels together with dedicated theatre time will promote competency and efficiency. This will enable SCS to be prioritised in order that this cost-effective treatment is made more readily available

to NHS patients, with the resultant population health care benefit for this chronic condition.

In conclusion, appropriate and early referral of eligible patients to pain management services for SCS will deliver efficiency savings in the primary care chronic pain management budget. This needs to be supported by a criteria-based access commissioning policy informed by the NICE TAG 159, and reinforced by provider-commissioner contracts that ensure service levels and capacity are adequate to meet demand. Taken together, this approach will improve uptake and promote a more consistent adoption of SCS across England.

What is SCS?

SCS is a minimally invasive procedure involving the surgical or percutaneous implantation of a small wire connected to a power source, under the skin. Low-voltage electrical stimulation is transmitted to the spinal cord, reducing pain and replacing it with a 'tingling' sensation (paraesthesia).

What evidence exists for SCS?

There have been three randomised controlled trials, six systematic reviews and more than 70 non-randomised clinical studies for SCS in the treatment of chronic neuropathic pain. Systematic reviews of randomised controlled trials have concluded that SCS provides an effective therapy for pain reduction in failed back surgery syndrome (FBSS) and complex regional pain syndrome (CRPS).¹⁰⁻¹⁶

Acknowledgements

We wish to acknowledge Ms Natalie Middleton of Medtronic UK for bringing the HES data to our attention.

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Outcome of combined injection and physical therapy in managing persistent musculoskeletal pain

Akilan Velayudhan and Shyam Balasubramanian *University Hospitals Coventry & Warwickshire NHS Trust, Coventry*

Does the addition of physiotherapy improve the outcomes of injections? The authors explain their audit and stress the need for use of injection therapy in a multi-modal, multidisciplinary, patient-centred collaborative approach.



Musculoskeletal pain is a common cause for referral to the pain management clinic. In the UK, about 1 million people are on incapacity benefit due to musculoskeletal pain.

The total economic burden of back pain alone is about £12.3 billion per year. In 2007, the NHS spent £584 million on 67 million prescriptions for analgesics and anti-inflammatory drugs.

In the Coventry area, patients with musculoskeletal pain conditions are referred to an integrated musculoskeletal service run by the physiotherapists in the community. Those patients who either do not respond to physical therapy or cannot comply with the treatment are referred to the hospital-based specialist services. In the pain management clinic, a range of

pharmacological and injection therapy interventions are offered for symptom relief and functional rehabilitation. We conducted an audit to assess the outcome of injection therapy for a variety of musculoskeletal pain conditions followed by post-procedural physiotherapy input.

Forty-three patients with different musculoskeletal pain problems such as low-back, neck and shoulder pain were included over a period of six months. Selection criteria included well motivated patients aged 20–50 years in active employment without major psychological issues. They had already been through conservative management prior to referral to the pain management clinic with limited benefit. Depending on their presentation, they underwent various injection procedures. Post-injection physiotherapy

was organised. Visual Analogue Score and Subjective and Objective Numerical Outcome Measure Assessment were used before the initiation of the treatment and following completion of a course of post-procedural physiotherapy.

The results are shown in Table 1.

As our audit reveals, a good proportion of patients who originally failed to respond to physical therapy did well with a combination of injection therapy and post-procedural physical therapy. Instead of using injection therapy as an isolated intervention in managing chronic pain, by judicious application as a part of a patient-centred rehabilitative approach, it has a valuable role in symptom management and facilitating functional restoration. Our audit finding supports the notion for a collaborative approach in effective pain management.

Table 1

Patient outcome after six months

Outcome	Number of patients (N = 43)
> 50% improvement	12
25%–50% improvement	10
< 25% improvement	2
No improvement	9
Did not complete the treatment	10



The Pain Management Plan

Frances Cole, Polly Ashworth, Laura Coote, Emily Toomer, Patrick Hill, Eve Jenner and Robert Lewin

The authors describe a new tool for use to help patients with persistent pain, the Pain Management Plan: a brief, cognitive-behavioural, manual based, self-management programme, facilitated by trained staff for people with long-term pain.

Background and Aims

The Chief Medical Officer has reported that every year 5 million people in the UK report long-term pain. In a recent survey only 14% had been referred to a specialist clinic and a tiny percentage of these were offered a multidisciplinary pain management programme: 'Very few respondents in our survey reported having been exposed to effective pain management strategies.'¹

It seems very unfortunate that there is so little help for the majority of people living with pain and likely that many more might benefit if they were able to try some simple pain management strategies. It is common for people completing a pain management programme (PMP) to say 'if only someone had told me all this earlier!' and intervening earlier in the 'pain cycle' might prevent some people's descent into a life dominated by pain.

A similar problem, too much demand, too few multidisciplinary programmes and a one-size-fits all policy, had existed in cardiac rehabilitation. It led to the development of brief, facilitated, cognitive-behavioural interventions.^{2,3} A recent Cochrane review concluded that these self-management programmes can be as effective in cardiac populations as hospital-based, group multidisciplinary team (MDT) programmes.⁴ Currently around 20,000 cardiac patients a year use the Heart Manual or the Angina Plan

and about 4,000 health care staff have trained as 'facilitators'.

We wondered if a similar resource could be developed for people with long-term pain. Our aims were to:

- increase the number of people receiving treatment for long-standing pain
- increase the number of ways to access pain management
- provide an option for people who do not need a full MDT programme
- make better use of specialist skills, reserving these for more complex needs
- offer an alternative method for people who cannot, or do not want to, take part in a group-based outpatient programme.

Together with our MDTs, we created the Pain Management Plan (PP) and pilot-tested it by adding it to the options being offered in each of our three pain services, in Bradford, Birmingham, and Gloucestershire and Herefordshire.

The Pain Management Plan

The PP is a workbook divided into two sections.

Part one introduces the ideas of self-management and addresses the common misconceptions that can lead to the pain cycle. It illustrates the key skills of pacing, goal setting and stress

management. A CD of relaxation, breathing and other stress management techniques is included.

Part two starts with a 'Menu' of information and self-management techniques, allowing the participant to generate solutions for issues that trouble them, such as:

- pain flare-ups
- sleep problems
- anger
- relationship problems
- the correct use of medications
- worry (anxiety)
- low spirits (depression).

The PP is written to engage people with quizzes, short vignettes of pain management stories, cartoons and humour. It has a readability quotient equivalent to a 9–10-year-old reading level (Flesch-Kincaid formulae).

The PP can be used in a number of ways but the key elements that must be observed are as follows:

1. A clinical assessment, to ensure that there are no medical or psycho-social contraindications.
2. A first, face-to-face meeting with the facilitator and, if the person agrees, his or her partner or a significant other. The aim of this meeting is to develop rapport, discuss what the participant wants to achieve, and to introduce the PP and set some initial

goals, including trying the relaxation and breathing CD.

3. A series of brief contacts, these can be face-to-face, by phone or in small groups to discuss and reward success with the goals, solve difficulties, discuss increasing the goals and 'signpost' the person through the 'Menu' in Part 2 or to external services.

The evaluation

The evaluation ran from April 2011 to January 2012. Each participant was asked to complete pre- and post-treatment measures, the Pain Disability Questionnaire (PDQ)⁵ and the Pain Self-Efficacy Questionnaire (PSEQ).⁶ We also collected information on people's experience and views about the PP using a specially written questionnaire (reported in the accompanying article).

Results

Data were collected for 88 participants, the mean age was 47.5 years with average pain duration of 10.8 years,

88% were female, and the average school-leaving age was 16.8 years. Reasons for referral to the pain services included: musculoskeletal (55%); fibromyalgia (20%); rheumatology (10%); others (including gastroenterological, neurological and unknown, 15%).

Seventy-five per cent of participants completed the whole of the intervention. Reasons for not completing included: intervening life events (e.g. diagnosis of cancer; moving to a group-based programme; literacy and dropout). People completing the intervention had an average of 4.5 contacts and a mean total duration of 2.9 contact hours, either face-to-face or on the phone or a mixture of both.

Disability as reflected in the PDQ scores was significantly reduced from a mean score of 85 prior to the intervention to 66 after ($p > .001$) (Figure 1). Self-efficacy (PSEQ) significantly improved from a mean score of 28 to 37 post-intervention ($p < .001$). Participant feedback is reported in the accompanying article. There were no gender differences in benefits or satisfaction with treatment.

Limitations

This was not a randomised trial and so we cannot be sure if these changes would have happened without the PP; however, left untreated, most people do not experience a rapid improvement in pain-related disability. The great majority of participants were very satisfied with their treatment. The PP uses the same cognitive-behavioural and self-management delivery methods that have an established efficacy from large multi-centred trials.⁴

It is part of the method of the PP to signpost people towards the help they need and a few people were given additional exercise advice and other medical interventions alongside it; these interventions may also have had an impact on the outcomes.

Figure 1
The reduction in Pain Disability Questionnaire scores

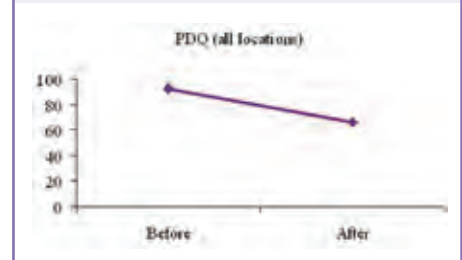
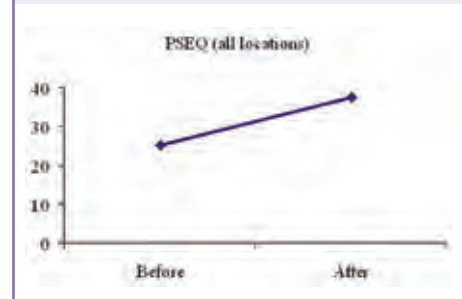


Figure 2
The improvement in Pain Self Efficacy scores



Discussion

Some people seeking help with pain will prefer, or need, a group-based programme, but others will prefer to work on their own or will not need or want to attend a resource-intensive, multidisciplinary, group programme. Another group of people will choose the PP because they are unable to fit their life around attending an outpatient group programme.

Many pain services are keen to extend their service. We believe that the PP will be another way in which people can access the key messages of pain management and that a flexible, stepped-care model, triaging according to need, is likely to prove attractive to commissioners. We intend to continue to use and develop the PP and we are testing other ways of delivering the intervention, for example using it in brief

Additional Information

The Pain Management Plan: how people living with pain found a better life. The things that helped them and the things that set them back.
ISBN: 978-0 9566628 0-4

Single copies are available on Amazon at £12.99 per copy. For health care providers it is supplied in boxes of 15 at £7.00 per copy (with further reductions for larger quantities).

Look inside, download a brochure, read FAQs or order from <http://www.Npowered.co.uk>

For details of staff training please contact Dr Frances Cole at frcole@btinternet.com

The Pain Management Plan



group meetings and using the PP within a traditional MDT PMP.

The PP, like most self-management programmes, probably works best for

people who have accepted that there is no further medical investigation or treatment available and who are keen to find better ways of managing their pain.

However the PP is used, some additional training is important because for many health professionals it represents a very different way of working. We have developed a one-day training programme for pain teams or individual staff wishing to use the PP. We have already provided several of these events, which have been well rated on anonymised feedback forms, and the PP is increasingly being taken up in other pain services. Further information about the training and the PP, including a 'look inside' can be found at <http://www.npowered.co.uk>

Conclusions

The pilot demonstrated that the PP can be successfully implemented by trained staff within an established pain service.

Clinical outcomes and user feedback are encouraging and the efficiency and effectiveness of our pain services has

been enhanced.

The PP does not replace a multidisciplinary PMP. It is an additional tool to improve people's access to pain management support and a cost-effective way to help 'motivated self-managers'.

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The users' experience of the Pain Management Plan

Emily Toomer, Laura Coote, Polly Ashworth, Frances Cole, Patrick Hill, Eve Jenner and Robert Lewin

In the previous article, we described a new tool for use in pain management programmes, the Pain Management Plan: a brief, cognitive-behavioural, manual based, self-management programme, facilitated by trained staff for

people with long-term pain. An accompanying quantitative assessment showed that it significantly reduced disability and improved pain self-efficacy. We also wanted to know what the people using it thought about it.

Method

A questionnaire about the Pain Management Plan (PP) was administered, comprising two sections. The first asked closed questions, such as 'Was the PP explained clearly?' or

'Would you recommend the PP?'. People were presented with four possible responses: two positive, 'yes' and 'mostly yes'; and two negative, 'mostly no' and 'no'. They could also answer 'don't know'. We scored the answers from 4 (yes) to 0 (no). As we could not tell what 'don't know' may have meant, we have assumed the worst, that it meant 'no' and added the 'don't know' to the 'no' responses.

The second section asked open-ended questions such as: 'How has the Pain Management Plan helped you or why wasn't it helpful?' Two of the authors (LC, ET) independently read all of the verbatim responses looking for common themes. These were discussed and differences were settled by discussion.

Results

The closed questions

Fifty-seven (65%) participants provided complete answers to Section 1. Adding all of the questions showed a positive satisfaction level ('yes' or 'mostly yes') of 93%. The highest possible satisfaction total a person could score was 21 and the mean score was 19 (SD = 2.1); 40% of people scored 100% satisfaction (Figure 1).

The open-ended questions

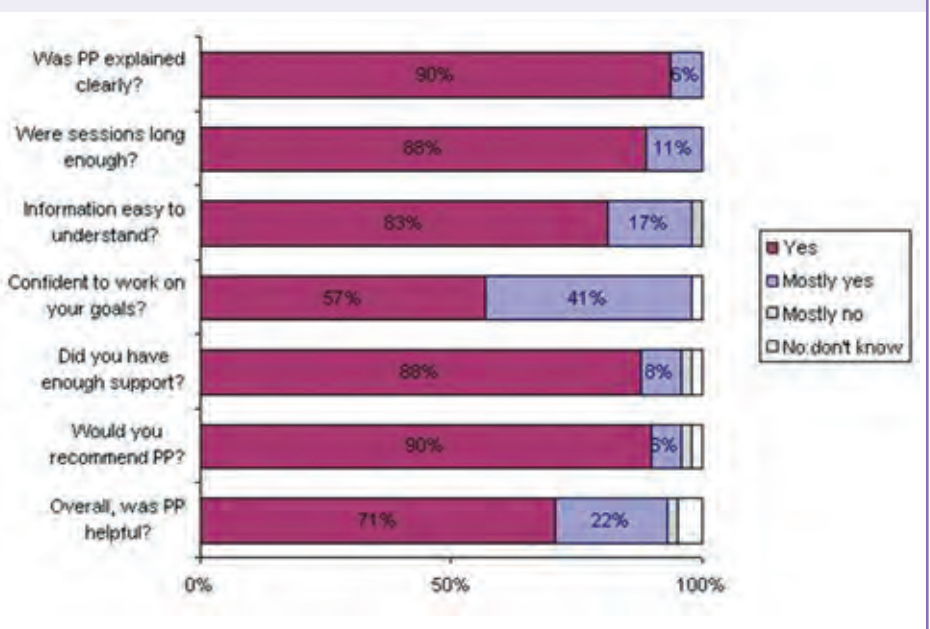
How has the Pain Management Plan helped you or why wasn't it helpful?

There were three common answers: being provided with an opportunity to talk to someone who could validate and explain their experience, being made aware they were not alone and how easy the PP was to follow.

What was the best thing about the Pain Management Plan?

Most of the answers to this question were repeats of the previous responses; several others mentioned the relaxation CD.

Figure 1 Responses to the closed questions on the satisfaction questionnaire (N = 57)



What was the worst thing?

The majority of respondents could not think of a worst thing. Six people reported difficulties with the acceptance of their pain. Problems with the relaxation and concentration exercises were reported by 5%. Other comments were on aspects of the delivery of the intervention unrelated to the PP, such as the time of the appointments or the cost of parking at the hospital.

How do you think we could improve the Pain Management Plan?

Sixty-three per cent of participants could not think of any improvements. Some suggested ideas such as facilitating the PP as part of a small group. Several commented that the PP should be made more accessible to people living with pain.

Do you have any other comments about the Pain Management Plan?

The most common response was that the PP had helped them. Others used the opportunity to report things such as

bereavement, which may have posed setbacks in their personal use of the PP.

The overarching themes

Eight themes were identified:

- Support and validation for the experience of living with pain
- Improved understanding of pain mechanisms and coping strategies
- The PP as a continuing resource after the end of the 'programme'
- The practicalities and constraints experienced in using the PP
- Understanding how mood, thoughts and beliefs alter the experience of pain
- The value (and occasional problems of) relaxation and the CD
- Success with goals and motivation
- Pacing techniques

Support and validation

A large number of respondents (26 out of 57) felt that the PP validated their experience of living with pain.

The users' experience of the Pain Management Plan



[It] gives examples of other pain sufferers' experiences and solutions which I could identify with, and use myself.

It made me realise that there are other people out there that suffer like me, and that it wasn't just in my head.

People 'felt believed' by 'the encouragement and support' and having 'someone to talk to, instead of being talked at'.

Improved understanding

Comments included:

It helped me understand my pain better and how to deal with it.

Understanding my medication and being given options.

It helped me identify how I was making it worse or magnifying it.

Resources

Most comments supported the idea that the PP will remain a useful and helpful reference for a long time. It was described as 'written in a light-hearted

but sensible way – not scary or boring like some textbooks can be.'

It was easy to understand:

... [it] helped me a great deal by simply following the easy instructions in the book.

Having the book there 100% is like having someone on tap... you don't feel like you're putting on anyone.

I have felt it to be a lifeline when I have been struggling.

If you lose some of the skills you can go back to reading, using the plan as many times as you need to.

One patient reported a negative experience:

I didn't find some parts of the book that helpful. Information not detailed enough... there were quite a few mistakes and grammar errors.

Practicalities and constraints

The PP worked for the great majority but some comments provided suggestions, for example 'email or text' might improve

communication. Four proposed the idea of the PP in group sessions.

Some highlighted the convenience: 'I couldn't make the classes in person so you did it over the phone for me, great stuff' and 'not time consuming'.

Mood and thinking

Most comments reported positive changes:

I now have a bit of positivity in my life.

[It] helped me... work out my thinking, change negative to positive.

[A]fter the first appointment I started feeling better.

Another reported being:

... a lot happier. Not as depressed. Able to manage pain a lot better.

For some the experience was noted as challenging:

[I] felt frustration towards the pain of how it had interfered with my career, learning to accept that my plans had to change was challenging.

But many suggested that the challenge was worth it:

It helped me to say "No" and not feel guilty.

I therefore placed the pain and all its effects as my responsibility. I had brought it all on myself. The course and one on one sessions enabled me to see that this was not the case.

Relaxation

For some, the relaxation CD was the best thing. One described the relaxation techniques as 'Simple but manageable'. Only three patients had negative comments: 'I found it wasn't deep enough for me'; another 'found it too relaxing, felt like I was wasting time!'

The users' experience of the Pain Management Plan



that unless they have the discipline of attending they will not be able to stick to their goals. Some people suggested combining both approaches and using the PP in a group setting; in Birmingham and Gloucestershire, we are following this idea in a pilot study.

Conclusion

The messages from the participants were clear: the great majority of people found the PP helpful in lots of different ways and would recommend the plan to others. There were few requests for improvement. The PP is not suitable for everyone but for those who can self-manage and have accepted that doing so is their only way forward, the PP is a welcome resource.

Goal setting

Goal setting was appreciated, with comments including:

The set your own goals plan is very good.

At first I found it was difficult to write things down as it looks stupid. My goals looked very small I have lately realised that writing things down is a help.

Pacing and other techniques

Comments included:

Helped me recognise that by taking breaks in between activities helps me to achieve so much more.

[The PP is] making me stop and look at myself – slow down and not try to overdo [it] – Tomorrow is another day!

Discussion

There is always a tendency for people to want to please those who have helped

them but the feedback was anonymous and overwhelmingly positive. There were, of course, a few who were not fully satisfied and the majority of negative comments and the 'mostly no' or 'no' scores on the questionnaire came from just one or two individuals. The PP was clearly not for them. The PP can be used in a number of ways but personal choice should be the main determinant. Some people will not attend a group however bad their pain; others know



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Mask:Mirror:Membrane

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THE BRITISH PAIN SOCIETY

Pain News

10(2) 104–111

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SAGE

face2face: What can art bring to a clinical context and medicine to a gallery context? Can an exploration of facial pain inform our understanding of portraiture and vice versa?

I am all day long fighting with pain ... It is a face so contracted and immobile.

The face is to express pain, to express happiness, to express joy. I think the face is a way of expressing ourselves even more than gesture. ... Everything can be expressed by the face. Tears, smiles, joy ...

Francine Ozarovsky in *Facing Pain* (Padfield 2011)

The face is the *membrane* through which we navigate the world; it negotiates between our personal thoughts and feelings, and their expression in the outside world – that is, between subjectivity and inter-subjectivities. But what happens when that face no longer expresses the feelings behind it in a way that others can read? The thoughts above, voiced so eloquently by facial pain sufferer Francine Ozarovsky, express the conflict between what we expect from the face and what in reality it can be for those in pain. Issues of communication, already inherent to the pain experience, are exacerbated when this ‘canvas’ normally used to express it, the face, is itself in pain. Unable to convey in a manner that others can comprehend, the face can become a contested and painful place, increasing the isolation of sufferers. It becomes either a *mask* hiding the emotions behind it or a frozen *mirror* reflecting the projections of others. What has been rewarding and fascinating about the *face2face* project,

and the resulting exhibition, *Mask:Mirror:Membrane*, has been bringing together so many different perspectives. If Scarry¹ is right, and pain’s resistance to language is achieved ‘in part through unsharability’, then this project and exhibition is an attempt to reduce such unsharability, using art to catalyse new discussion around a concept as slippery and difficult to communicate as pain.

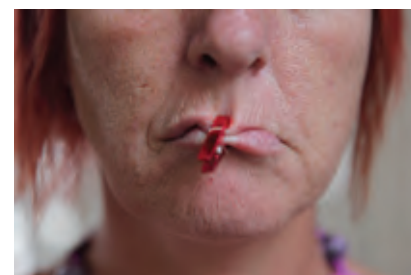
The face2face project at UCLH

Facial pain is common. Up to 7% of the British public suffer from chronic facial pain at some point in their lives and in 70% of these, it has a significant impact on their quality of life. It affects many aspects of social functioning such as talking, drinking, eating and kissing, causing patients to withdraw from social action, increasing their distress and isolation. Most aspects known to be so distressing for those with chronic pain are also present for those with chronic facial pain but with an exacerbated impact on communication and loss of identity.

Face2face is an interdisciplinary collaboration between myself (artist and pain sufferer), facial pain specialist Prof Joanna Zakrzewska and pain clinicians and patients from University College London Hospitals NHS Foundation Trust (UCLH). It builds on my previous research with Dr Charles Pither, *Perceptions of Pain*,² at Input Pain Unit, St Thomas’ Hospital, which argued that visual

Figure 1

Photograph by Deborah Padfield with Liz Aldous from the series *face2face*
© Deborah Padfield



images, particularly photographs, can provide an alternative visual language for communicating and externalising the subjective experience of pain. Many of the British Pain Society (BPS) members took part in this earlier study launched at the International Scientific Meeting in Manchester 2004, and their feedback has been invaluable in guiding the direction of our subsequent research and validating the need for further investigation.³ Our hypothesis was that a visual language might be able to address some of the limitations of existing numerical and verbal measures. How for example can you constrict the image and sentiment below, onto a scale of 1–10 (Figure 2)?

The *face2face* research is continuing to demonstrate that visual images can reinvigorate verbal language and vice versa, in both a clinical and gallery

Figure 2

Photograph by Deborah Padfield with Rob Lomax from the series *Perceptions of Pain* © Deborah Padfield



setting. In the clinic the image provides a shared reference point from which to negotiate meaning through language; in the gallery the viewer similarly moves between image and testimony, reinvigorating both. Artist and researcher Jane Wildgoose eloquently described this process when she reviewed the *Perceptions of Pain* exhibition for the *The Lancet*:

Concentrating from the outset on visual language, the project also successfully reinvigorates verbal narrative. The photographs are powerful and compelling; they draw you into an imaginative world that is not always immediately comprehensible and lead the viewer to the text for more insights, and then back again to the image ...

Wildgoose 2002, *The Lancet*

Methods: Overview of the face2face project

The *face2face* project has several strands through which it explores the ways in which aesthetic spaces can allow access to other ways of 'knowing' and communicating pain:

1. The co-creation of images of pain with facial pain sufferers at different

Figure 3

Photograph by Deborah Padfield with Alison Glenn from the series *face2face* © Deborah Padfield



Figure 4

Photograph by Deborah Padfield with Yante from the series *face2face* © Deborah Padfield



points as they progress through pain management.

2. The integration of a selection of these images into a pack of pain cards for clinical use.
3. Research into the effect of using these cards within NHS pain consultations, video recording their clinical use by a variety of different pain specialists.

4. Art workshops for clinicians and patients to attend together, delivered in association with the National Portrait Gallery between October and December 2009.
5. The creation of a new film exploring experiences of having and treating facial pain.

The first strand of the project aims to co-create images in one-to-one workshops, which give tangible visible form to each person's unique subjective and invisible experience of pain. Jo Spence⁴ spoke powerfully about the sense of control brought about by the reversal of the gaze through control of the lens). Similarly, patients who co-create images directly control how their pain is visualised and represented to others, and this increases their control over the experience, in contrast to being placed on the passive receiving end of a medical gaze, however well intentioned. The hope is that the process of co-creation and negotiation can spill over into a more negotiated dialogue within the consulting room, encouraging elicitation of the most significant and disturbing aspects of the pain experience for that individual, contributing in a concrete way to current ideals of patient-centred care.

The gallery space

The *Mask:Mirror:Membrane* exhibition at the Menier Gallery in London, July 2011, comprised of 40 large photographs of facial pain (100 cm x 67 cm); patient self-portraits and testimonies; a selection of drawings from clinician/patient workshops; and a new film made in response to working in a facial pain environment, exploring intersects between patient and clinical perspectives. The exhibition was a chance to reflect on the material we had produced together and to see the products of different strands of the project in dialogue with each other. It

Mask:Mirror:Membrane

was also an opportunity for further discussions between other patients, health care professionals, practising artists and academics at the forums and interdisciplinary seminar.

One of the challenges of a move from a clinical to gallery space is resisting the desire to pin down the meaning of photographs to the individual narratives that catalyse them. At the same time it is imperative to value the very personal narrative and painful experience out of which these images have been carved and without which they could not have been born.

One participant in the gallery discussion commented that in an age of spreadsheets where everything is analysed in terms of evidence outcomes, it was refreshing in this exhibition to be able to make 'that personal connection and to see the subjectivity involved'.

At the artists forum accompanying the exhibition, academic and curator, Dr Emma Chambers, noted how often images with medical subject matters become more medicalised when they are translated into a gallery setting. Her explanation was that 'often the notes are written in medical language, so the sense of collaboration which comes out of this exhibition, and which pervades all the artworks and the texts here can often be missing.' She observed that viewers generally are more interested in the narratives and interaction between the visual image and a life narrative than in medical explanations. What she valued in our exhibition, she said, was that the viewer was able to see both the symbolism of the image and to read the narrative of the patient. She described *Mask:Mirror:Membrane* as an important model for how exhibitions dealing with medical subject matter should be presented.

The way we had curated the exhibition meant that viewers would see the large photographs as they entered the gallery, unaccompanied by text, so they would

Figure 5

Photograph by Deborah Padfield, *Mask:Mirror:Membrane* exhibition, Menier Gallery © Deborah Padfield



Figure 6

Photograph by Deborah Padfield, *Mask:Mirror:Membrane* exhibition, UCH Street Gallery © Deborah Padfield



be free to project their interpretations onto them and then move to the back of the space where the smaller images depicting the 'patient journeys' were accompanied by patient testimonies.

For some this was problematic: they felt much of the power came from the personal narrative and they wanted it from the outset. For others, such as photographer and therapist Rosy Martin, it allowed a space for the audience: 'I like the way it's hung, I like the way I can appreciate the images and then read the story.' She went on to emphasise the importance of a space for the viewer:

Figure 7

Photograph by Deborah Padfield, *Mask:Mirror:Membrane* exhibition, Menier Gallery © Deborah Padfield



Figure 8

Photograph by Deborah Padfield with Alison Glenn from the series *face2face* © Deborah Padfield



Figure 9

Photograph by Deborah Padfield, *Mask:Mirror:Membrane* exhibition, UCH Street Gallery © Deborah Padfield



To me this is not a traditional portrait at all, it is storytelling through metaphor, through association, and there is a lot of openness offered so in that sense the work is very mediated. It gives me the space to enter it, as it isn't overly determined. It has to be open enough to speak to an audience.

The comments cards left by visitors to the exhibition gave us an idea of the impact of the images on viewers – those who walked in by chance, those who came specifically because they lived with, treated or made images of pain, as well as those in allied fields and those who had participated in the project. Taken together they make one feel that all the hard work, and the creativity and courage of all those who took part to raise awareness of facial pain, has been worth it. Time and time again visitors asked for the work to be made more widely available and to tour beyond London:

Walked in by accident immediately struck by the pain experienced by those I knew who suffered too much and died too young (including my wife age 43). Wonderful and thoughtful.

Powerful and sensitive exhibition ... I think it could be an extraordinarily effective way for communication between patients and clinicians in every field of medical pathology and would love to see the idea rolled out across the NHS.

The use of visual imagery is more profound and more specific a way of communicating than the traditional face-to-face verbal exchanges/rating scales.

Pain cards – an excellent tool.

The opportunity to meet and question and listen has been brilliant.

Figure 10

Photograph by Deborah Padfield with Alison Glenn from the series *face2face* © Deborah Padfield



Figure 11

Pain cards © Deborah Padfield



An excellent interesting insight into facial pain I will try to incorporate this into my clinical practice.

Exceptional ... This work should really be shown to a wider audience.

Visual images unpack how it feels – language isn't enough and is very final. Images allow growth.

Was the most amazing project to have been involved in and I hope that in some way it can help others to describe their facial pain.

The exhibition subsequently returned to a clinical context when it moved to the Street Gallery, University College Hospital (UCH), a busy hospital corridor, where its reading inevitably re-transformed.

The Clinical Setting

A new aspect of the process since *Perceptions of Pain* was the introduction of a sense of journey, of seeing patients not at one, but several points in their treatment/management path. Psychologists from Input Pain Clinic had wondered if there was a danger in leaving people stuck with very distressing images of their pain. The idea in *face2face* was to reflect the positive changes people make in their relationship to pain through images made at different points during pain management, before, during and after. I think this notion of progression, suggested by the clinicians on the team, has been a valuable addition to the project, and its value was evidenced in the feedback:

I couldn't see anything other than being stuck in that pain cycle ... I was locked in a place with this pain and couldn't move forward. I think through coming here and having a look at a beginning, a middle and an end, it somehow moved me on to the next phase and psychologically I could look at it differently. I don't know, without this, how I would have moved.

Participating patient, study no. I3

The pain cards being developed, using images from these patient journeys, will be offered as a new communication tool for use within NHS pain consultations.

The images selected have been drawn from hundreds made during both *Perceptions of Pain* and *face2face*. Feedback from patients, clinicians and from BPS members during the pilot study has guided their design and format. We are continuing to pilot them to arrive at the optimum size and number of images.

From my perspective, the aim of these photographs/pain cards is to expand dialogue around pain to include discussion of sensation, emotion, the meaning and significance of the pain to a person, and its impact on their life rather

Mask:Mirror:Membrane

than as diagnostic tools. Early analysis from Prof Zakrzewska's piloting of them within routine consultations at UCLH, feedback from her team and video recordings of consultations using the images, have identified circumstances in which the images are particularly helpful, such as where emotional elements are significant and where English is not the first language. Through eliciting discussion of significant narrative, the cards can complement current narrative-based approaches argued for by many, notably Rita Charon.⁵ The evidence is growing that selected photographs of pain placed between clinician and patient can help trigger a more collaborative approach to dialogue within the consulting room. They are one means of facilitating an integration between 'physiological, psychological and social meanings', advocated by Kleinman^{6,7} as core to patient complaints.

Concluding thoughts

There is a value in the dream space that images and film can conjure up, revealing through experiential rather than logical means, what is less conscious, less known and less tangible. It is important to remember, however, that the flip side of the dream is the nightmare, and that this process is not helpful for everyone – it is not a panacea for pain, conversely it can be an uncovering of pain at its most raw. There is both power and danger in using images to elicit such intense experience and the process always needs to be entered into with caution and within a safe environment. For some, the effect of almost reliving the experiences in order to make the images can be painful; for the majority it was therapeutic, some even citing it as contributing to their return to work:

I found it very therapeutic. It has allowed me to come from a point where I have been off work since 2003 to actually taking that step

Figure 12

Photograph by Veronica Vossen Wood. *Facing Pain* film © Deborah Padfield

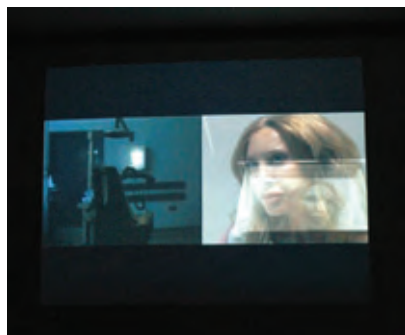


Figure 13

Photograph by Deborah Padfield with Chandrakant Khoda from the series *face2face* © Deborah Padfield



to going back to work, and I think, if I hadn't worked on this, I would not have been able to have taken that step, so I feel very grateful.

Participating patient, study no. I2

Images and image-making processes appear to be capable of playing a role within the healing process, while retaining their own language and aesthetic. Perhaps this relates to their capacity to embody experience, to create spaces we enter with our bodies as well as our minds – their capacity to engender

Figure 14

Photograph by Deborah Padfield with Ann Eastman from the series *face2face* © Deborah Padfield



empathy and elicit multiple interpretations. In a review of the film *Facing Pain* in *The Lancet*, Denna Jones highlighted the value of empathy and dialogue:

The skill clinicians need, Zakrzewska says, is "empathy". Deft employment of empathy allows the patient to give the clinician the diagnosis. Whether she realises it or not, Zakrzewska comes across as the doctor we all wish we had. Padfield's film is a powerful clinician–patient dialogue and it is a remarkable first stage from which all the co-creators can move forward to making chronic pain less of a lonely, personal journey.

Jones 2011, *The Lancet*, 30 July

If the project and exhibitions have contributed to raising awareness or

increasing empathy, then our central hypothesis has been valid: not only is medicine capable of providing new material for the gallery space, but art is capable of bringing new knowledge into the consulting space. In the words of one of the participating patients: *'If in some way it can help one other person then it has been worthwhile.'*

Acknowledgements

I would like to thank all the pain sufferers and patients who have worked with us on these projects and given so generously of themselves and their creativity, in particular Liz Aldous, Ann Eastman, Alison Glenn, Chandrakant Khoda and Yante. I would also like to thank my collaborators, particularly Prof Joanna Zakrzewska and her team, and also Dr Amanda C de C Williams for her continuing support and discussions, Prof Aidan Halligan, Guy Noble (director, UCH Arts), Helen Omand (project assistant/video editing), Karl Otto Karl (photo

assistance) and Monica McKee-Vincent for the administrative support that has facilitated the project. I would like to thank Stuart Davie, Helena Copsey, Damian Hebron, Graham Treacher for their comments, my research supervisors, Dr Sharon Morris, Prof John Aiken, and Dryden Goodwin, for their ongoing insights, and the following organizations, which have generously supported us:

- National Portrait Gallery
- Paintings in Hospitals
- Menier Gallery
- London Arts in Health Forum
- Eastman Dental Hospital
- UCLH
- Slade School of Fine Art, UCL

and our funders without whom *face2face* could not have happened:

- Arts Council England
- Arts & Humanities Research Council

- UCLH Arts
- UK CLRN

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Informing practice

Children with pain – Still the therapeutic orphans of analgesia?

Alison Bliss

Adults admitted for surgery are undergoing major changes in the management of their post-operative experience. For them, the importance of good pain relief has been brought into the spotlight and innovative pain-relieving strategies are now the cornerstone of most 'enhanced recovery programmes'. The 'standard' post-operative epidural infusion is now 'higher', 'lighter' and less restrictive, with a greater focus on

non-opiate oral analgesics and co-analgesics.¹

Parents bringing children to hospital are anxious that their child does not experience any pain or discomfort,² yet it seems that our paediatric patients – surgical, oncological or other – are less well placed to benefit in parallel from these innovative developments in adult practice. These novel changes are occurring at a time when long-standing

techniques for post-operative analgesia are being questioned and limited within paediatric practice, and still little new is arising from the ashes to replace them.

Adult 'models' ill fit paediatric practice, when the patient may vary in age, from a 23-week premature neonate to a 25-year-old young adult with a relapsing cancer, or in weight, from 500 g to 130 kg, with all the

Children with pain – Still the therapeutic orphans of analgesia?



inherent variations in physiology and pharmacokinetics. Following the adult lead often means prescribing 'off-label' medication (e.g. a drug not licensed for use in children) or administering 'unlicensed' products (e.g. a drug produced in liquid form by the hospital pharmacy). This practice is endemic, affecting 90% of neonates, 70% of patients in paediatric intensive care units and 67% of all children in hospital.³ A licensed drug has a marketing authorisation for use for a specified purpose in a defined population, having been examined for safety, efficacy and quality. Approximately 70% of medicines in Australia and approximately 80% in the USA lack specific information about their use within paediatrics, yet only 38% of new products with potential use in paediatrics were labelled as such in a 2004 study.⁴ This lack of critical safety and efficacy information leads to a dichotomy of prescriptive conservatism: sticking to the imperfect older tried-and-tested drugs with established safety but limited efficacy, versus the risks of the unknown newer drugs with potential for improved

outcomes.⁴ The need to undertake this research is countered by a lobby to limit experimentation on children,⁵ particularly where profit is concerned. Yet the lack of financial recuperation is often seen as a barrier to paediatric research by 'big pharma'. The worldwide paediatric market is small compared to adult use; nonetheless a new

paediatric medicine is estimated to cost approximately \$20 million to develop.⁶ Both the Food and Drug Administration (FDA) in America and the European Medicines Agency (EMA) in Europe have introduced financial incentives, in terms of patent life extensions and exclusivity, to encourage industry to develop medicines for children.⁴ Since 2007, pharmaceutical companies are now required under European law to undertake studies in children as part of the development plan for most new medicines. This measure aims to increase the number of medicines licensed for use in children.

In the interim, how then can we apply the Department of Health's standard of utilising safe and effective medicines based on sound information about risk and benefit, on the basis of the best available evidence?⁷ Where can practitioners find guidance?

Historically, much of the available guidance for pain relief in children has been written by internationally recognised experts within the field, from eminent institutions. Over the years, the opinion and experience of such

professionals has formed the basis of many guidelines and recommendations for clinical practice, which are still in clinical use today. By current standards, such guidance would only be classed as predominantly level 4 evidence supporting grade D recommendations, yet many have stood the test of time. When the available knowledge base provided by high-quality research lags behind that which is required for high-quality clinical practice, 'thought leaders' can have a beneficial effect to challenge long-held misconceptions and false beliefs among health care professionals, effectively shaping future practice.⁸ Conversely, there must be awareness that those same expert opinions may also promote dogmatic beliefs that restrict the advancement of medical thinking.⁹

Since the 1990s, the evidence for paediatric analgesia has been extrapolated principally from the World Health Organization (WHO) Cancer Pain Relief Programme, as 'the Analgesic Ladder'.¹⁰ A meeting of 17 experts in Milan 1982 aimed to describe an effective, simple, cheap and easily disseminated regimen of drug use that would overcome the deep social concerns of the time regarding drug addiction. The final programme included the three-step ladder, round-the-clock dosing, information on a variety of adjuncts and advice for the management of side effects.¹⁰ Because of its advocacy of liberalising the use of narcotics, it took until 1986 to be fully published and endorsed. From its inception, the authors' recommended using the WHO ladder 'with imagination', for optimal success, but mechanical application of 'by-the-ladder' and 'by-the-clock' was soon established practice. While rigorous application could promote success rates over 70%,¹¹ it left the programme open to criticism as being too simplistic or mechanistic.¹²

Influential paediatric guidelines on the management of childhood cancer pain^{13, 14} also began following a consensus conference of 19 experts, in Connecticut, USA in 1988, two years after publication of the 'analgesic ladder'. Frustrated by the limitations of the available paediatric literature, their remit was to consolidate all available information and best practice to produce a practical algorithm for a state-of-the-art approach to pain management in children with cancer.¹³ The WHO analgesic ladder formed the centre of a new flow chart, with the management of side effects, invasive approaches and non-pharmacological modalities given greater prominence.¹⁴ The resultant algorithm was complex and bulky, but comprehensive. Unlike the 'blended polypharmacy' of the WHO ladder,¹⁵ this paediatric algorithm began to recognise the distinction between nociceptive and neuropathic pain. In 1993, the WHO collaborated with the International Association for the Study of Pain (IASP) at a conference of 23 invited experts, to address further issues of paediatric cancer pain management. *Cancer Pain Relief and Palliative Care in Children*, published five years later, contained a specific section on the role of invasive analgesic techniques.¹⁶

Before the early 1990s, published work on the use of invasive analgesic techniques in children for the control of chronic pain outside the post-operative setting was limited to a handful of case series and case reports. In the last decade, a slowly increasing number of case reports and case series in the literature provide a foundation for the wider use of novel analgesic techniques in paediatric pain management.¹⁷ Of greater impact and applicability to the non-specialist was the production of the British National Formulary for Children

(BNFc), first edition published in 2006. Avoiding simplistic pro rata adjustments of adult doses, the BNFc filled the information gap, providing dosing recommendations validated against emerging evidence, best practice guidelines and expert opinion.

Where are we now? Ongoing opportunities for clinical research are supported in the UK by the Medicines for Children Research Network established in 2007, facilitating appropriate prospective randomised trials and other well-designed studies. The management of acute post-operative and procedural pain is aided by systematic evidence-based, expert-reviewed UK national guidance from the Association of Paediatric Anaesthetists. Rather than producing a universal 'one-size-fits-all' analgesic algorithm, the committee reviewed and graded the available analgesic options applicable in individual clinical settings.¹⁸ Revisions for the second edition are currently underway.

Guidance for the management of chronic pain in children is now being considered by a specific group within the British Pain Society (BPS) and their recommendations are awaited.

In the current decade, the WHO analgesic ladder, now over 30 years old, is often criticised for its lack of evidence base, with 'freedom from pain' unachievable for all in its original format.¹⁵ Paediatric practice is finally catching up and more closely reflecting adult practice, including the judicious use of novel techniques. Such techniques may actually produce better outcomes, with the possibility that they will form an integral part of a new ladder for both adults and children in the future.¹²

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Enhanced recovery programmes in paediatrics

Gwen Porter Norfolk and Norwich University Hospital & Chair of the Pain in Children Special Interest group of Society

Enhanced recovery programmes (ERP) involve a redesign of the patient pathway for elective surgery. It is an evidence-based approach to anaesthetic and surgical care. The success of an ERP is in no small measure, due to multidisciplinary care and the provision of clear protocols for the delivery of that care. Good patient selection and appropriate pre-assessment, combined with the provision of high-quality, multi-modal, timely analgesia peri-operatively and for discharge, are also essential. The care pathways focus on rapid recovery and optimising post-operative rehabilitation. The proven cost savings and increased patient throughput have attracted the attention of hospital management who have been supportive of the development of such services. Additional funds have been made available to launch and develop programmes nationwide.

An unexpected benefit has been an increased awareness of the importance of pain relief, and, in the hospital in which I work, the Norfolk and Norwich University Hospital, there has been a

noticeable increase in the profile of the pain service throughout the hospital. The concepts of pre-emptive analgesia and recognition of neuropathic pain have filtered out to the wider hospital, as has a greater familiarity with less mainstream analgesic strategies.

Children and adolescents should be able to take advantage of the benefits of ERPs. It would seem appropriate to consider this approach to the management of selected patient groups in the under 16s. In the adult hospital population, there is a sufficient throughput to inform practice and most services are modifying their guidelines with experience. However, with a smaller and more fragmented population, it is more difficult to develop and refine similar services for paediatric patient groups. There is also the reluctance to embrace the use of drugs that have a limited experience base when used in young people in the peri-operative situation.

Guidance in many areas of paediatric anaesthetic practice has historically been

from the specialist national children's hospitals. More interactive arenas available nationally include the Paediatric Pain Travelling Club, a group of specialist paediatric pain nurses and anaesthetists that meet annually. The annual meeting provides opportunities for formal and informal discussions and the club also hosts an email forum for specific clinical queries and requests for advice. The Pain in Children Special Interest Group (SIG) within the British Pain Society (BPS) also provides a forum for discussion and dissemination of ideas and examples of best practice. It is available to all members of the BPS.

At the 2011 Annual Scientific Meeting (ASM) a consensus on the use of ketamine in young people was obtained from members of the group and is available to inform and support individual practice. It is proposed that, at the next ASM (2013), the SIG meeting will explore the potential for enhanced recovery protocols in children and adolescents. We encourage interested practitioners of any discipline to join us and share their relevant experiences.

Books on Prescription



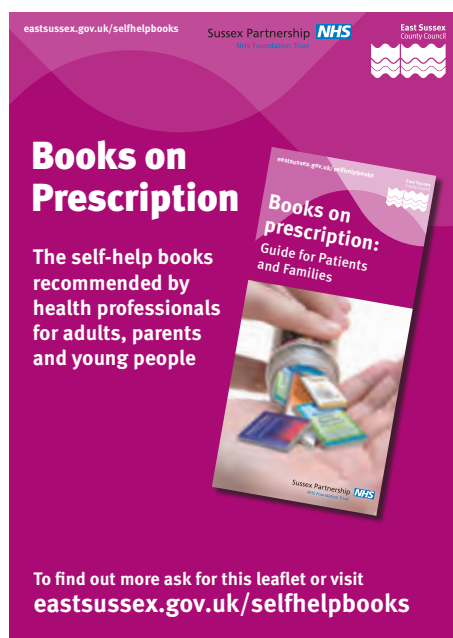
THE BRITISH PAIN SOCIETY

Pain News
10(2) 113–122

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In any situation of suffering, like many people, I turn to books and latterly to the internet, searching for answers but also for reassurance, for as CS Lewis said: 'We read to know that we are not alone.'

Chronic pain sufferers often speak of feeling alone and struggling to cope with the alteration in their lifestyle as much as with the pain itself. Many wait for years before being referred to a pain clinic. With such scarce resources, and with over 8 million sufferers from chronic pain in the UK, it is important that they have every opportunity to learn to manage their chronic pain as early as possible. Self-help guides using cognitive-behavioural techniques are used by the major pain management programmes but equally can be useful for the individual committed to working on their own, particularly if such a book has been recommended and follow-up supported by a clinician. With the wealth of

information, and misinformation, now available on the internet it is ever more important for clinicians to direct their patients to high-quality self-help literature, and what better way than by writing a prescription for a self-help book?

The Books on Prescription scheme was pioneered by Professor Neil Frude, a clinical psychologist, in Cardiff in 2003. The original list of self-help books was drawn up in consultation with mental health professionals from titles that they had found useful in practice. An initial list of 35 titles written predominately by psychologists, psychiatrists and psychotherapists was constructed.

The list includes books on many common psychological problems including depression, stress, eating disorders, panic and low self-esteem. The initial scheme was so successful that it has now been adopted by NHS Wales and has also been developed in many English regions. As it developed, each regional library authority constructed its own list and although many advertise the scheme as one for mental health patients, some libraries have also included chronic pain in their list. My own library service, run by East Sussex County Council, already had 14 copies of *Overcoming Chronic Pain* by Frances Cole on their list. The County librarian was enthusiastic about the scheme and purchased additionally, at my suggestion, six copies of *Manage Your Pain* by Dr Michael Nicholas et al.

Books can be prescribed by clinicians, usually by a GP, from the list and the prescription presented at the local public library for loans at the usual standard term. There is no charge if books need to be requested on inter-library loan and

books can usually be renewed for further terms. Every GP practice in my area was sent an initial pack containing leaflets, the reading list and special library prescription pads.

In March 2012, the Reading Agency was successful in a bid to Arts Council England to develop a new, national Books on Prescription model combining a national self-help reading list with mood-boosting creative reading recommendations of novels and poetry. They are considering the two above texts on chronic pain for the national reading list. This new development is an exciting time to be involved in this line of pain education and I would welcome any suggestions for additional texts for inclusion in the chronic pain section.

NHS interest in self-help reading and Books on Prescription is being driven by policy directives such as the promotion of healthy living and self-care, the development of expert patient programmes and the need for effective use of resources. While the evidence base for the effectiveness of Books on Prescription is building, it is still relatively undeveloped, and it is hoped that a national scheme would have a higher profile and enable more effective evaluation. The current fragmented approach has meant wide variation in uptake. At present, operational data appear much more common than impact data, although some work is being undertaken in this area. The Cardiff scheme, which dispensed around 1,600 prescriptions in its first six months, has certainly met a need within the sector. In Wales, a process evaluation is currently underway alongside the development of a protocol for a much bigger piece of impact research.

Books on Prescription

The reading material supporting Books on Prescription caters predominately for a 'mainstream' literate adult audience. Self-help content does not appear to be very accessible outside of this audience, although the use of other formats such as audio is increasing. However, few schemes cater for younger readers, readers with special needs, such as the visually impaired, or those with a basic level of literacy or readers with English as a second language. There is obviously much scope to extend the scheme; while this exclusivity can be a disadvantage, the Books on Prescription scheme is an effective form of treatment for certain patients, freeing up resources for other groups

to receive more specialised care from the health sector.

The scheme is particularly attractive to non-internet users, many of whom are elderly, and will enable non-library users to join the library and perhaps engage with some of the group activities that bibliotherapy offers. Many libraries are developing lists of mood-boosting books and running reading groups to promote health and well-being through imaginative literature.

The library service is very keen to work in partnership with clinicians to promote health and well-being. Indeed, with the increasing responsibility being given to local authorities for public health, health and well-being is a key area of concern. From the point of view

of chronic pain, the scheme could be developed to include book groups for patients with similar conditions and even short courses run at the library, prescribed by the patient's GP. Internet searches for those patients without their own facilities could easily be offered at the library. Our public libraries are a wonderful resource for people living with pain and I urge all clinicians to start prescribing books if they do not already do so.

For further information on Books on Prescription schemes in your area, contact your local library service, or on the proposed national scheme please contact debbie.hicks@readingagency.org.uk (<http://www.readingagency.org.uk>).

The National Pain Audit: the patients' perspective

Stephanie M Stokes *Member of the Patient Liaison Committee, The British Pain Society*

Many patients enquire about the National Pain Audit and its progress; the author gives a detailed explanation that will be helpful to guide our patients.

In the recent edition of *Pain News*, you would have read details of the National Pain Audit and of its Phase One Report (*Pain News* Summer 2011). This audit is a very important tool in the development of pain services across England and Wales. Its findings will help inform clinicians, other health care workers and patients about the pain management services available in the regions that they work and live. Finding out this information is vital to help push forward pain management as a priority for the NHS and to help develop new protocols

(or plans) for future pain services.

The members of the board of the Pain Audit and its committees who are overseeing the project consist of statisticians from Dr Foster Intelligence, clinicians who are all specialists in pain medicine and me. I bring the patient's perspective to the proceedings. I have arthritic and neuropathic pain and as such I am a member of the Patient Liaison Committee of the British Pain Society (BPS). I can advise (with the help of the Patient Liaison Committee or our patient reference group) about the sorts

of questions that patients might wish to see in the audit questionnaires and answer audit colleagues' patient-oriented questions.

Some of you may have wondered, what exactly is an audit? Audits are surveys of data (e.g. numbers of patients, numbers of clinicians, age of patients) that together give statisticians the material with which to create a picture of what is happening with respect to the topic under study (here it is 'pain management'). Statisticians can then draw up descriptive data pictures



(graphs, for example) of the data found and put the data into well-known and tried statistical tests to find out if the suspected picture is 'true' within the limits of probability. When all this has been done, then there may be firm data

to back up the view of the audit commissioners (BPS) that change is necessary in pain management services across England and Wales. Phase One data has confirmed that there is not equality of provision across these countries.

There have been many previous pain audits, but these have focused on particular areas of pain, such as that of Harmer, Davies and Lunn¹ who carried out a survey of acute pain services in the UK. These audits have not investigated broadly what pain services are like for patients across the length and breadth of England and Wales. Phase One of the audit has found out that, as was suspected, provision is not equal across this area and that some people with pain have better access to management than others. For example, if you have chronic back pain and you live in a city with a big teaching hospital pain centre, then in addition to regular visits to a specialist, you may be referred for other types of support. If you live in a rural area with no easy access to such a centre you may only see your GP, with an occasional visit to a specialist. In short, some people see a team of experts including psychiatrists,

counsellors, complementary health professionals, on an ongoing basis, while others see only one or two clinicians infrequently.

The audit is now entering its third phase, having been awarded funds to continue its search. Case mix data from Phase Two (when new patients who agreed to participate in Phase One were asked about their subsequent experience) is currently undergoing analysis and the findings will tell us what we should look at next. Should you be a patient who is asked whether you would consent to participating in the audit at some stage, please be assured that all data collected is anonymised and stored according to data protection rules and regulations.

I hope this helps some of you to understand how and why the audit is being undertaken and what the BPS hopes will be the outcome: better pain services for all patients in England and Wales.

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Informing practice

Being human and in pain

Kate Maguire, Social Anthropologist and Psychotherapist, Middlesex University

The author presented this talk in the Philosophy and Ethics Special Interest Group meeting, which has been transcribed by Peter Wemyss-Gorman. We apologise for any omissions and errors that might have occurred without our knowledge during this process. Full transcripts are available from pwgorman@btinternet.com

Being human

I worked with survivors of torture for several years so my narrative has become tied up with the narrative of

the people I have worked with. I want to share some of what I have learnt *being human* is from this experience.

The centre of life is pain, and pain is life. But for some the pain is excessive. For others it is redundant and useless. For some it is chronic and never-ending.

Being human and in pain

There is pain in being born, living and dying. It has life-saving elements and life-destroying elements. Humans try to make meaning not just of life but the pain of life through philosophy, religion and art. Many people come into psychotherapy to try to make meaning of it, knowing they're not going to get rid of it. When you have been tortured it is very difficult to actually get rid of pain and maybe that isn't such a good idea, but one can try to find a place for it to make meaning from it. Medicine tries to cure pain or control it through external intervention. Melzack and Wall have contended that the perceptual experience of pain is influenced by the history of the individual, *the meaning they give to the pain-producing situation* and their state of mind at the time; and that these factors play a role in determining the function of pain pathways in the central nervous system, so that pain becomes a function of the whole individual. This concept of accumulation of things – the individual's experiences, their past and what situation they are in at the time – is a very *human* definition and that is what I have come across in my work.

Psychotherapists and psychologists often try to make meaning out of suffering to give people a feeling of control over it and a measure of healing. Belief systems also try to make meaning of it to make it more acceptable. I have asked people from different religious cultures whether this had any impact on their belief system. Some have rejected it utterly, and yet when you read their poetry it is among the most spiritual you will ever see. What they are denying is the man-made construct that this is what God does... Torture is about ripping off the mask of illusion about civilization and everything. But they still have this notion of God within oneself.

As humans we usually try to avoid pain, but sometimes we precipitate it to feel more alive, as with self-harm, to try to counteract the numbness of a greater

inaccessible pain. To feel nothing may be the greater pain. Conversely sometimes, we anaesthetise it through substances and coping or maladaptive behaviours. Most behaviours are a response to pain or an avoidance of pain. Power dynamics are based on pain. State-sanctioned torture is all based on pain – the fear of it, or the threat of it. Organisational structures from businesses to religion are based on it, or at least discomfort: what will happen if you lose your job? – that's a form of pain.

The Inhumanity of Pain

Pain, particularly redundant pain, can be inhuman, and requires being human to alleviate it. Pain separates you from yourself and from others. It shifts your locus of control from *internal* – the confidence that anything you do will make a difference – to *external* – what's the point? why bother? I'm powerless. Pain makes you feel 'chosen' in a very awful way – why me? why have I got this pain? This is very important to you as therapists, because the locus of control for a person in pain may become located in you. Pain makes people aggressive or withdrawn and depressed, and it causes fear and anxiety and irritation in others. Pain can be said to apparently cause deafness in others and dumbness in oneself. The families of people with chronic pain stop hearing, so after a while they stop talking.

A man who had been tortured very severely and had badly damaged feet, used to go around giving talks about surviving torture. When offered surgery that would have enabled him to walk again, he refused it because he was being *heard*. His feet were the witness to what was done to him. He thought that if his feet were repaired he wouldn't be believed, and nobody would understand that he still felt his pain, and furthermore that it would reduce what torture is if people think you can recover from it.

As practitioners we try to make pain go away – but what with, and *who for*? I come from the island of psychotherapy. Psychotherapists have time; we see patients for an hour or more every week. What can we exchange about our knowledge to manage extreme pain or psychological pain? Can we adapt some things to time-limited contact?

The haunted house of pain

Most of my clients, who are either survivors of torture or who have come back from working in conflict zones with Médecins Sans Frontières (MSF), use a lot of metaphors. One of these is 'entering a house of pain' – like approaching a haunted house: Oh my God! I don't know what's in there! Often you don't want to get further than the front door because you might need to have a conversation. But what if you get invited in or have a strong instinct to go into the haunted house? What might be in there? You might find the whimpering animal in the corner of the room who bites your hand off. Extreme experiences like sexual abuse and torture internalise the abuser so people who have been severely traumatised have a lot of anger and aggression within them.

You might find the ghosts of someone's past life – like the mother from Afghanistan who had lost three sons, having sent them out before her and she didn't know where they went. She was now in the UK, extremely ill and nothing could work for her, no painkillers, nothing, because she didn't know what to do about her sons. A terrible pain – it might have been easier for me as a practitioner if her sons had been dead. I had to do something with this information which took months but we did track down her sons and she was reunited, and she lost most of her pain. You might find shattered fragments that don't seem to be able to be put back together again or make any sense – it can be frightening. You may find

someone you wish you had never met! You might find a 'time eater'.

What do we need to bring into the encounter? What language do we need?

Are you going in there with the right gear? Because if you're not you might feel even more powerless. You may disappoint them – you're not this great doctor. You may even become dependent on them. You might feel deskilled. It may trigger off your own fears of pain in yourself or those close to you; you begin to see what it's like to be in that house of pain and to wonder whether you could cope. Do you need to be an exorcist? In a way that is what seems to be expected but is of course not always realistic. But do we sometimes act that way, with our potions and so on?

The kind of pain I work on can defy verbal language. One of my clients could tell me everything about his torture. He told me that story with no feelings attached to it – it was dissociated. He said:

I can tell this story because I have to. If I want to live in this country, if I want my children to have a roof over their heads and go to school, I have to tell that story. *I have prostituted my pain* for the safety of my family.

Words do not reflect the complexity, the experience and the impact of redundant pain, but verbal language can keep it all cognitive and safe. If we keep to just talking we keep the exchange in a very cognitive place, but as human beings we are not just cognitive, we are emotional and empathic as well.

Maybe we need to be a hermeneut – an interpreter – rather than an exorcist. Hermeneutics (from Hermes, messenger of the gods, originally the Egyptian god Thos – the god of interpretation) is the study of understanding. Hermeneutic study how we understand one another

and how we build bridges into each other in a kind of common humanity. If you are a pain practitioner you might be in pain, and maybe you can manage your pain, but maybe the person that comes to you is in a different realm of experience. So how do you build the bridge? – and it's not just one way. A pain hermeneut needs to be a very good listener and a good translator for both the patient and themselves. Often pain has separated parts of the individuals from themselves, and you as the human practitioner can help to make these connections. There is no making sense at a distance; one must always work out some kind of internal connection with what one seeks to understand.

You have to be a storyteller – somebody who uses metaphors. If we allow people to draw or write about their pain we may encounter metaphors that they might never reveal just by talking. Joanna Zakrzewska and I found that people with trigeminal neuralgia who had provided pictures and poetry felt much better after working with the pictures. Perhaps you have to be a trickster and find something positive to replace 'crumbling spine' language by using something out of your bag of metaphors, such as culturally appropriate and enhancing storytelling and visual imagery.

What you need to know to keep you and them safe?

This is the model used for systematic torture (Figure 1). It was used in South America in particular as a model of deprivation. First you deny the prisoner their physiological needs: food, water and clothing (we have our clothes on because we feel safe in them; they protect us from shame and all kinds of things). Then you deny them safety, their social needs and so on. Systematic torture is about the deconstruction of an individual so you can't put them back together again; they are no use to

anybody and least of all to themselves. So if you have people coming to you who are refugees or survivors of torture or of sexual abuse with a pain you can't explain, their pain may be compounded by some of these layers. You might not be able to get through unless you do something; we have to work in this area with refugees and it is very difficult if they don't have somewhere to stay or are going to be deported. Restoring social needs (which are replaced in some models by love and belonging needs) is something we have a really good chance with: the human in us meeting – or trying to find or re-engage, or helping them to re-engage – with the human in themselves.

Quality of listening

In true listening one enters not simply into another's subjectivity but into what is said... in German the word for listening (*gehoren*) and hearing is also the word for belonging. When one listens, one steps out of the aggressive mode of grasping and knowing into the mode of belonging. Heidegger

If we listen in this way we stop being an 'I' and become a 'we'. But when you become a 'we', you take on responsibilities of being a fellow human being.

This listening is tuned into what is not said as much as to what is said through an attitude of observation, respect and engagement of the heart and mind.

Carl Rogers

If you're not sure what your patient has said, reflect back to them what you think you have understood – this is a non-intrusive way of listening. If you listen well you'll get into the rooms of the haunted house, and even just that interest alleviates pain.

Figure 1
Maslow's hierarchy of needs

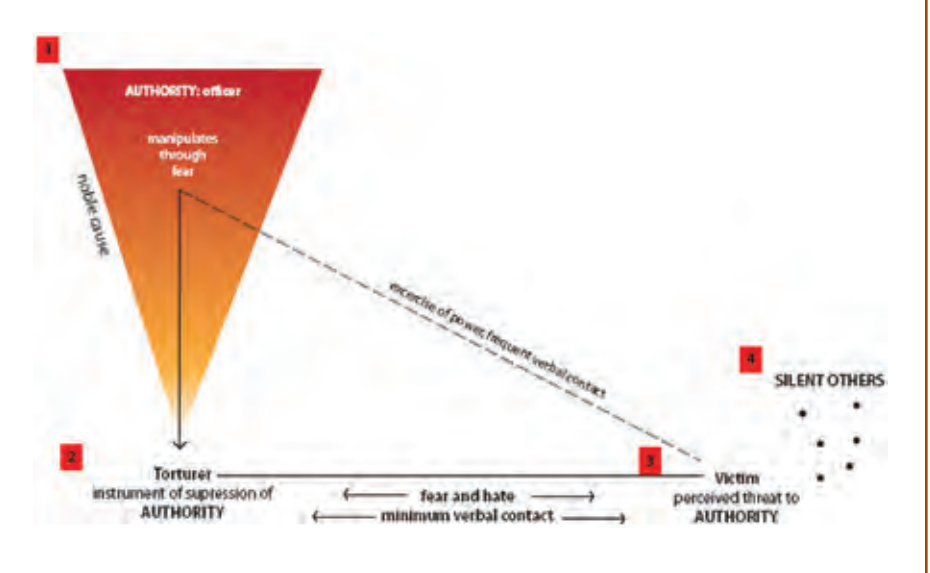


Authority dynamics

In torture, all the activity takes place between the torturer and the victim. The person who is the authority stands back from this, so the victim thinks: if I can get to the authority, they will be more reasonable than the torturer and will be able to knock some sense into him. It's like a game being played out between the torturer and the victim. The authority says: 'It's really nothing to do with me – I'll have a word.' It's actually designed that way because the torturer is also tortured (Figure 2). Torturers are not, on the whole, psychopaths. They are part of this awful system. In South America, the torturer was initiated through ways too awful to describe and therefore if they weren't a torturer they would be a victim.

I was told a story by a Chilean mother and daughter who had been tortured; their brother was also in London, and that he had been a torturer. I asked the women why they didn't denounce him and they said: 'Because he is also a victim.' He had been arrested and tortured, and then they got hold of his little son. From that point he broke and went over to them. So the Chilean community would never turn him in, because there was recognition of the shared pain. You can discern the same dynamic in many other situations, such as the relationship between managers and professionals in academia and medicine.

Figure 2
Torture relationship dynamic



Possession and identity formation

Many of the people I work with tell me that pain is like a torturer: a possession by extreme pain. They feel the victim of their torture. So in that way you become the authority that can do something about this torture; you have the skill to take away their pain. We may need to challenge that dynamic. There are times when you might not want to be drawn in.

MSF developed a mentoring system, and a lot of their returning fieldworkers, although they know all about analgesics, found that through talking to others and psychosocial therapists they could make meaning of and alleviate pain. One young fieldworker had been in Sierra Leone during the 'epidemic' of limb-hacking. He went to university, and something happened to make him walk out of a lecture and just be drunk for three days, and his friends brought him to see us. He said to the therapist:

And what would you know about hurting, about this terrible pain that gnaws away at your very being. How can you learn when there aren't the words? How can you hear anything when the words you use silence the scream of it?' ... Don't start pretending you understand. You sit here safe in your middle-class office thinking you know how to help people like me. Then you read something in the newspaper about dying babies in Romania ... you shed a tear, then it's gone out of your existence ... [you] give something to a charity, salve [your] conscience and keep it all distant, then bin it.

... [returning to the lecture that had precipitated his breakdown] The b-----d lecturer was talking about the severing of hands in Sierra Leone being an act of frustrated creativity. F-----ng frustrated creativity.

This was a guy tortured not only by his experiences but by the way they were interpreted by others.

Being human and the inhumanity of pain

For being human, to reduce the inhumanity of pain requires meeting the sufferer and the suffering with openness. It recognises the necessity of providing emotional and empathic support as well as the cognitive and prescription interventions which may not heal pain but can alleviate it. It is to recognise that a rupture to one's humanity is healed by the mirroring of humanity in another's face; to be met as a human who is more than their pain. As a pain practitioner, I may need to enter the house of pain; I am not sure I can live with myself if I don't. But I should not enter if I am not equipped. I have a duty of care to myself as well as to my patient.

Pain is another form of difference. I need to connect to that difference as I would to any other through knowledge, respect and finding a solution in the context of the patient to find the patient's solution; not your solution. We must be prepared to explore our practice relationally with patients, and not try to manage it without them. There is so much qualitative research we can do in this way instead of surveys and questionnaires. I think everything I have learnt has been from my clients.

Humanity and understanding

Hermeneutics is not about prescribing a procedure of understanding but to

clarify the conditions in which understanding takes place.

Gadamer

Working with pain requires getting the conditions right, and one of these is being human and relating, being equipped to enter that house, and providing that humanity; and then I think understanding begins to take care of itself.

Further reading

Scarry E. *The Body and Pain: The Making and Unmaking of the World*. Oxford: Oxford University Press, 1985

Pain in older adults – Guidelines for the management of pain (2012)

Professor Pat Schofield, *University of Greenwich*

Dr Aza Abdulla, *South London Healthcare NHS Trust*

Professor Nicola Adams, *Northumbria University*

Dr Margaret Bone, *Consultant in Pain Medicine, Leicester*

Dr Alison M Elliott, *Centre of Academic Primary Care, University of Aberdeen*

Mrs Jean Gaffin, *Lay Representative*

Dr Derek Jones, *Northumbria University*

Professor Roger Knaggs, *Nottingham University Hospitals NHS Trust*

Professor Denis Martin, *University of Teesside*

Dr Liz Sampson, *University College London Medical School*

Background

Pain is described as an 'unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage'.¹ It is classified as acute; associated with trauma or injury; or chronic, which is often linked to back pain and serves no useful purpose. Millions of people in the UK live with chronic pain and as we go into older age, it is suggested that 0%–93% of people have pain that is often 'expected to be part of ageing' or something that they have to 'learn to live with'. One of the fundamental issues regarding pain management in any age group is assessment of pain and with older adults this can be particularly challenging due to age-related changes in vision, hearing and cognition. Assessment of pain has been addressed elsewhere (http://www.britishpainsociety.org/pub_professional.htm#assessmentpop). The purpose of this guideline document is to focus on the management of pain in older adults. The emphasis, however, is on chronic pain management. This paper provides headlines of the main recommendations that are stated within the guidelines.

Search strategy

An estimated 5,000 records were found. The main PubMed search found 3,691 records and the CINAHL search found a further 837 records, giving a total of 4,528 returned by the core searches. Further results were found in PsycInfo and AMED, but exact numbers are not available. A separate search of Scopus, which found 7,472 records, was used only to refine the results of one of the search topics, and may have found items missed by the other databases.

Inclusion/Exclusion criteria

The publication date of 1997 to the current date (2010) was used. No other inclusion/exclusion criteria were used

during the searching stage. Further inclusion and exclusion criteria were decided during the appraisal stages.

Number of papers into themes

- Pharmacology = 191
- Psychiatry = 553
- Physiotherapy and rehabilitation = 260
- Prevalence = 444
- Intervention and invasive = 194
- Barriers, attitudes and education = 0
- Guidelines = 162
- Complementary therapies = 171
- Communication and self-management = 333
- Specific pathologies = 0
- Palliative care = 225

The full document of the guideline can be accessed through the British Pain Society or the British Geriatric Society.

Prevalence of pain in older persons

Until relatively recently, our knowledge of the prevalence of pain in older persons, particularly the very elderly was relatively poor. Pain tended to be considered as part of the ageing process and was rarely investigated in its own right. There have, however, been an increasing number of studies into the prevalence of pain in older persons in the last decade or so.

Methodological challenges to measuring pain prevalence

Since pain is a subjective phenomenon, it is extremely difficult to measure and reliance on self-report of the experience means that there are no gold standard tools by which the experience can be verified. Wide variations in prevalence are often found due to differences between the studies in the definitions used, population examined and the methods used.

Studies included in the review

A total of 64 studies were included in the review.^{2–65} The majority of studies had taken place in Europe (27 studies) or North America (17 studies). Most studies focused on a community population (40 studies), although studies of residential care populations (12 studies) and mixed populations (12 studies) had also been undertaken. None of the studies used exactly the same definition of pain. In addition, the time period of prevalence examined varied and some studies examined pain at only one site while others examined pain at multiple sites.

Prevalence

The prevalence of any type of pain in older persons ranged from a low of 0% to a high of 93%, clearly illustrating how variations in the population, methods and definitions used can affect prevalence estimates. The prevalence of current pain at any site in those living in the community ranged from 20% to 46%. For those living in residential care, the prevalence was higher at 28%–73%. The prevalence of chronic pain (pain that had persisted for three months) at any site in those living in the community ranged from 25% to 76%. For those living in residential care the prevalence was higher at 83%–93%.

Gender differences

37 of the 41 studies that reported prevalence rates in older men and women separately found that women had a higher prevalence than men. One study reported that men had a higher prevalence of pain than women and three studies reported no difference between the genders.

Age differences

The relationship between prevalence of pain and age in older persons was less clear, with different patterns seen in

men and women and in different sites of pain. Broadly speaking, age differences could be categorised into four groups:

- A continual increase in pain prevalence with age (13 studies)
- An increase in prevalence with age up to 75–85 years and then a decrease with age (five studies)
- A continual decrease in pain prevalence with age (10 studies)
- No difference in pain prevalence with age (six studies)

Most Common sites of pain

Of the 22 studies that examined pain at different sites, the three most common sites of pain in older people were: (1) the back; (2) the leg, knee or hip; and (3) other joints.

Each of the key themes identified within the guidelines are presented below.

Barriers and attitudes

In common with the working-age population, older people's attitudes and beliefs influence all aspects of the pain experience. Stoicism appears to be more evident in current generations of older people and may contribute to the under-reporting of pain. Spouse beliefs can have a negative impact on the development of adaptive responses to chronic pain. Professionals may be fear-avoidant in relation to activity recommendations.

Communication

There is a need to conduct further research into issues of communicating pain information as there is a paucity of research upon which to base any recommendations. The level of cognitive impairment should be considered in the assessment of pain as patients with severe cognitive impairment are unable to convey pain information by self-report methods of assessment.

Assessment of pain information should be multidimensional to include eliciting pain treatment information, as well as location and sensory aspects of pain information. There is a need to develop assessment tools that can specifically assess these aspects of communication. More pain information is elicited by the use of open-ended rather than closed-ended questions, which is a consideration in any form of pain communication assessment that has implications for assessment and use of pain assessment instruments.

Health practitioners should not interrupt when patients are conveying pain information as this disrupts the amount and nature of pain information conveyed. Information regarding prognosis is considered important by older adults with chronic musculoskeletal pain but this is reported to be provided in only about one third of the general practice consultations.

Pharmacology

Paracetamol should be considered as first-line treatment for the management of both acute and persistent pain, particularly of musculoskeletal origin, due to its demonstrated efficacy and good safety profile. There are relatively few absolute contraindications relative cautions to prescribing paracetamol. It is important that the maximum daily dose (4 g/24 hours) is not exceeded.



Non-selective non-steroidal anti-inflammatory drugs (NSAIDs) should be used with caution in older people after other safer treatments have not provided sufficient pain relief. The lowest dose should be used for the shortest duration. For older people an NSAID or coxib should be co-prescribed with a proton pump inhibitor, choosing the one with the lowest acquisition cost. All older people taking NSAIDs or coxibs should be routinely monitored for gastrointestinal, renal and cardiovascular side effects, and drug–drug and drug–concomitant disease interactions.

Opioids have demonstrated efficacy in both cancer and non-cancer pains. All patients with moderate and severe pain should be considered for opioid therapy,

particularly if pain is causing functional impairment or reducing the quality of life. Patients with continuous pain should be treated with modified-release oral or transdermal opioid formulations aimed at providing relatively constant plasma concentrations. As there is marked variability in how individual patients respond to opioids, treatment must be individualised and carefully monitored for efficacy and tolerability. Opioid side effects (including nausea and vomiting) should be anticipated and suitable prophylaxis considered. Appropriate laxative therapy, such as the combination of a stool softener and a stimulant laxative, should be prescribed throughout treatment for all older people prescribed opioid therapy. Regular patient review is required to assess therapeutic benefit and to monitor adverse effects.

Tricyclic antidepressants have demonstrated efficacy in several types of neuropathic pain. Adverse effects and contraindications limit the use of tricyclic antidepressants in older people. The lowest dose should be initiated and the dose increased slowly as tolerated. Regular patient review is required to assess therapeutic benefit and to monitor adverse effects.

Anti-epileptic drugs have demonstrated efficacy in several types of neuropathic pain. Adverse effects and the need for blood monitoring limit the use of older anti-epileptic drugs in older people. Dose adjustment of gabapentin and pregabalin is required in renal impairment. Regular patient review is required to assess therapeutic benefit and to monitor adverse effects.

Interventional therapies

There is limited evidence to support the consideration of epidural adhesiolysis for spinal stenosis and radicular symptoms in the elderly. The evidence in all age groups for facet joint interventions is

mixed, although there is some evidence to support radiofrequency lesioning in appropriately selected patients. Until further studies in the older population become available, no firm recommendations can be made. No studies of spinal cord stimulation specifically targeting the older population exist, but evidence from randomised clinical trials (RCTs) in mixed aged groups including over 65s support its use in failed back surgical syndrome, complex regional pain, neuropathic and ischaemic pain.

There is weak evidence to support the consideration of sympathectomy for neuropathic pain in the elderly. There is no RCT evidence for the use of continuous neuraxial infusions in older people, but supportive prospective open studies in all age groups. The current evidence for vertebroplasty and kyphoplasty is conflicting; until further larger studies become available, no firm recommendations can be made regarding their use in the treatment of painful vertebral fractures.

Intra-articular corticosteroid injections for osteoarthritis of the knee are effective in relieving pain in the short term with little risk of complications and/or joint damage. Intra-articular hyaluronic acid is effective and free of systemic adverse effects. It should be considered in patients intolerant to systemic therapy. Intra-articular hyaluronic acid appears to have a slower onset of action than intra-articular steroids but the effects seem to last longer.

In older people, nerve block using a combination of local anaesthetic and corticosteroid is effective in acute herpes zoster and post-herpetic neuralgia.

There is also evidence for the use of botulinum toxin in these patients. The evidence suggests that microvascular decompression is the treatment of

choice for TGN in healthy patients and percutaneous procedures are indicated for elderly patients with high co-morbidity.

Psychological approaches

Older nursing home residents with chronic pain may benefit from cognitive behavioural therapy (CBT) pain management interventions. Studies did not show a significant effect for self-management strategies on pain. There is limited/weak evidence that mindfulness, meditation and enhancing emotion regulation has an impact on chronic pain in older people.

Complementary therapies

It would be expected that there would be more literature regarding complementary therapies such as transcutaneous electrical nerve stimulation (TENS) or acupuncture. In fact, the literature in this area was also very sparse and generally inconclusive in any of these approaches.

These guidelines for the management of pain in older adults have been a challenging piece of work to carry out. While there are a few recommendations that can be made, these are often based on research with adults translated across to older counterparts overall. There is a need for much more research to be carried out in the area that specifically addresses the needs of the older population. With the potential ageing 'time bomb' that is fast approaching, we really do need to prepare our services to meet the needs of the older age group.

Professor Pat Schofield, University of Greenwich

References are not printed, but can be requested from P.A.Schofield@greenwich.ac.uk



Knight I. *A Guide to Living with Hyper-Mobility Syndrome: Bending without Breaking*

London: Singing Dragon, 2011
ISBN 978148190689

Reviewed by Jane Brown
Patient Liaison Committee Member,
British Pain Society

Any addition to this relatively scarce area of books aimed at patients with hypermobility syndrome (HMS) should be welcomed. There is still a dearth of information specifically for sufferers of this condition. It is a detailed book within which, even after two full readings, I am still finding new things. It does have an index, which is useful as a reference tool so you can look up key issues when you need to, but as the book seeks to be very comprehensive, many common issues for sufferers of HMS are covered only very briefly. Some people may turn to the book wanting assistance and not be able to find enough to help them. Issues are awarded space in the book, primarily based on the author's experience, although some notable additions are made, such as two chapters on HMS in children and adolescents.

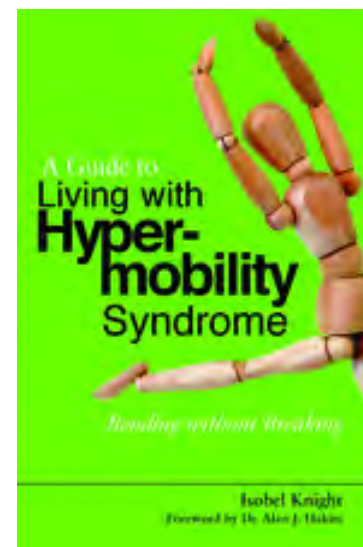
Isobel Knight's book is very much based on her own experience and this will work well for patients whose experience is similar but not so well for those with very different experiences. Given the wide range of symptoms that can now be associated with this condition, there is a fair chance of a patient's experience being very different indeed. Certainly in my case, and that of my daughter, who also shares the condition, Isobel's experience bears only

limited similarities to our own. This is the danger of personalised accounts with such wide-ranging and differing conditions. Of course, some readers would find themselves 'looking in a mirror' reading of Isobel's experience and may well gain great benefit from doing so. Dancers particularly may appreciate the section specifically for them. The author does draw on other people's experience too, but to a lesser extent.

Patients and clinicians are quoted throughout the book and extensive reference is made to clinical studies and research. In a way there is a tension, which feels unresolved, between whether the book is a personal insight or an explanation for patients of current medical knowledge about the condition. As a personal insight, I can make allowances for the fact that it bears little resemblance to my experience – we are all different. As a review of medical knowledge, I am less forgiving and find the book complex and not as coherent or comprehensive as its 240 pages would suggest.

Some patients may find the book worries them, as the range of potential symptoms associated with HMS is so lengthy. Although I am never in favour of hiding issues from patients, this book can, even for the well-informed patient, make you wonder what else you might be in for next! In the context of a supportive, ongoing relationship with a clinician this should not be a problem, as questions can be asked, but many HMS patients have very little specialist support with whom to check out such issues.

For the professional clinician, the book may be more suitable to recommend to some of your patients than others – it is probably best suited to the more informed patients, who have a good basic grasp of the



condition and associated medical terms. The book suffers from problems caused by the complexity and uncertainty surrounding some of the symptoms that may, or may not, be associated with the condition. Research into this area is constantly drawing new conclusions, so the task of writing an accessible book for patients is a difficult one. However, the early chapters, covering the nature of the condition, are not easy to understand – even after two readings, and years of knowledge as a patient with the condition, I found them confusing. Contradictions in medical evidence are also not always clearly highlighted, so at points the book contradicts itself without explaining the reason (i.e. inconclusive medical evidence), for example over the issue of whether people with HMS are more or less likely to suffer from arthritis.

Pain management is covered in a dedicated chapter, although mentioned throughout. A real plus point in the

book is how it emphasises the need for patients to take ownership of their own health. It clearly explains the cycle of pain, leading to reduced movement and inactivity, then leading to increased pain, and so on. This is important in any condition, but particularly in HMS, where muscle tone is lost very quickly

due to the laxity of tissue. It stresses the need to undertake regular exercise, with professional guidance as necessary.

Overall, the book fills a gap in the market and will be an invaluable resource for some, but not all, people with HMS. It may be as appropriate, if not more so, as

a resource for non-specialist clinicians to get a sense of the variety of symptoms that can be associated with HMS and the complexity of the patient experience in a condition about which they often have limited knowledge. Indeed, I am aware of at least one person who has bought a copy for their GP.

End-stuff

Course review

Clinical Management of Chronic Pain, Pain Relief Foundation, Liverpool

Reviewed by Dr Devjit Srivastava
Ulster Hospital, Belfast



The Walton Centre NHS
for neurology and neurosurgery
NHS Foundation Trust


The Pain Relief Foundation

CLINICAL MANAGEMENT OF CHRONIC PAIN COURSE

5-9 NOVEMBER 2012
An advanced practical course in Clinical Pain Medicine for Pain Specialists and Pain Specialists in training
Limited to 30 participants
FEE £850

Demonstration pain clinics
Practical Pain Imaging
Case Presentations
Managing common pain clinic problems
The Pain Clinicians Role in Palliative Care
Implants for Chronic Pain
Demonstration Theatres
CRPS demonstration clinic
Practical Pharmacology
PMPs—How to assess and treat patients
Setting up and running a pain clinic & PMP
Course Dinner included

Contact: Mrs Brenda Hall, Pain Relief Foundation, Clinical Sciences Centre, University Hospital Aintree, Lower Lane, Liverpool L9 7AL, UK
Tel: 0151 529 5822 or email b.hall@painreliefoundation.org.uk
www.painreliefoundation.org.uk
Registered Charity number 277732



There has been a growing awareness of chronic pain as an important long-term condition with a significant impact on society. Chronic pain is therefore one of the most challenging conditions in medicine today. There is a complex interplay of psychological, sociological and biological factors in the genesis and

perpetuation of chronic pain conditions. This makes the task of educating professionals who manage pain very challenging. There are very few courses that offer an overview of the whole spectrum of pain medicine. This course at Liverpool provides a comprehensive overview of the most pertinent pain issues facing clinicians in their day-to-day practice.

I attended this course prior to starting a pain medicine fellowship. The course is meant for health care professionals who have an interest in chronic pain management and who have had some training or are embarking on a career in chronic pain. Participants at the last course included anaesthetic trainees, fellows in chronic pain, pain consultants from abroad, anaesthetic consultants with an interest in pain, general practitioners, staff-grade anaesthetists, as well as doctors from palliative care. This course is organised by the Pain Relief Foundation (a registered charity) in association with the Faculty of Chronic Pain at The Walton Centre for Neurology and Neurosurgery and takes place at the Clinical Sciences Centre, University Hospital Aintree, Liverpool and at Walton Centre.

There was a healthy mix of theoretical and practical demonstration sessions. The faculty was knowledgeable and friendly. The practical sessions involved real patients with live consultations. For me, this was the most significant

strength of the course. It was a five-day intensive course and initially those of us attending were apprehensive about maintaining interest. However, we found that even on the afternoon of the fourth day our enthusiasm remained high. This was because the course content was diverse and involved real patient consultations and the involvement of course participants in stimulating discussions. It was quite interesting to note the wide spectrum of approaches to chronic pain management.

The course faculty was truly multidisciplinary and included pain physicians, neurosurgeons (with pain interest), neurologists, anaesthetists, radiologists, pain nurses, physiotherapists, occupational therapists, psychologists and a physiologist. The Walton Centre for Neurology and Neurosurgery holds the distinction of starting the first pain management programme in Europe; hence sessions on the programme and its evolution were outstanding. In addition, there was a physiotherapy clinic and theatre sessions on interventional pain management.

The first day included lectures on lumbar imaging, facial pain and neuropathic pain, along with five demonstration pain clinic sessions. Day two started with case presentations on myofascial pain, chronic neck pain, low back pain and cancer pain. In the afternoon, we learned how to assess patients for spinal cord stimulators and

manage related issues. Day three started with a grand round followed by a salmon lunch (truly delicious!) at the Liverpool Medical Institution and then an informative session in palliative care pain.

Day four was devoted to the pain management programme. We attended clinics on medical, psychological and physiotherapy patient assessment. This was followed by a session in which patients talked about their experiences. The final programme included complex regional pain syndrome and the course concluded with a session on how to set up and run a pain clinic in a district general hospital and a pain management programme.

However, there are a few areas where the course could offer more. There are no sessions specific to the Fellowship of the Faculty of Pain Medicine of the Royal College of Anaesthetists (FFPMRCA) examination. Additionally, a session to provide a broad overview of how chronic pain compares with other long-term

conditions would be useful in terms of providing perspective before diving into the nitty-gritty of pain management. Also, the course does not cover paediatric pain problems.

This course is primarily aimed at medical professionals interested in pain management. I would highly recommend this course to any trainee/health professional contemplating or already working in the management of chronic pain. For those in anaesthetics, this course provides an overview of current practice. For those from rheumatology, neurology, orthopaedics and general practice, this course would be an introduction to the complexities and current state-of-the-art treatments available for managing pain. The discussions are fairly informal and I learned a lot from the question time during each session. For doctors already working in pain management, this course offers good value as during the five days you get a comprehensive overview of current chronic pain practice and go

back with batteries recharged and having made new friends in the world of pain management. The course also attracts doctors and faculty from a wide variety of specialties; hence there are plenty of opportunities for learning by 'cross-pollination'.

The course fee was only £750, which included teaching sessions, downloadable lecture notes, lunch and tea on all days with a course dinner on day four. Accommodation is not included but there are plenty of convenient and reasonably priced hotels near the venue, including the hotel run by the Aintree Hospitals. The course is held only once a year and is very popular, so you need to book in advance to secure a place (contact: b.hall@painreliefoundation.org.uk).

In summary, these are exciting times for the specialty of pain medicine and this course would be a great stepping stone on the pathway to understanding the huge challenges facing pain medicine today.

End-stuff

Letters to the Editor

Response to a letter to the Editor: Training in pain medicine and the ability to diagnose

I would like to thank Dr Barry Miller for his interest in our article on 'Dilemma of diagnosis in the pain clinic', which was published in *Pain News* Winter Edition 2011 pp. 19–22. He raises important issues, questioning our reasoning and also raising the adequacy of training of the modern pain physician. He states that both lead to the legal problems for individuals as given in this scenario. In his letter, he states rather *worryingly* in my opinion that 'it falls outside their [the pain consultants'] remit and specialist knowledge to investigate for causes [of the pain]'.

He then goes on to state that the realpolitik issue, as he puts it, is that of training.

My response to Dr Miller is to fully accept that the training for pain medicine for current trainees has changed in terms of the time constraints produced by Calman, Postgraduate Medical Education and Training Board and the General Medical Council. I think that we have done a disservice to medicine in general, but that is another issue. For pain trainees, time is limited because of the requirements to also be fully competent in anaesthesia. We all have to work within constraints, but my own perception of trainees as they come and attend my clinics is that many feel very frustrated at the short period of time that they get to spend in clinics and on

interventional lists. In my opinion, the trainees are willing to learn so long as they are given the opportunity to develop not only their skills in areas specific to the pain medicine but also their skills as clinicians generally in line with their training in medicine.

I felt pleased at a recent letter from the Vice Dean and the Chair of the Court of Examiners Dr Kate Grady and the Dean Professor David Rowbotham of the Faculty of Pain Medicine of the Royal College of Anaesthetists clarifying the role of the FFPMRCA examination, in which it was emphasised:

...that the examination is not an exit exam and is not required in order to complete the CCT program for

Anaesthetics or for entry on to the specialist registrar. It is however a requirement to become a fellow of the Faculty and in particular examination has been introduced to make explicit a high standard of pain medicine practice and enhance the practice of pain medicine and ultimately benefit our patients.

The letter also states:

it will bring the FPM into line with other Faculties nationally and internationally. The examination is intended to be a rigorous test of knowledge in clinical pain medicine. The general principle is that we will be looking for the standard of a competent and knowledgeable doctor about to become a pain medicine consultant.

In my opinion, a competent and knowledgeable doctor in pain medicine will have the ability to understand the arts of history-taking, clinical examination and diagnosis – both as a general physician and pain medicine consultant. How can we possibly do otherwise? As was

pointed out by the barrister James Aldridge, if the symptoms we are given do not match the supposed clinical diagnosis, then the courts will need us to have suspicions raised and to investigate or certainly send the patient on to somebody for investigation. In this role, we are no different to general practitioners, who have to make the same decision on whether to ignore or palliate or investigate or refer on the basis of symptoms and signs. This is the essence and art of medicine.

Certainly until recently, pain clinics often managed patients for a prolonged period of time; any caring and competent pain physician would have to continue to check whether the symptoms that were complained of continued to match the diagnosis that had previously been made. A considerable degree of clinical expertise is required for this.

If Dr Miller states that the current pain training is not adequate for this, then in his role as being on the training committee, I would ask him to look again at pain training and how much time pain trainees get to spend in a pain clinic.

The only other solution I see is to accept pain trainees, preferably with the FFPMRCA, which raises the standard even further, as consultant colleagues but continue to accept that for a number of years after being appointed as a consultant, in a sense be a junior consultant being mentored by a more senior colleague. We accept that as doctors and indeed consultants in pain medicine we are always learning through going on courses, through clinical experience and through reflection of our practice. As our experience increases, we are able even more competently to manage our patients; as in the words of Dr Grady and Professor Rowbotham: 'to ultimately benefit our patients'.

As Albert Einstein mentioned: *'Learning is not a product of schooling, but the lifelong attempt to acquire it.'*

Dr Rajesh Munglani, Consultant in Pain Medicine
Council Member, British Pain Society

The views expressed here represent Dr Munglani's own views.

Sir,

I read the debate on 'Dilemma of diagnosis in pain clinic' and the response from Dr Miller. One of the issues raised by Dr Miller was about the training in pain medicine.

The pain training has changed significantly in the last decade. In the current system, the training programme includes basic training in the early years of anaesthetic training, which mainly involves management of acute pain with little exposure to chronic pain. At the intermediate and higher level, exposure to chronic pain varies from one to three months. At the advanced level lasting for a year, the trainees spend most of the time training in acute and chronic pain.

The current pain training programme is more focused, structured and competency based. The introduction of exams will ensure that the necessary knowledge required to practise as a pain physician is possessed by all. The training does prepare one to practise safe and effective pain medicine, but is limited by time. Mastery and expertise in pain medicine cannot be obtained from training in pain medicine over a period of 15 to 18 months. Learning is a continuous process and it is expected that this will continue after trainees become consultants.

The second issue raised by Dr Miller addresses the diagnostic role of a pain specialist. Although we do diagnose

certain chronic pain-related conditions, it is not a specialty where we are trained to provide a diagnosis. The expertise required for that role is very different; our training programme in pain medicine does not prepare us for this role. To be a safe pain physician, we need to be able to recognise our limitations and seek expertise from other specialties to aid management as part of a multidisciplinary approach.

Competing interest: I am currently pursuing my advanced pain training. This letter is only a personal opinion.

Yours sincerely,
Karthikeyan Dhandapani
Advanced Pain Trainee, Leeds

Sir,

I read the three excellent articles under the heading 'Does a diagnosis in pain medicine promote disability' with a mixture of pleasure and sadness. What the authors have to say is clearly eminently worth saying but the question is: why does it *still need* saying after all these years? When I came into pain medicine more than three decades ago, it was already apparent that I had to change my dualistic mindset, and I spent much time and energy working on my colleagues and with my patients to help them do likewise. The damage caused by careless use of language in presenting depressing diagnosis and prognosis was already only too obvious. I fear my medicolegal reports caused some exasperation in the legal profession with my efforts to explain that long-standing chronic pain was usually complex and multifactorial in nature, but even then this was nothing new.

I am sure I am far from alone in this and that the theme is only too familiar to many of your readers. But the question remains: why have we apparently still failed to put over these concepts to so many in the health and legal professions, or for that matter the public? Surely it cannot be for want of trying. The difficulty is perhaps understandable: relatively simple concepts like mind-body dualism hold a natural appeal for professionals and patients alike. (We are perhaps inclined to forget that not all of the latter have enjoyed the same benefits of education as ourselves – or sometimes, conversely, to assume this and not bother to try to explain such difficult issues.)

It isn't easy for any of us to avoid thinking simplistically about complex issues or to hold apparent contradictions in mind at the same time. The culture of scientific medicine has sometimes seemed to encourage dualist thinking. (The reductionist method may recognise

the complexity but often fails in the more complicated task of putting the pieces together in a complete picture relevant to human suffering.) The law asks for simple certainties (such as could this patient's continuing pain be attributed to a single incident many years ago) where they are difficult to prove.

What is to be done about it? Here I fear I find myself somewhat bereft of new solutions to a problem that appears to have defeated us for so long. Much of the onus would appear to lie with those responsible for medical, or indeed general education. And pain professionals will have to continue to bang on about it to colleagues and patients, however discouraging the response may sometimes seem. But may I invite your readers to contribute some fresh ideas? It would certainly seem to be necessary!

Yours sincerely,
Peter Wemyss-Gorman

Response from the author: Expectation and the experience of pain and disability

I would like to thank Dr Peter Wemyss-Gorman on his interest and his contribution to the three linked articles 'Does a diagnosis in pain medicine promote disability?', published in *Pain News* 2012 vol. 10 no. 1. He states that what was said was eminently worth saying but questions why does it need to be said still after all these years?

I entirely agree, but what fascinates me is that there is no direct relationship between injury, physical impairment, the perception of pain and disability. Medicolegally, we talk about conscious and unconscious exaggeration; what fascinates me is the increasing neurobiological evidence that expectation of pain or disability will produce it in a very real way.

In a fascinating paper entitled 'Descending analgesia – when the

spine echoes what the brain expects', published in *Pain* 2007 vol. 137 p. 143 by Goffaux et al., it is stated that changes in pain produced by psychological factors (e.g. placebo analgesia) result from activity in specific cortical regions. Goffaux et al. state that some cortical nuclei including the periaqueductal grey and the rostral ventral medulla also show selective activation when subjects expect pain relief. These brainstem regions send inhibitory projections to the spine and produce diffuse analgesic responses. It is stated by the authors that the precise contribution of spinal mechanisms in predicting the strength of placebo analgesia is unknown.

In this study, subjects in the 'analgesia expectancy group' were told that immersing the right arm in cold water would help lessen the painful sensations of the stimulus applied elsewhere in the body, and a painful electrical stimulus

was applied to their sural nerve (near their left ankle). In the 'hyperalgesia expectancy group', participants were told that the immersion procedure would have pain-enhancing effects. Immediately prior to the testing session, participants rated the extent to which they *expected* the immersion procedure to change the pain produced by the electrical stimulation.

What was the remarkable was that the change in pain intensity perceived after painful electrical stimulation of their sural nerve by the immersion of their right arm in cold water matched their expectations and importantly those subjects that *expected to feel a decrease* in pain because of the immersion did so and, in those who *expected to feel more pain*, also did so. Moreover and even more remarkably, the sural reflex electrophysiological response also actually changed depending on the expectation and

magnitude of pain relief. This is a profoundly illuminating study and I would urge others to read it.

Like Dr Wemyss-Gorman, I believe that the only way to practise pain medicine is to throw the mind-body duality and Cartesian logic out of the window as an unhelpful model in being able to understand and treat patients. There is no doubt that severe chronic pain will

profoundly affect the mind of an individual but in addition the power of the mind to influence the experience of pain is just as profound.

As attributed to Job in the oldest book of the Bible: *'For the thing which I greatly feared is come upon me, and that which I was afraid of is come unto me.'*

The strength of the membership of British Pain Society is to recognise the

multidisciplinary nature of generation, maintenance and treatment of pain. The days when interventionists no longer talk to non-interventionists, I hope, is gone. We recognise that not all pain is in the brain, but neither is the power of the mind to be ignored.

Dr Rajesh Munglani, Cambridge.

Sir,

The article by Ian Yellowlees is a bold and thought-provoking take on the current uncertainty surrounding the pain service.¹ Many of us, I am sure, are concerned about the uncertainty surrounding the long-term viability of the pain service. As members of the Pain Society, we passionately believe in the need for specialisation and the importance of our expertise to patients we serve.

In reality however, the schism within specialists supporting procedural treatments and those supporting comprehensive psychosocial interventions creates confusion in the marketplace. Which part of the package will the commissioners fund? In the face of the drive to minimise secondary care referrals and reduce outpatient clinic episodes, how will the service be funded? Can the localisation of multidisciplinary team (MDT) services, including Improving Access to Psychological Therapies (IAPT) services in the community work? Is it the suitable framework for chronic pain care in the 21st century?

I do not have the answers but agree with Yellowlees that a number of packages of treatment that we provide do not result in overall improvement and service appears to be faltering. To speak about the goal of treatment, an improvement for chronic pain patients is clearly an improvement in their perception of functioning ability, both physical and emotional.²

How can one evaluate it? In the 21st century, we have access to valid, sensitive, generic, health-related quality of life questionnaires for measuring function. For example, the SF36 questionnaire has been used extensively and was found to be a suitable in chronic diseases evaluation.³ To an external observer, the logical method of resolving conflict would be a comparison of outcomes of the varied interventions. If we are to convince others that we are the experts for resolving the problem and enabling patients to function better, it is in our interest to incorporate the objective outcome evaluation of our practice. Although international

consensus recommendations for the measurement were published a decade ago (<http://www.immpact.org>), routine use is not established in practice.

Unless we take up the challenge to objectively measure outcomes and publish guidelines incorporating them, will we be listened to? By avoiding routine objective assessment of chronic pain measurement, we will not only end up kidding others but kidding ourselves too. We have a window of opportunity to make a difference.

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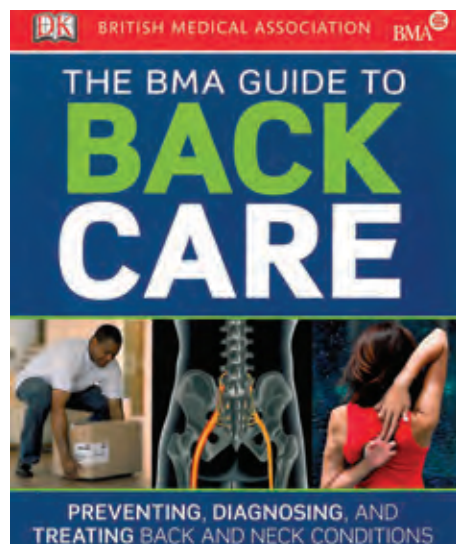
Competition results



THE BRITISH PAIN SOCIETY

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The winners of ***The BMA Guide to Back Care*** book competition are:

*Christina Hambrook, Kent Community Health NHS Trust

*Beverley Hopwood, Royal Devon and Exeter Hospital

*Kathryn Nur, Withybush General Hospital

*Neeraj Saxena, Cardiff University

*Alan Brown, Ceredigion

*Gareth Parsons, University of Glamorgan

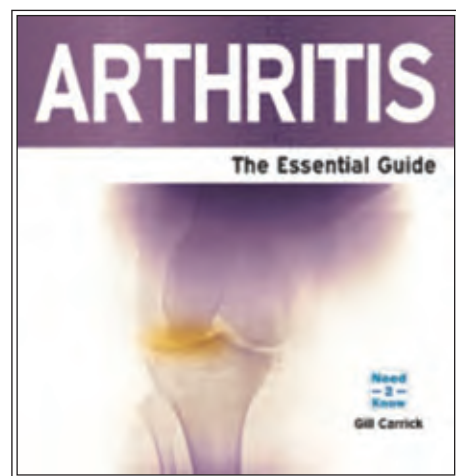
*Atef Al-tawafsheh, University College Hospital, London

*Tina Elliott, QEQM Hospital, Margate

*Rajinikanth Sundararajan, Queen Elizabeth Hospital, Kings Lynn

*Pete Moore, Pain Toolkit, Essex

Each winner will receive a copy of the book by post soon. *Pain News* thanks all the members for their support and participation.



The winners of ***Gill Carrick's Need-2-Know Series Book of Arthritis*** are:

*Sara Brookes, Northumbria Healthcare

*Lucy Williams, Great Western Hospital, Swindon

*Vinod Sanem, Hull Royal Infirmary

*Yaroslav Stefak, St George's Hospital, London

Each winner will receive a copy of the book by post soon. *Pain News* thanks all the members for their support and participation.



The gift of knowledge

Michael Bavidge

The author presented this talk in the Philosophy and Ethics SIG meeting, which has been transcript by Peter Wemyss-Gorman. We apologise for any omissions and errors that might have occurred without our knowledge during this process of converting lectures into essays. Full transcripts are available from pwgorman@btinternet.com

I want to look at the differences between knowledge of persons and knowledge of the non-personal world. The differences are philosophically significant and they have implications for clinical practice. My interest is not just academic. It comes from a concern that the distinction between personal and impersonal knowledge is frequently denied; in fact its denial seems to be embedded in some scientific disciplines and in general cultural attitudes.

In a recent review in the *Guardian*, Dorothy Rowe wrote:

We can never know precisely what another person is thinking and feeling. As neuroscientists have established, we cannot see reality directly. All we can ever do is to create theories or guesses about what is going on in the human-sized world in which we appear to live.¹

In three casual sentences she announces, as if it were too obvious to be worth saying, first that we, the most communicative of animals, cannot know or cannot know *precisely* what other people are thinking and feeling (what is that word 'precisely' doing there?); and second, that we, the animals who strive to understand the nature of the world objectively, cannot know reality *directly* (whatever 'directly' means).

Colin Blakemore, Professor of Neuroscience at Oxford, gives another example of the denial of the distinction between personal and impersonal knowledge:

. . . increasingly, those who study the human brain see our experiences, even of our own intentions, as being an illusory commentary on what our brains have already decided to do.

Perhaps we humans come with a false model of ourselves, which works well as a means of predicting the behaviour of other people – a belief that actions are the result of conscious intentions. Then could the pervasive human belief in supernatural forces and spiritual agents, controlling the physical world, and influencing our moral judgments, be an extension of that false logic, a misconception no more significant than a visual illusion?²

He argues that thinking of ourselves as experiencing and intending creatures involves a 'false logic'; he speculates that religious beliefs result from an extension of this mistaken way of thinking to supernatural forces. But that seems an artificial line of thought even for a five-star atheist. If there is an error in supernatural beliefs, it is not in the way we think about ourselves, but in extending the way we think of ourselves to supernatural beings.

The well-known neurological experiments of Benjamin Libet purported to show that unconscious brain activity leading to a person's movement occurred before the awareness of an intention to move. These findings are

supposed to support Blakemore's contention that our awareness of our intentions is an illusory commentary on what our brains have already decided to do. The conclusion is that our experience of what is going on relates to brain events as a sport commentary relates to a game; in other words it is epiphenomenal – but worse than that, it is an illusory commentary. Not only is the commentary not a working part of what is happening on the pitch, it is a mis-description of what is happening there; it is about the wrong sort of game altogether, like talking of goals in a cricket match. Similarly, Blakemore suggests that when we talk about intentions we are really talking about something that does not exist in reality at all.

We ought to take these claims with some degree of seriousness as they affect the way we think about ourselves and other people and the world. If we take Rowe and Blakemore together, at their word, we get a triad of denials: we do not know the world directly; we know other people only in the sense that we can predict their behaviour on the basis of fictions; and we are seriously deluded about ourselves.

This depressing story is based on a narrow idea of what knowledge must be. To resist it, we must recognise that there are different but mutually dependent sorts of knowledge: there is no objective understanding of the world without a community of inquirers – that is, without a community of people who understand

(sometimes precisely) what others are thinking; and there is no community of inquirers unless they are embedded in a shared environment – that is, a common world in which they cooperate intelligently.

Two kinds of knowledge

Personal knowledge is structurally different from impersonal knowledge. It differs in the data on which it is based. There are two senses of 'data'. Data has come to mean a group of known or assumed facts from which by calculation or theoretical interpretation, conclusions can be drawn; but etymologically, data is the past participle of the Latin verb *dare*, to give: data means *given* in the sense of a gift. It is in this second sense that the data on which we build personal knowledge is something that we have to be given. This explains my title 'Knowledge as gift'. Our knowledge of each other is based on direct, interpersonal transactions of which gift-giving is a particularly important example. We cannot acquire it through our own resources. It can only be acquired by waiting on the interventions of others – on their ability and willingness to communicate with us, on their expressions, avowals and disclosures.

This idea runs counter to deep assumptions: we live in the information society; all information is equal; it does not matter where it comes from or who discloses it. We are not always comfortable about this. For example, we think people have a right to privacy. They have a right that certain facts about them do not become common knowledge – their medical history, for instance. One's medical history consists of information, personal, perhaps sensitive, but facts all the same. However, there are cases that raise issues beyond the obvious moral and legal questions: sometimes the method of disclosure materially affects what is disclosed; it is not just a matter of

not upsetting someone's sensitivities or breaching their proprietary rights. We are no longer dealing with information, with facts, even sensitive facts, but with facts insofar as they relate to the person's broader feelings, intentions and interests. For example, it may be possible to regard someone's sexual orientation as a fact about them, but we may want to know what they make of their sexuality. If that is what we want, we have to wait for them to tell us. Only they are in a position to tell us. Personal knowledge can be thought of as a gift because we can only acquire it through the good offices of others.

In his foreword to *Pain Suffering and Healing*, John Loeser supports this view of personal knowledge: 'suffering can only be addressed through the patient's narrative. . . . Suffering cannot be found in a laboratory test or imaging study; it is only observable by communicating with the sufferer.'³ Loeser emphasises our dependence, when it comes to understanding suffering, on the patient's own account, but there is still a philosophical trap waiting for us. He writes: 'We also know that eye witnesses are notoriously unreliable; a patient is the epitome of an eye witness.'³ This suggests that we need the patient's own narrative because they have exclusive access to the information we want; the trouble is that the patient is unreliable. But inner states are not as private as we have come to think and access to other people's inner states is not through their witness reports but through their direct communicative talk and behaviour.

We need personal disclosure, but not because each individual is the only eyewitness of the events in his or her own inner life. We are not, in the first instance, eyewitnesses at all. We speak out of our experiences before we speak about them. We express ourselves and our inner states; we do not observe them and then report on them. People suffer and they express their suffering;

later they may report, describe or tell the story of their suffering. Expression is primitive.

Wittgenstein argues that descriptive language is not required to mediate between experience and expression. Reports and narratives do not get between our experience and its expression. He imagines someone asking 'but isn't the beginning the sensation – which I describe',⁴ and he answers 'No'. Expression comes first: 'For how can I go so far as to use language to get between pain and its expression?'⁵ As if, for example, we could prise the person undergoing the pain from the pain itself and insist that, before he gives expression to his pain, through crying or in words, he takes note of the *fact* that he is pain.

The difference between expression and description is important, but there is instability between them. In the rough and tumble of life, we move between them – sometimes easily, sometimes with difficulty and sometimes in anguish. Facing real suffering, we are caught between anguished expression and the narrative that is dragged or enticed out of us, both threatened by the silence of suppression or despair.

Wasp sting

Personal knowledge is made possible by spontaneous expressions of thought and feeling. But in the argument against those who have lost confidence in our power to communicate, another idea is just as important: we should show how our inner experience is not as inner as all that; it is shaped by aspects of the world around us. This seems to be true of those mental states such as beliefs or intentions that have a high cognitive content. I could not form the intention to go for a drink this evening unless there were real pubs and real beer. But it is equally true of those states, sensations for example, that seem to have little or

no intellectual content, and which seem to fit perfectly into our inner world without any overspill.

When my five-year-old son, Colin, was stung on the lip by a wasp he screamed and screamed until my brother, who happens to be a doctor, managed to get his attention. He agreed with him that it really hurt, but said that every quarter of an hour by the mantelpiece clock it would hurt less and stop after one hour. Colin stopped crying and went out to play. Every few minutes he ran back to look at the minute hand, to check how bad his pain was. This seems a good illustration of another of Loeser's remarks: 'What we experience is colored by our past experiences and the anticipated consequences. The placebo response demonstrates this with clarity.'³ But there is still something odd about a little boy looking at a clock to find out how bad his pain is. Surely he already knows how bad the pain is just by having it; or we might say in a philosophical moment, he knows how bad the pain is through introspection. What my brother did was trick him into distorting his account of his own experience. But is that right? Wittgenstein says in Zettel:

I may know that he is in pain, but I never know the exact degree of his pain. So here is something that he knows and that his expression of pain does not tell me. Something purely private. He knows exactly how severe his pain is? (Isn't that much as if one were to say he always knows exactly where he is? Namely here.⁶

My brother was not just using diversionary tactics to help his young nephew through an unpleasant experience. He was communicating something about the concept of pain: it is something of which you can take an overview; it is to be endured but also managed; it has degrees; it comes and goes. In particular, he related it to time objectively realised – the hands on the face of the clock. He was not explaining the meaning of the word 'pain', but sharing with his nephew an idea of where pain fits into the woof and warp of life. Every mother does the same when she kisses the baby better or tells the child who has hurt him or herself to count to 10. When we interact with infants in these ways, we give shape to their experience. Just as we give shape to the

world they live in when we communicate concepts like bus or dog or dinner. We organise our experience as well as the world, using concepts we learned at someone else's knee.

Unfortunately space does not permit inclusion of the important and illuminating discussion that followed these talks. The transcript of this and the rest of the proceedings of last April's meeting is now available as a booklet, available from Peter Gorman (pwgorman@btinternet.com), and will also be on sale at the Philosophy and Ethics SIG parallel session at the ASM in Liverpool. Spaces may still be available at the 2012 meeting of the Philosophy SIG at Rydal Hall on 2–5 July *The Ethics of Care*. Please direct enquiries to Diana Brighouse (dbrighouse@aol.com).

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- 3 Loeser JD. Foreword. In P Wemyss-Gorman (ed.) *Pain, Suffering and Healing: Insights and Understanding*, Radcliffe Medical Press, 2011
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- 6 Z 536

Essence

No Pain No Gain?

Pursuing valuable goals reduces pain-related avoidance behaviour. The researchers found that pain task trials were completed more if there was a monetary reward compared to the group where there was none. This proves that the association between avoidance behaviour and fear of pain was smaller in the competition group than in the control group (*Pain* 2012; 153(4): 800–4).

Pre-Operative Pregabalin Reduces Post-Operative Opioid Need

A recent study in *British Journal of Anaesthesia* (May 2012; 108(5): 845–9) has shown that 300 mg of pregabalin given an hour before anaesthesia in patients having transperitoneal nephrectomy reduces the post-operative consumption of opioids and also decreases the area of mechanical hyperalgesia. This randomised, triple-blinded, placebo-controlled study showed that a single pre-operative dose could reduce pain sensitivity and hyperalgesia post-operatively.

NICE Guidance on 'Improving the Experience of Care for People Using NHS Services'

The National Institute for Clinical and Health Excellence (NICE) has recently published this guidance to improve the experience of patients using NHS services (February 2012). One of the key recommendations of this document is to ensure that the patient's pain relief is adequate at all times when they are unable to manage their own analgesia by *not* assuming that it is adequate. The guidelines suggest that the patient should be asked regularly about their pain (<http://guidance.nice.org.uk/CG138>).

Are Mast Cells the Clue for Inflammation in CRPS?

Animal experiments have shown that Substance P acting through neurokinin-1 receptor results in mast cell accumulation, degranulation and nociceptive sensitisation leading to

complex regional pain syndrome (CRPS). This was done by histological and immunohistochemical analysis of rats that underwent tibia fracture and casting for four weeks (*Anesthesiology* 2012; 116(4): 882–95). If this is proven, it might in future be possible to histologically identify high-risk patients from fracture who might develop CRPS.

Tests and Treatments to be Avoided

A recent news item in the *BMJ* (2012; 344: e2601) reported on the *Choosing Wisely* campaign from family doctors in the USA. This campaign urged doctors and patients not to seek or perform imaging tests for low back pain of less than six weeks unless red flags are present. They also stressed the need to avoid dual-energy X-ray absorptiometry (DEXA) scans for osteoporosis in women under 65 and men under 70 with no risk factors.

Warmth is Analgesic in Newborns

Hot-water bottles and pads might help chronic back pain, but recent evidence has shown that newborns had less pain during vaccination with warmth when compared to gold standard treatments of sucrose or a pacifier. The scores were less in all categories including crying, grimacing and heart rate differences (*Pain* 2012; 153(5): 960–6).

Publication Bias in Literature

A recent study in *Anesthesia & Analgesia* (May 2012; 114(5): 1042–8) has reported publication bias in the anaesthesiology literature. The shocking news is that the incidence is more in higher clinical trial impact factor journals. The study recommends authors to submit negative studies to high-impact journals.

Patients with Pain Behaviour – Less Likeable, Less Dependable?

Researchers in Montreal, Canada asked observers to watch and judge video

sequences of patients with chronic back pain performing physically demanding tasks. The results showed that patients with protective pain behaviours were perceived as being significantly less likeable, less dependable and less ready to work than patients displaying other forms of pain behaviour (*Pain* 2012; 153(4): 843–9).

Acupuncture Improves Neuropathy

Nerve conduction studies were done to measure outcome in patients having acupuncture treatment for chemotherapy-induced peripheral neuropathy. The study had the limitation of having only six patients in the study group and five in the control group. Five out of the six study group patients had improvement in nerve conduction studies after acupuncture (*Acupuncture in Medicine* 2012; 30(1): 4–7).

NSAIDs Increase Risk of Atrial Fibrillation

The Danish national registry of patients with atrial fibrillation or flutter was analysed to find the risk of NSAIDs. The study confirmed the association and showed that it was strongest for COX-2 inhibitors and for new users of the medication (*BMJ* 2011; 342: d3450).

Dance between Intrinsic Neuronal Currents and Neuronal Connectivity

Until now, emergence from anaesthesia was considered a passive process. An editorial and study in a recent issue of *Anesthesiology* (2012; 116(1): 977–9) has highlighted that waking up from general anaesthesia is not just the inverse of induction. It mentions that by activating a number of natural wake-promoting brain systems, we induce a partial physiologic antagonism to general anaesthesia.

Video podcasts on pain

Our Society organised a workshop in the Winter Scientific Meeting of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) in January 2012 in London. The video podcasts of

these presentations are available freely on the video platform of the AAGBI website at <http://videoplatform.aagbi.org>

The three topics presented were:

(1) Pain corrupts the neural circuitry;

(2) Poorly controlled acute pain leads to chronic pain; and (3) Perioperative care of patients with chronic pain. Each of these three lectures is about 20 minutes long.



IPM SIG Annual Scientific Meeting, 28th September, 2012

Venue: Radisson Blu Hotel Manchester Airport, Manchester, M90 3RA
(www.radissonblu.com)

8:30 – 9.30 Registrations

9:30 – 9.40 Welcome and Introduction: Dr Manohar Sharma

1st session Neuromodulation updates (9.40 – 11.00 hrs.) Chair: Dr Simon Thompson

9.40 – 10.10 Dorsal root ganglion stimulation: Indications, evidence and experience: Dr Liong Liem (Netherlands)

10.10 – 10.40 High frequency dorsal column stimulation: Indications, evidence and experience: Dr Iris Smet (Belgium)

10.40 – 11.00 Discussion/Questions

11.00 – 11.20 Coffee / Tea

2nd session Neuroablation updates (11.20 – 13.00 hrs.) Chair: Dr Kate Grady

11.20 – 11.50 Neurosurgery, Pain and Neuroablation; When to refer to Neurosurgeon? Mr Paul Eldridge (Liverpool)

11.50 – 12.15 Cordotomy for cancer pain: Evidence and progress on Registry study? Prof Matthew Makin (Wrexham)

12.15 – 12.35 Lumbar Chemical Sympathectomy: The evidence and future directions? (TBC)

12.35 – 13.00 Discussion/Questions

13.00 – 14.00 Lunch

3rd Session Update on current issues in Interventional pain medicine (14.00 – 15.15 hrs)

Chair: Dr Rajesh Munglani

14.00 – 14.20 Good practice guidelines (Lumbar Radiofrequency): Dr Neil Collighan/ Dr Sanjeeva Gupta

14.20 – 14.40 Update on research feasibility group; Progress so far: Dr Vivek Mehta (London)

14.30 – 15.00 TBC

15.00 – 15.15 Discussion/Questions

15.15 – 15.30 Coffee / Tea

4th Session Cancer Pain Management (15.30 – 16.40) Chair: Dr Sanjeeva Gupta

15.30 – 16.00 Role of Interventional Pain Medicine in Palliative care: Palliative care perspective. Prof Sam Ahmedzai (Sheffield)

16.00 – 16.25 Absolute alcohol and Neurolysis for cancer pain: Indications, technique and Outcome: Dr Arun Bhaskar (Manchester)

16.25 – 16.40 Discussion/Questions

16.40 – 17.00 Business meeting IPM SIG members

17.00 Close of meeting

New members



THE BRITISH PAIN SOCIETY

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Name	Position	Institution
Dr Rosalind Adam	GP	Aberdeen Royal Infirmary
Ms Jenny Lorimer Allison	Health Psychologist	Royal Free Hampstead NHS Trust
Mr Andrew Richard Atkinson	Acting Charge Nurse Pain Management	Birmingham City University
Dr Colin Robert Wilson Baird	Advanced Trainee in Pain Medicine	NHS Lothian
Miss Lisa Danielle Bentley	PhD Research Student	Birmingham City University
Dr Iain Brew	GP	HMP Leeds
Dr Waqas-Ashrae Chaudhary	Student (Msc Pain Management)	University of Leicester
Dr Hannah Connell	Consultant Clinical Psychologist	Royal National Hospital for Rheumatic Diseases
Miss Laura Coote	Undergrad Student on work placement	Gloucestershire Royal Hospital
Mrs Emma Davies	Advanced pharmacy practitioner	Morriston Hospital, Swansea
Dr James Robert Day	ST4 Anaesthetics	Wexham Park Hospital
Dr Parveen Dhillon	ST5	Peterborough City Hospital
Prof. Anthony James Elliott	Consultant Psychiatrist	Shelton Hospital
Dr Alan Fayaz	ST4 Anaesthetics	Homertone Hospital
Dr Ann-Katrin Fritz	ST6 Anaesthetics	Ipswich Hospital
Dr Praveen Kumar Ganty	Consultant in Pain Medicine	The Walton Centre
Dr Babita Ghai	Commonwealth Fellow in Pain Management	St Barts
Dr Ian David Goodall	Consultant in Pain Medicine	Chelsea and Westminster NHS Trust
Mrs Vanessa Gordon	Operating Department Practitioner	Basildon & Thurrock NHS FT Hospital
Miss Alexandra Ho	Medical Student	Chelsea and Westminster NHS Trust
Dr Shefali Kadambande	Consultant in Anaesthesia and Pain Medicine	University Hospital of Wales
Mrs Linda Knott	Clinical Specialist Physiotherapist	Torbay Hospital
Dr Deepak Kumar	SpR Anaesthesia and Pain Medicine	Mater Misericordiae Hospital, Dublin
Dr Laura Lister	Anaesthetics SpR	Royal Surrey County Hospital
Dr Patrick Malhotra	ST4 Anaesthetics	Royal Liverpool Uni Hospital
Dr Rajiv Malpus	Clinical Psychologist in Pain Management	Wythenshawe Hospital
Miss Zoey Gail Mann	PhD Researcher	Russells Hall Hospital, Dudley
Dr Stacey McHugh	Senior Research Fellow	Huddersfield Hospital
Dr Helen Meehan	Acute Pain Sister	South Warwickshire NHS FT
Dr Christopher Salvatore Monella	GP	Edics Medwyn Pain Clinic, Dorking
Mrs Joanne Moss	CNS Pain Management	Churchill Hospital, Oxford
Dr Rob O'Donnell	Foundation year 1 Doctor, General Medicine	Gartnavel General hospital
Mrs Fiona Challoner Owen	Clinical Nurse Specialist Chronic Pain	Ysbyty Gwynedd
Mrs Jennifer Claire Owens	Clinical Nurse Specialist	John Radcliffe Hospital
Dr Angus Robin	GP	Rockwell Medical Centre, Bradford
Mrs Allison Janet Rogers	Pain Management Sister	Birmingham City University
Dr Yee Cze Tang	ST7 Anaesthetics	Leicester Royal Infirmary
Mrs Tracey Alison Taylor	Acute Pain Nurse Specialist	Peterborough City Hospital
Miss Emily Kate Tommer	Undergrad Student on work placement	Gloucestershire Royal Hospital
Mr Joseph Anthony David Walsh	PhD Student	University of Bath
Mr Benjamin James Wetherell	Medical Student	Bradford Royal Infirmary
Dr Sandra Wiltshire	Principal Clinical Psychologist	Churchill Hospital, Oxford
Dr Leda Lignos	Academic F2 Doctor	John Radcliffe Hospital
Dr Yvette Georgina Maria Coldicott	Advanced Pain Training Fellow	St Peters Hospital, Chertsey
Dr Jean Laurent Vonsy	Medical Liaison Neuroscience (Scientist)	Eli Lilly & Co Ltd

Actual letters from the article in page 85

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Dr. A J. Kind,

Dr VRY Nice,

Dr VRY An Gry,

Dear Dr A Lone,

12/02/2050

Re: Jude Houston (DOB 09/10/1945), 145, Rise Lane, Coverdale, CRE 16C

Thank you for your input into this gentleman's care who is well known to our practice. He came to us three months ago with sudden onset of low back pain while he was working in the garden. Simple painkillers and physiotherapy did not help him. Now his pain has extended to his right buttocks and occasionally radiated to his right leg. Even though he complains of problem with bladder, on questioning I found out that it is dribbling rather than incontinence. He is very much troubled by this pain at nights to the extent that he told me that he has not slept for nearly few weeks. I wonder whether you could look at him and let us know your plans to help him.

Please send this patient back to our surgery after two visits unless you believe that he can't be managed in primary care closer to home.

Please call me if u need any more information.

Thank you,

Your Sincerely

Dr VRY Nice

Dr A Lone
The Only Pain Clinic
Only DGH
The Lonely Place
Loose End LOL17V

Dear Dr Nice

10/12/2050

Re: Jude Houston (DOB 09/10/1945), 145, Rise Lane, Coverdale, CRE 16C

Thank you for sending Mr. Houston to my pain clinic. He came to see me with low back pain of six months duration. As you mentioned in your letter, the pain started while he was working in the garden. There is some radiation of the pain down to the right leg but it is not associated with any pins and needles or numbness. So far he has tried simple and complex analgesics, physiotherapy, TENS machine, chiropractic and acupuncture without much benefit. He not only struggles with his activities of daily living but also has problem with sleep. He has tried TCA but had to stop it because of side effects. He is a hypertensive and on ramipril for that. He is retired and lives with his wife. There are no psychosocial yellow flags in his history.

Examination showed that he is walking with a limp and standing with his right knee flexed. There is no pain behaviour but there is some fear avoidance. Flexion, rotation, side flexion and extension in the lumbar region were limited. Palpation was painful on the right side lower lumbar region. Straight Leg raising test was positive on the right side at 40 degrees. There is mild reduced sensation at the right L5 dermatome. Reflexes were normal.

After the clinic, I sent this gentleman for MRI scan of the lumbosacral spine which showed disc prolapse at L5/S1 area compression the right L5 nerve root.

In my opinion, this gentleman's pain may be because of the lumbar degenerative disc disease with sciatica. For his symptomatic pain relief I have prescribed him gabapentin and booked him for root sleeve injection.

Thanking You,

Yours Sincerely

Dr A Lone