

MARCH 2012 VOLUME 10 ISSUE 1

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

Pain Summit report

ASM Liverpool

Does diagnosis promote disability?

Social media and Pain

Knitting and Pain

Spinal steroid injections

Cost-effectiveness of Pain Clinic



THE BRITISH PAIN SOCIETY





British Pain Society

Calendar of Events 2012

Annual Scientific Meeting
Tuesday 24th - Friday 27th April 2012
Liverpool ACC/BT Convention Centre, Liverpool

Back Pain (24th Study Day)
Wednesday 13th June 2012
Churchill House, London

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

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>

Tempora mutantur



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Pain News

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Tempora mutantur, nos et mutamur in illis

(Times change and we change with them)

I hope that you all had a very nice festive season and have started the New Year with more vigour and passion. Before we realise, we will once again be preparing for the next Christmas. In some ways, it is good that time runs so fast. Similar to the pebbles that change their shape slowly when rolling in the tide of water, we do make small changes and get changed ourselves also!

The publications of our Society have gone through great strides and here is the time for yet another big change. Both our newsletter and the *Reviews in Pain* have developed so far due to the contributors as well as the feedback from

our members. The Society, in particular the Communications Committee, takes all this feedback seriously and has acted in a positive manner to satisfy the needs of our members.

From this New Year, we have changed our publishers to SAGE Publications; SAGE is a pioneer in the field of medical publications and its vast experience will help enhance our quality. All our appreciations go to Felicia Cox, the Editor of *Reviews in Pain*, who has played a big role to initiate and make this change happen. SAGE publishes more than 645 journals, of which 280 are published on behalf of learned societies and institutions. We should expect to see big changes in both our publications. We will take all your feedback seriously; please do comment on what you like and what we can do better. You would have already received a copy of *British Journal of Pain*, which was previously the *Reviews in Pain*.

The Council works hard to fulfil the aims of our Society – to advance the understanding and management of pain for the benefit of patients; however, we need further help from the wider membership. As Rajesh Munglani and Sam Eldabe mentioned in the last issue of our newsletter, we need specialist opinion to review many of the NICE guideline requests we receive; we need members to help us with the webpage and the enormous work that goes into the publications of the Society; we need feedback on various projects including Pain Pathway work; we need your participation in various special interest group works (SIGs); and last but not least, we need you to air your views through *Pain News*! Please don't ask what the Society did for you; you make

the Society; ask yourself what you can do for the Society!

As our Treasurer John Goddard mentioned in the last issue, our Annual Scientific Meeting (ASM) registrations contribute significantly to the financial status of the Society and the maintenance of our office. Here is your chance to help the Society again! The Scientific Programme Committee of our next ASM in Liverpool (24–27 April 2012) has worked hard to develop an interesting, didactic and thought-provoking meeting. Your participation is vital to make this a big success. I hope I can meet you all in Liverpool!

I started with a Latin adage at the beginning of this editorial that dates back to the 16th century, but John Owen gave a variant of this adage (Epigrammata, 1615):

Tempora mutantur, nos et mutamur in illis;

Quo modo? fit semper tempore peior homo

(Times change and we change with them;

How's that? Mankind always gets worse with time)

I can assure that this will not be true with *Pain News*; I hope that you all will continue to support me in this task. Now, enjoy this issue of our newsletter!

Thanthullu Vasu
Bangor, North Wales

Professor Richard Langford



THE BRITISH PAIN SOCIETY

Pain News

10(1) 4-6

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In writing this soon after the turn of the year, my first message of 2012 includes important items of news from late last year and the areas we propose to focus on in 2012. Two of our Society's major projects, namely the 'Pain Patient Pathways' and our 'Publications Strategy', reached developmental milestones, and the Pain Summit on 22 November was universally acclaimed as a resounding success.



BPS Publications Strategy

Our Editors, Council and the Communications Committee have aspired to take our publications to a higher level. Building on John Raphael's

pioneering work as the founding Editor-in-Chief of *Reviews in Pain*, and Mike Platt's Co-Editorship, Felicia Cox has led two years of planning and negotiation with Sage Publications, culminating in an agreed contract to publish and distribute both *Pain News* and the renamed *British Journal of Pain*. This exciting new venture both secures our publications within a leading international publishing house, offers a new professional level of online submission and editing, and in the case of the *British Journal of Pain*, the opportunity to potentially gain formal listing and widen its portfolio from reviews to taking original research articles. Felicia Cox, Thanthullu Vasu, John Goddard (Honorary Treasurer) and Nick Allcock (Chair, Communications Committee) are owed the Society's appreciation in recognition of this achievement.

Pain patient pathways

The untiring, passionate and lively contributions of over 60 members have culminated in the template pathways and the amassing of a large body of evidence, consensus statements and expert opinion. Meanwhile, in response to the rapidly changing NHS landscape, including the review of the Health White Paper, evolving NICE policy and

processes, and the new commissioning consortia, we took further soundings, and satisfied ourselves that the Map of Medicine remains the best platform for our pathways. The contract is signed, and the first pathways have been submitted for evidence grading and fashioning into the Map of Medicine's online format. We expect to see the five Maps being uploaded sequentially from spring 2012 at six-weekly intervals.

The next phase of this project is deemed 'Implementation', in which we also aspire to 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.

The memberships of the two committees and that of each of the five pathways are outlined below. The work and dedication that has gone into this project has been colossal, and I would like to take this opportunity to thank each and every one of my fellow participants in this major venture, both personally and on behalf of the Society.

Executive committee

Dr Andrew Baranowski (Chair)

Prof. Richard Langford

Dr Cathy Price

Dr Martin Johnson

Dr Beverly Collett (ex officio – CPPC)

Ms Jenny Nicholas (BPS Secretariat)

Full committee

Dr Andrew Baranowski - Chair

Prof. Richard Langford - BPS President

Dr Martin Johnson - Primary Care representative

Dr Cathy Price - Implementation representative

Dr Barbara Hoggart - Clinical Information SIG representative

Prof. Roger Knaggs - Pharmacy representative

Prof. David Rowbotham - FPM representative and Academic

Ms Suzy Williams - PMP SIG representative

Dr John Lee - NICE/Guidelines representative

Dr Sanjeeva Gupta - Interventional Pain Medicine SIG representative

Mr Douglas Smallwood - Patient Liaison Committee representative

Ms Jenny Nicholas - BPS Secretariat

Pathways audit

Dr Barbara Hoggart (Lead)

Assessment and early treatment

Ms Ann Taylor (Lead)

Dr Martin Johnson

Dr Chris Barker

Ms Val Conway

Dr Neal Edwards

Ms Sonja Bigg

Mr Douglas Smallwood

Ms Jo Cummings

Prof. Roger Knaggs

Mr Owen Hughes

Neuropathic pain

Dr John Lee (Lead)

Dr Mick Serpell

Dr David Bennett
Dr Andrew Rice
Dr Sam Chong
Prof. Blair Smith
Ms Heather Wallace
Dr Claire Daniel

Spinal pain

Dr Sanjeeva Gupta (Lead)
Dr Ollie Hart
Dr Tim Williams
Dr Karen Eastman
Dr Amanda C de C Williams
Dr Patrick Hill
Mr Jonathan Hill
Ms Ruth Sephton
Ms Liz Killick
Ms Christine Hughes
Dr Tony Hammond
Dr Manohar Sharma
Dr Stephen Ward
Dr Ganesan Baranidharan
Dr Simon Dolin
Dr Joan Hester
Mr Jake Timothy
Mr John Carvell
Dr Justin Taylor
Ms Keren Smallwood

Musculoskeletal pain (non-inflammatory)

Dr Benjamin Ellis (Lead)
Prof. David Rowbotham
Ms Suzy Williams
Dr Frances Cole
Dr Nick Allcock
Mr Neil Betteridge
Dr Alan Nye
Dr Andreas Goebel
Prof. Paul Watson
Dr Karen Walker-Bone
Mr Neil Berry
Prof. Ernest Choy
Dr John McBeth
Ms Pamela Stewart



Pelvic pain

Dr John Hughes (Lead)
Dr Andrew Baranowski
Dr Beverly Collett
Dr Amanda C de C Williams
Ms Judy Birch
Ms Judith Lee
Ms Suzanne Brook
Ms Katy Vincent
Dr Suzy Elneil
Dr Alex Freeman
Dr Anton Emmanuel

The Pain Summit

Working in collaboration with the British Pain Society (BPS), the Faculty of Pain Medicine (FPM), the Royal College of General Practitioners and patient organisations, the Chronic Pain Policy Coalition led this vibrant, landmark event. It was the culmination of our collective lobbying and canvassing activities spanning 2011, that over 150 highly placed policy makers, commissioners and notables in health care participated and attended.

The Summit took place on 22 November in Westminster Central Hall, with distinguished keynote speakers: Earl Howe (Under-Secretary of State for Health), Sir Bruce Keogh (NHS Medical Director), Dame Carol Black and Sir Liam Donaldson, whose '2008 CMO's Annual Report' has enabled so much progress

in our field. Without exception, these highly influential figures in health care pledged their unequivocal support for the promotion and development of pain medicine. In addition, both patients and professionals made significant presentations and participated in panel discussions. Initial and final reports will be posted on the Society website.

NICE low back pain guidelines

1. Costings meeting 25 Oct 2011
2. Letter to Prof. Peter Littlejohns

As you will know well, the BPS had serious concerns over the quality of the data used to calculate the costings prepared during the NICE guidelines review for lower back pain (LBP). These were integral to the deliberations and must have been material to the panel's decision-making. A protracted series of exchanges led by Sam Eldabe and Stephen Ward served to confirm our suspicions that the quoted prevalence numbers and resulting treatment costs were seriously flawed, and I called for a meeting with Jennifer Field at NICE to resolve the matter. The responses to our detailed enquiries suggest that the NICE costings may be out by a factor ranging from at least 10-fold, but could be as high as 40-fold. NICE has agreed to withdraw its costings from its website pending further review and revision as necessary.

Professor Richard Langford



In the run-up to the expected triennial review of the NICE LBP Guidelines, I have written on behalf of the Society to Prof. Peter Littlejohns expressing the above concerns and other aspects regarding the review process. The following is extracted from that letter:

Meanwhile, I am sure that you are aware of the inclusion of Pain as a topic in the proposed library of Quality Standards, and that we have also attended a meeting at your Manchester offices entitled 'Pain Workshop', at which we were scoping potential guidelines to cover both acute and chronic pain. If this wider ranging process were to proceed, would this in fact supersede or encompass the Low Back Pain Guideline activity?

Of course if the LBP panel is reconvened for a review, the BPS would very much hope that pain medicine would be appropriately represented. Since the publication of the original LBP Guidelines, we have devoted considerable attention to the costings, including attending a meeting recently with Jennifer Field, at which we outlined our evidence and position concerning the number of patients presenting with LBP. In view of our impression that the original calculations may well have been out by a factor in the range of 20–40-fold, we

would also hope that we might be permitted input to revision of the costings, so as to inform the panel's decision-making.

National Pain Audit and the Atlas of Variation 2

You will recall that in our discussions with Sir Bruce Keogh in January of last year, it was proposed that we explore the possibility of an NHS Atlas of Variation exercise.

The availability of one aspect of pain services, namely the 'Access to specialist multidisciplinary care for the management of pain', was derived from the first phase of the National Pain Audit and was published on 29 November 2011 in the *Atlas of Variation 2*, together with our accompanying commentary. As might have been predicted, it revealed a large number of primary care trusts that do not have access to the multidisciplinary range of practitioners, particularly psychologists, to satisfy the requirements for delivery of a complete service. The Atlas map was presented as a poster at the Pain Summit, and the findings of this exercise have also been noted within the Department of Health.

BPS elections

The first quarter of the year is of course

the run-up to the Society's next AGM (on the afternoon of Thursday 26 April at the ASM in Liverpool) and hence the period during which we hold our elections. Please make your voice heard by remembering to cast your votes for both new Council members to take up post at the AGM, and also for my successor, who will of course start as President-elect, on the same day. The shape of the Society is collectively in your hands.

E-learning for pain

We received an unexpected Christmas present in the form of the truly excellent news that e-Learning for Healthcare (e-LfH) wishes to allocate £170,000 for 'e-learning for Pain'. This of course relates to the bid submitted over two years ago on behalf of FPM and the BPS by Doug Justins and Michael Bond, respectively.

David Rowbotham, Doug Justins, Sharon Drake (Director of Education at the Royal College of Anaesthetists) and I have subsequently met with Alan Ryan (National Programme Director for e-LfH) and Ed Hammond (Joint Lead for the highly successful e-learning for anaesthesia project). The funding was confirmed and advice has been given on the strategy for delivery of the project.

At this stage, the contents are intended to be for all health care professionals, rather than for specialists in pain medicine.

In due course, the FPM and BPS will be in touch to look for contributors to develop the e-learning modules, so please do consider expressing your interest in the project.

Finally, I very much look forward to seeing all of you at the ASM in Liverpool (24–27 April), which promises another rich programme of plenaries, workshops and SIG meetings.

With kindest regards,

A handwritten signature in black ink, which appears to read 'Richard M. Langford'. The signature is written in a cursive, flowing style.

19 January 2012



Evidence and guidelines Symposium on Interventional Pain Procedures 10th & 11th May 2012

Comprehensive Review course for FIPP exam 10th & 11th May 2012

11th UK Hands-on Cadaver Workshop on Interventional Pain Procedures 12th & 13th May 2012

Course organizer Dr. M.H. Ather

Symposium topics

- Evidence and Guidelines of Interventional Pain Procedures for Trigeminal Neuralgia. Prof. S Erdine
- Evidence and Guidelines of Interventional Pain Procedures for atypical facial pain. Dr O. Rohof
- Evidence and Guidelines of Interventional Pain Procedures for cervicogenic headache including A/A and O/A treatments. Dr O. Rohof
- Evidence and Guidelines of Interventional Pain Procedures for cervical axial pain. Prof. L Lou
- Evidence and Guidelines of Interventional Pain Procedures for cervical radicular pain. Prof. G Racz
- Evidence and Guidelines of Interventional Pain Procedure for thoracic spinal pain. Dr M. Ather
- Evidence and Guidelines of Interventional Pain Procedures for sympathetic mediated pain. Prof. M Day
- Evidence and Guidelines of Vertebro/Kyphoplasty/Osteocool in metastatic bone pain. Prof M Gofeld
- Evidence and Guidelines of Interventional Pain Procedures for cancer pain. Dr A Bhaskar
- Medicinal cancer pain management TBC
- Evidence and Guidelines of Interventional Pain Procedures for lumbar facetal pain. Dr C A Gauci
- Evidence and Guidelines of Interventional Pain Procedures for SI joint pain Prof N Patel
- Evidence and Guidelines of Interventional Pain Procedures for lumbar discogenic pain. Dr R Ruiz-Lopez
- Evidence and Guidelines of Interventional Pain Procedures for lumbar radicular pain Dr L Gerdesmeyer
- Evidence and Guidelines for epidural adhesiolysis/epiduralscopy. Dr L Gerdesmeyer
- Evidence and Guidelines for spinal cord stimulation implants. Prof G Racz
- Evidence and Guidelines for drug delivery implants. Prof. S Erdine
- Evidence and Guidelines for the use of botox in chronic myofacial pain. Dr C A Gauci
- Evidence and Guidelines for the IA injections and PRF. Dr O Rohof
- The use of ultrasound in interventional pain management. Prof. M Gofeld
- The role of minimum invasive surgery in spinal axial pain. Mr. D Plev

Topics for Comprehensive Review Course for FIPP Exam

- WIP and FIPP exams. Prof. M Day
- Drugs used in interventional techniques. Dr M Ather
- Principles and mechanisms of radiofrequency. Prof. N Patel
- Fluoroscopy and radiation safety. Prof. L Lou
- Identification of the equipment. Dr R Reddy
- Intervention techniques for facial pain. Prof. S Erdine
- Sympathetic nervous system: its role in chronic pain management. Prof. M Day
- Splanchnic/coeliac/lumbar sympathetic and hypogastric plexus blocks. Prof. M Day
- Spine anatomy and interlaminar epidurals including cervical/thoracic/lumbar. Dr L Gerdesmeyer
- Transforaminal epidurals/DRGs. Dr R Ruiz-Lopez
- Spine anatomy and facet joint interventions including cervical/thoracic. Prof. M Gofeld
- Lumbar facet and sacroiliac joint generated pain. Prof. N Patel
- Lumbar discography and intradiscal therapies. Dr R Ruiz-Lopez
- Epidural Adhesiolysis. Dr L Gerdesmeyer
- Implantables: SCS Prof. G Racz
- Implantables: Intra-thecal Infusions pumps. Prof. S Erdine
- Myofascial pain and Botulinum toxins injections. Dr C A Gauci
- Intra-articular joint injections/Peripheral nerve blocks/pulse radiofrequency. Dr O Rohof
- Vertebroplasty/kyphoplasty/osteocool. Prof. M Gofeld
- Risk management and minimising complications with interventional techniques. Dr M Ather
- MCQ's. Prof. L Lou
- Case presentation/Mock Viva exam. Prof. L Lou

Fees:

1 day Symposium/Review course £250
2 day Symposium/Review course £450

1 day Symposium/Review course and Workshop £1250
2 day Symposium/Review course and Workshop £1450

Pain fellows for symposium £200 per day
Workshop and symposium (maximum 6) £1350

Nurses for the symposium £200 per day

Apply to:

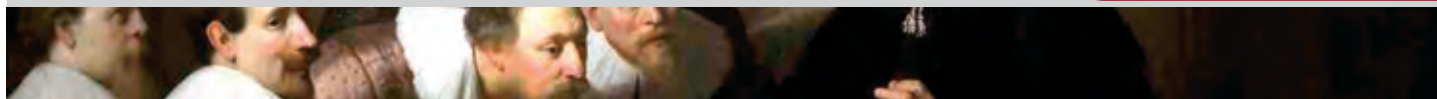
Dr M H Ather, Interventional Spine and Pain Institute P.O.Box 11071, Brentwood, Essex CM14 9JN

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Professor Pat Schofield



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Pain News

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As we start another year, we look forward to the many new challenges and opportunities that lay ahead. The Annual Scientific Meeting (ASM) will be upon us before we know

it. Information will be posted on the British Pain Society website very soon. In the meantime, note the dates for your diary: Tuesday 24 – Friday 27 April 2012.

We are also planning some study days in the next year organised by our Education Committee, so keep an eye on the website for these. The next one is as follows:

Back Pain (24th Study Day)

13th June 2012

Churchill House, 35 Red Lion Square,
London WC1R 4SG

The following study day has already taken place this year, and feedback was very positive.

Acute Pain – Preventing Chronicity (23rd Study Day)

24 January 2012

Churchill House, 35 Red Lion Square,
London WC1R 4SG

Along with meetings organised by our special interest groups (SIGs), the Philosophy and Ethics SIG has a conference already planned for July. Further information is available at our website: http://www.britishpainsociety.org/meet_bps_study_days.htm

Membership

Membership of the Society continues to grow and remain healthy, at the time of writing this report, the membership stands at 1,531 and is represented by 722 anaesthetists, 268 nurses, 98 psychologists, 88 physiotherapists,

10 general practitioners and others. Other disciplines include occupational therapists, rheumatologists, neurologists, pharmacists and basic scientists. As usual, we encourage members to promote our Society to their colleagues. Information on joining can be found at http://www.britishpainsociety.org/join_home.htm and the benefits of joining are many.

A couple of other important items to note on the website: we have the draft of the Pain Patient Pathway Document on the available to view, which is a really important document that sets out normal patterns of pain management for chronic pain sufferers. The *Guidelines for the management of pain in older adults* is also available for consultation and we would welcome any feedback on this guidance. We plan to launch this document at the ASM in the SIG workshop. If you know of any patients who may be interested in getting involved with our work, we are looking for patient/carer representatives to join the reference group.

News

Pain Summit 2011

On Tuesday 22 November last year, the Pain Summit 2011 took place at Central Hall, Westminster, London. The Summit was an initiative of the British Pain Society (BPS), the Chronic Pain Policy Coalition, the Faculty of Pain Medicine and the Royal College of GPs and was attended by over 150 people. The Summit attracted a wide variety of delegates including healthcare professionals, commissioners and patient groups.

The morning session featured addresses from Earl Howe, Parliamentary Under-Secretary of State for Quality; Professor Sir Bruce Keogh, Medical

Director of the NHS; and Professor Dame Carol Black, National Clinical Director for Health and Work. There were also accounts from patients and professionals and two panel discussions that focused on the impact of chronic pain and the delivery of services for people living with pain. Delegates then split into smaller groups to attend workshops on the themes of Education, Public Health and Quality Commissioning to discuss the issues that these subject areas raised.

While the workshop facilitators prepared to report back on the findings of their sessions, we heard from four



speakers about current measures and initiatives, including the Health Foundation's Co-creating Health Initiative, the formation of Pain UK, the BPS's Pain Patient Pathway Mapping Guidelines and the role of the Royal College of GPs' Clinical Champion for Pain.

After brief reports of the workshops, Dr Beverly Collett, Chair of the Pain

Summit Steering Group, spoke about next steps for the Pain Summit work, before the day was concluded with remarks from former Chief Medical Officer Professor Sir Liam Donaldson.

There was a tremendous buzz about the day and it was a privilege to see so many interesting and varied conversations. 22 November 2011 is just

the beginning of the Summit's work; a report detailing the activities of the day was published in December and a copy can be downloaded from the Pain Summit website (<http://www.painsummit.org.uk>). Feedback received from the workshops will provide the basis for a post-summit report to be published in June 2012.

News

Annual Scientific Meeting, BT Convention Centre, Liverpool, 24–27 April

Gary J Macfarlane *Chair, Scientific Programme Committee*

Plans are at an advanced stage for the British Pain Society's second visit to the new convention centre in Liverpool, on the banks of the River Mersey. Those of you who regularly attend the Annual Scientific Meeting (ASM) will have become accustomed to a high quality of international and national speakers; I believe 2012 will be no exception. The Scientific Committee is delighted to have secured a distinguished faculty from the UK, Europe and the USA. Professor Gerry Gebhart, Director of the Pain Research Centre at the University of Pittsburgh, will deliver the Patrick Wall Lecture, while the British Pain Society Lecture will be given by Professor Chris Eccleston, Director of the Centre for Pain Research at the University of Bath.

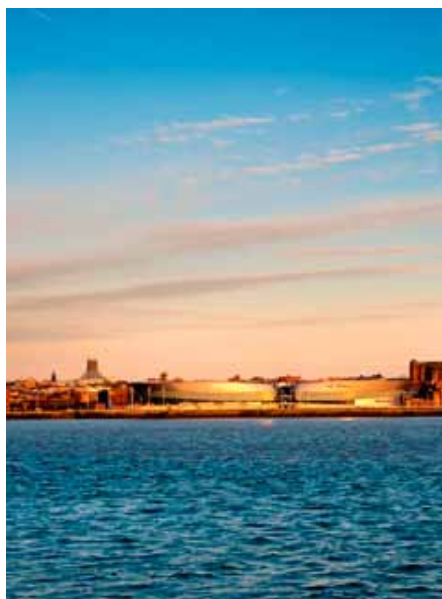
The other plenary lectures will cover: psychological therapies for pain (Mark Jensen), pain in older persons (Gisèle Pickering), neuropathic pain (David Bennett), pain management in primary care (Nadine Foster), chronic migraine (David Watson) and cancer pain (Stein Kaasa). Each of the plenary speakers will also be participating in a conference workshop where they will expand on one aspect of a topic covered in their



plenary lecture and there will be an opportunity for a question-and-answer session.

The plenary session will be complemented by the parallel workshops. These are a combination of special interest group (SIG) workshops and workshops submitted by the members. The member-submitted workshops at this year's meeting include:

motor disorders in patients with chronic pain, 'road traffic accidents – more than just a pain in the neck', neuro-ablation in chronic pain, improving facial pain consultations, cancer survivorship, managing musculoskeletal pain, qualitative methods in pain research and e-pain. The Scientific Committee was pleased by the number and diversity of suggestions submitted this year and



THE BRITISH PAIN SOCIETY

Registration Programme

Annual Scientific Meeting
Liverpool
24 - 27 April 2012

particularly encourage those who did not submit an idea to think about submitting one for 2013.

We have introduced some innovations this year. Based on the feedback from previous meetings, we took on board the frequent comment that there is not sufficient time to view posters. Therefore this year one of the plenary session slots will instead be dedicated to poster viewing. We have also restored the prize

abstract session for trainees to a plenary slot and in addition there will also be prizes for the best poster presentations at the conference.

In addition to hearing scientific updates, I know that one of the most important elements of the ASM is networking with colleagues. We are fortunate to have secured the Museum of Liverpool, a brand new landmark of the city opened in December 2011, for the

conference drinks reception on the Wednesday evening of the conference.

Finally we are always looking for ways to improve the ASM, so please remember to fill in your evaluation sheet after the meeting. Alternatively, you can drop me an e-mail at g.j.macfarlane@abdn.ac.uk or tell me in person at this year's conference.

I look forward to seeing many of you there!

News

Wanted: Emerging researchers in pain!

Are you:

- A member of the British Pain Society?
- Currently studying (PhD or MSc) in a pain-related subject?
- Interested in meeting and working with other trainees?

We are two PhD student researchers who are both members of the British Pain Society. We feel that there is a need for improved communications between trainee members of the society. We propose the development of a member-led group for trainees working in the field of pain where we can support each other, identify our support needs and develop the resources we require. Some of our own ideas include:

Encouraging peer support

Sharing your research successes and dilemmas can help both you and your fellow trainees; a problem shared is a problem halved, a triumph shared provides inspiration.

Career development

As a group, we can support each other with career decisions, discuss career opportunities and invite established researchers in our field to offer us advice.

Social gatherings

Research can be rewarding, but it's not without its stresses and taking time to relax is important. Make getting to know your fellow trainees one of your relaxation methods!

Networking

Events helping early researchers develop the skills to network effectively and make the contacts they need would be beneficial – and then practice your new skills with other group members!

If you are interested in forming a trainee researcher group within the British Pain Society, then let us know by joining us at LinkedIn and sharing your ideas:

Carrie Stewart
Carrie.Stewart.06@aberdeen.ac.uk

Paul Cameron
Paul.Cameron@abdn.ac.uk

News

Well – do GPs assess pain?

Dr Martin Johnson

We have discussed it many times but do my primary care colleagues use assessment tools to assess pain problems? Well, according to research

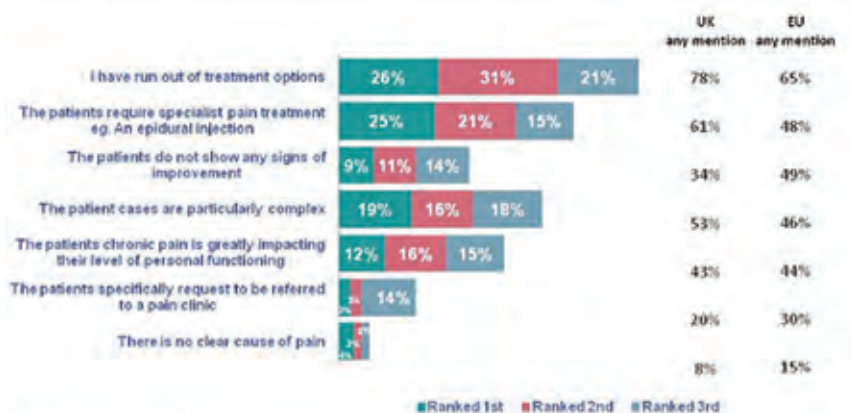
published back in October 2011, as part of the European Week Against Pain, 52% of European primary care physicians (PCPs) do not use any assessment tool

of any description to assess the level of their patient's pain. In the UK, however, 74% of GPs admitted to not using assessment tools.

Well – do GPs assess pain?

Reasons for patients being referred to a pain clinic

Over three quarters of UK GPs refer patients to a pain clinic because they have run out of available treatment options. Access to specialist pain treatment is also an important trigger for referral



Base: UK n=104, EU n=116 GPs referring patients to a pain clinic

Q15: What are your top 3 most common reasons for referring these subjects to a specialist pain clinic? Please rank these 3 reasons in order of how common they are

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Reasons for no training in CNMP in past year

UK GPs that have not received training in the last year tend to cite a lack of available time, other commitments, or lack of priority as the reason



Base: UK n=31, EU n=332 GPs who did not undertake additional training or education in the area of non-malignant chronic pain management

*Caution: Low base size

Q20: What are your top 3 reasons for not undertaking additional training or education in the area of non-malignant chronic pain management?

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The research PROACT (Primary care Resources, Objectives And Challenges in Treatment) study¹ was published as part of the OPENMinds Primary Group and funded by Mundipharma. The study looked at the views of 1,309 PCPs in 13 European countries including the UK. The PCPs had to complete an online questionnaire that was divided into four sections: assessment, guidelines, education and questions about opioids. The research was conducted between May 2011 and July 2011 by Ipsos MORI.

Ninety-six per cent of UK GPs had access to a pain clinic to which to refer their patients, compared to 87% in Europe.

Some of the key UK findings were:

- Chronic non-malignant pain (CNMP) is considered one of the lowest priorities in the healthcare system but one of the more challenging conditions to treat.
- Interestingly, only 2% of UK GPs felt chronic pain should be

could be considered just a symptom.

- The commonest guideline followed by GPs for CNMP in the UK was published by NICE (although I am not sure which ones they are actually looking at!).
- Morphine was ranked as the most potent opioid (fentanyl third).
- UK GPs use opioids more commonly than their EU colleagues. In the UK, 51% of CNMP patients are being managed with weak opioids alone.
- Not surprisingly the GPs were more confident in using strong opioids in malignant pain compared to CNMP.
- UK GPs stated that on average they had had three hours of CNMP training in the previous year compared to an average of 10 hours for European GPs. Thirty per cent of UK GPs had received no training in CNMP in the previous year.
- GPs typically follow up patients between 11 and 15 days after starting strong opioids.
- When GPs do use assessment 'tools', they tend to use a numerical rating scale or a *visual analogue scale* (VAS).
- In a UK-specific question, 83% of the GPs felt that chronic pain should be included in the clinical commissioning process.

Overall, the study only surveyed a small number of UK GPs (104) and it did not produce any major surprises; however, it does confirm what we suspected – more education is required! Hopefully the roll-out of the Pain Pathways will address some of these issues.

A more formal paper on the findings of this research is being prepared.

For more information, visit the OPENMinds website at <http://www.openmindsonline.org/openminds.html>

References

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Synaesthesia

Arasu Rayen *Birmingham*



I asked my daughter: 'What colour comes to your mind when I say pain?' She answered: 'Red, Daddy.' I asked her why. She explained that she had pain when she was bleeding. That was why it was red.

Does pain have a colour? Can anyone see pain as a colour? Have you ever had pain? If yes, what was the colour of your pain? It is common for people to use cross-sensory metaphors to describe their pain. Some of my patients have told me that their pain was 'like someone poking the red hot iron'. Some artists use different colours to show the severity and the effect of pain: www.painexhibit.com has more than hundred exhibits in the form of paintings and sculptures done by chronic pain patients across the globe. Even in that collection, it is difficult to get a common theme colour for pain.

Have any of your patients ever said: 'My pain in the leg is black with silver

lining'? Or 'My headache is purple' or 'My CRPS pain is a mixture of red and orange with occasional purple flare'. It may sound abnormal to many of us, but apparently it can happen! There is a group of patients who feel their pain as colour. This phenomenon is called 'synaesthesia'. People with such phenomenon are called 'synaesthetes'.

The word 'synaesthesia' is derived from Greek words 'syn' which means together and 'aesthesia' meaning sensation. Synaesthesia means that stimulation of one sensory modality produces stimulation of and experience in a different modality; for example, hearing a specific sound produces the sensation of seeing certain colours, or in some cases it is a specific taste. Simply, it is 'joining of sensations'. I call it 'confused or cross-wired sensations'.

Synaesthesia can occur after stroke and also in some psychiatric disorders like schizophrenia. In most instances the affected individual does not even know that the sensory experience they have is special and different from most of the population. There are specific questionnaires to identify whether a person has synaesthesia. One example is The Synaesthesia Battery,¹ with specific questions like:

- Do numbers or letters cause you to have a colour experience? Example: Does the letter J 'mean' yellow to you? Or does '5' make you perceive purple?
- Do weekdays and months have specific colours? Do you imagine or visualise weekdays, months and/or years as having a particular location in space around you? Does hearing a sound make you perceive a colour? Do certain words trigger a taste in

your mouth? (*These are only a few examples given from this questionnaire and are not exact reproductions.*)

Synaesthesia is rare with the frequency of 1 in 200 to 1 in 2,000. It runs in families. There are nearly 60 reported forms of synaesthesia.^{2,3} The most common forms are:

- Grapheme → colour synaesthesia
- Sound → colour synaesthesia
- Pain → colour synaesthesia

Nomenclature of synaesthesia is as $x \rightarrow y$, x being the primary sensory stimulus and y being the sensation the person feels.

Grapheme → Colour synaesthesia

This is a common form of synaesthesia where the person sees the letters and numbers (grapheme) with shadows and tint of colours. Each synaesthete perceives a different colour for different numbers and letters. In one article, Dixon⁴ describes a synaesthete thus: 'She is a 22-year-old undergraduate grapheme-color synaesthete. When she views black digits, her identification of each digit is accompanied by a highly specific color experience (e.g., 2 is red, 7 is yellow).' This form of synaesthesia is present in 2% of the population.⁵ The neural basis for grapheme → colour synaesthesia is unclear, but one study showed that there is increased grey matter volume in certain parts of the brain (fusiform and intraparietal cortices) leading to the assumption that increased neuronal activity in these areas may be the reason for the synaesthesia.⁶



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Synaesthesia

Figure 1
Synaesthesia for pain



Reproduced from Fitzgibbon BM, Enticott PG, Rich AN, Giummarra MJ, Georgiou-Karistianis N, Tsao JW, et al. High incidence of 'synaesthesia for pain' in amputees. *Neuropsychologia* 2010; 48: 3675–8 with permission from Elsevier.

Sound → Colour synaesthesia

This is the phenomenon where people feel sound as colours and flashes. Various sounds from the surroundings, like voice and music trigger colour and 'flashes like fireworks'. The flash moves around and becomes brighter or fades depending on the intensity of the sound. Some people see the music as a 'screen in front of their eyes'.

Pain → Colour synaesthesia

This is the phenomenon where a person feels pain as colour. In the above-mentioned article, Dixon mentioned that for a synaesthete, pain was orange.⁴ There are numerous online blogs and forums where people mention their synaesthetic pain experience.⁷

Synaesthesia for Pain

This phenomenon is when patients feel pain when they see another person in pain (Figure 1). It had been observed

that some amputees without phantom pain sense pain when they see other amputees in pain.⁸ Some scientists believe that this phenomenon may be because of 'mirror neurons'. A mirror neuron is a neuron that gets excited both when an animal does an action and when the animal observes the same action performed by another.

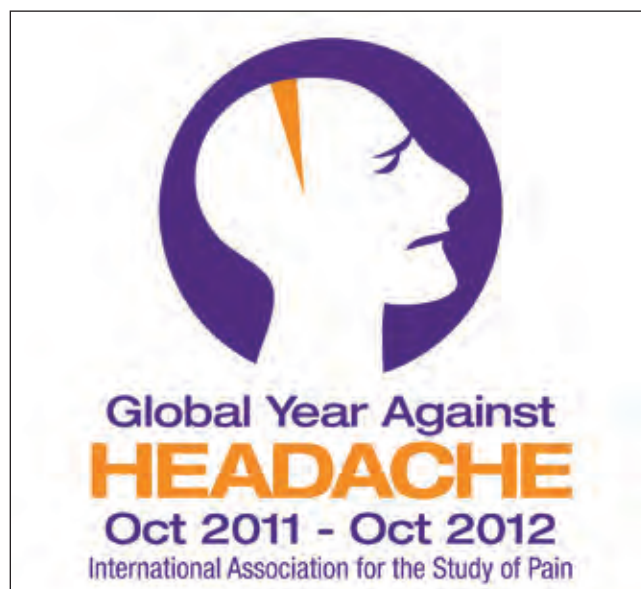
Osborne⁹ showed that even in a normal population, some can feel both emotional and physical aspects of pain when they are shown static images of people in pain. *Functional magnetic resonance imaging* (fMRI) also confirmed that in this population, the parts of the brain associated with pain are activated by seeing the pictures, even in the absence of the physical presence of pain.⁹ A recent electrophysiological study also showed that amputees developed abnormal electroencephalography (EEG) when they had synaesthesia for pain.¹⁰

Synaesthesia, although identified in the 18th century, has not gained much attention until recently. There are numerous studies going on around the globe; hopefully we will get a better understanding of this exciting phenomenon soon. If anyone is interested in more up-to-date publications on the various forms of synaesthesia, please visit <http://www.seeingwithsound.com/newpubs/synaesthesia>

[seeingwithsound.com/newpubs/synaesthesia](http://www.seeingwithsound.com/newpubs/synaesthesia)

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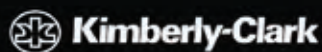
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PAIN?

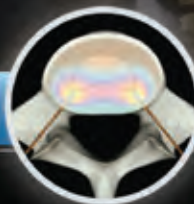
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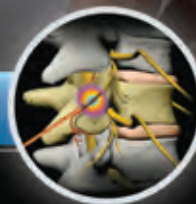
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SAGE

Does a diagnosis in pain medicine promote disability?

Rajesh Munglani *Consultant in Pain Medicine, Cambridge*

Pain News thanks Rajesh Munglani for organising yet another interesting debate. In this article, elite eminent clinicians debate on the fact whether a diagnosis will promote disability.

The power of words?

I remember many years ago sitting at the back of a meeting where someone had come to impart the 'fire of revival' from the so-called Toronto blessing – it had all arisen from a religious revival that had started in a small church situated at the end of a runway at Toronto airport.¹ The characteristics of this revival were manifested in a number of ways; first, that the spirit of revival was passed on to the new congregation by the blessing of someone who had already been touched. In this regard we were lucky to be near the source, someone who had been at the actual church at the end of the runway had blessed a priest who was now with us at this church in Cambridge.

He was a charismatic and sincere priest who did his best not to overexcite, but the congregation was ready for him regardless. Even before the close of his short testimony and blessing, in which he indicated that the power of God was greater than anything in our physical realm, the fireworks began ... consisting of shaking, guttural utterances and speaking in tongues that went on for hours leading to some very tired people at the end, but this also was accompanied another well-described characteristic of this particular revival. This was the presence of an unusually large number of healings that took place during the services. Indeed, during this and similar services, I saw people

apparently healed of various chronic diseases; certainly people got up out of wheelchairs they had occupied for many years and some even danced.

Many years later, I sat in the back of another meeting,² this time another very charismatic person at the front explained how pain was literally in your head, in your mind, a result of irrational and maladaptive patterns of thought; all you had to do was learn how to think different thoughts and the pain would go. On this occasion the history of all three clients had been characterised by some sort of viral illness, and because they did not seem to get better they had eventually been diagnosed by their GPs and consultants with something like chronic fatigue syndrome (CFS)/*myalgic encephalomyelitis* (ME). One person had spent a number of years in a darkened room, and I think another used a wheelchair and had not walked more than a few metres a day.

The life coach (the best way to describe, I think) explained how the only thing limiting them were their own thought patterns and introduced them to techniques to think differently, including breaking the pattern of their old thoughts by actually physically acting out thought-blocking and thought-changing manoeuvres and asking themselves what they wanted in the future. This could be quite exhausting performing this every time an old pattern of thought came into one's head. The repetitions could go on

dozens of times. It was physically exhausting for the clients.

At the end of the first day, the client who had sat in her wheelchair got up and walked out of the meeting. That late afternoon and evening she walked five miles, something she had not done since the start of her illness many years previously. She proudly announced at the next day's session that she was physically drained, with bleeding feet – but exhilarated and 'cured'.

Since that time, I have sent a number of chronic pain patients on such a programme, all of whom had exhausted the standard biomedical approach. Most achieved significant or remarkable results and one dropped all medication, coming off 600 µg/hr fentanyl patches and methadone and literally coming out of his wheelchair. Others, again despite the presence of severe spinal degeneration, achieved a quality of life that had not previously been achieved by multiple complementary therapies, injections, drugs and in some cases surprisingly conventional Pain Management Programmes (PMPs). What amazed me was the improvement achieved by the appropriate use of a few simple words, perhaps on a background of anticipation and expectation of improvement among the congregation, client or patient. In both situations of dramatic improvement, the diagnosis itself or its implications were minimised or ignored.

Does a diagnosis in pain medicine promote disability?



The religious service introduced the dimension of God, the other used what I think is best described as a mixture of cognitive behavioural therapy (CBT) and neuro-linguistic programming (NLP) and something like self-hypnosis.

I was amazed by the many similarities of both events, the explicit or implicit message that the chronic illness or condition or the results of it need not limit the individual, that there was something greater, either the power of the mind or the power of God (*or both ... is there any difference? But that's another story*).

If such a simple process can produce change, what does it say about the patients? Were they making their disability up in some way; worse still, were they malingering? I don't think so as they all wanted to get better, which is one of the characteristics one looks for when deciding to send people on such a programme. Interestingly, in response to the person getting better, relatives or partners often become angry as if the condition hadn't been 'real' if it could be cured so easily. Had the significant other been duped into caring for someone who had been 'gilding the lily' all these years?

The immediate question for me was why the conventional approaches hadn't worked – physical therapies, drugs, CBT, PMP etc. Or a more uncomfortable question was raised: does the way we practise medicine actually increase or maintain disability?

By giving someone a diagnosis of neuropathic pain, *complex regional pain syndrome* (CRPS), fibromyalgia, CFS/ME, to name but a few, are we cursing them, or perhaps less strongly, enabling them to become disabled; to live with the diagnostic label and its perceived disability? As doctors and others become involved in the healing arts, does what we say and do, help or hinder? Many have suggested that we need to talk to others in different ways.

One example is, when we prescribe a tricyclic, do we say to the patient 'this is for *Your Depression*', thereby perhaps promoting the sentence of depression. Perhaps more positively we should say '*this is to improve your mood*'.

In an interesting article, Monika Hasenbring wrote about the attentional control of pain and the chronification of symptoms.³ She sought to answer a question posed by Cioffi in 1991: Does the plasticity of somatic interpretation which is mainly influenced by individual attentional focus play a role in the chronification of pain? The answer turns out to be unsurprisingly yes, but even more profoundly than we realise. Essentially, the more one attended to symptoms of pain, the more likely they were to become chronic. Many studies and observations suggest that this mechanism seems to contribute in fibromyalgia, CFS/ME and probably in most chronic disease including pain.

Let me make it clear, before I get a few more vitriolic emails from some patient lobby groups, I don't think any of these illnesses are purely psychological, but as Meyer said in 1936, psychosocial factors influence the course and outcome of every illness. Indeed, Plato also said some years earlier: so neither ought you to attempt to cure the body without the soul.

Unfortunately simply asking patients 'to stop concentrating on their pain' does not work; in fact it had the opposite effect according to the studies: it made the pain worse in the long term. Hasenbring, Eccleston and others have shown that certain 'distraction tasks' were helpful in minimising chronic pain, but worked best if the distraction tasks themselves were effortful and fatiguing. The comparison with the life-changing meetings described at the beginning of this article could not be clearer. Essentially you have to impart a new way of looking at things, but this new way has to involve effortful commitment on the part of the patient to engage with the problem. Importantly, this new way of looking at things not only has to involve the patient but also the doctor/therapist; or else, one had to draw a line under the previous medical involvement.

Having pondered the above, and becoming more concerned that by continually 'naming the disease' and its implications we are promoting the disability and dependency on ourselves as healthcare professionals, I decided that my team and I should look at the way we communicate; we all attended a systemic psychotherapy course⁴ and also a 'language as medicine course'.⁵ Much of the time, the disabling way we may speak to patients was so ingrained in us that I found it difficult to appreciate what I was doing wrong!

But now I always say to patients after I have treated them 'I will see you in a month to see *how well you are doing*' rather than '*how the pain is*'. I also usually tell them 'to walk as far as possible every day and ignore everything else'. I try and concentrate on the 'getting better' and achievement rather

Does validating the patients' symptoms promote disability?

than defining the diagnostic process. It is more complex than I have described, but gives you a flavour.

The further implication of this is that we should not compartmentalise the psychotherapeutic dynamic and leave it all to the PMP or psychologist. The experience of seeing these radically transformed lives has led me to the

conviction that the power of words and integrating it into everyday consultation will help to minimise the disabling effect of the diagnostic process.

A further thought in the same vein: is there a better name than the 'PAIN' clinic? What about a '*to help you move better and live life to the full*' clinic? Answers on a postcard please to the British Pain Society, addressed to me.

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Does validating the patients' symptoms promote disability?

Christine Waters *Lead Clinical Nurse Specialist, West Suffolk NHS Foundation Trust.*
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As clinical nurse specialists, we see psychological factors such as catastrophic thinking and fear of movement influencing the behaviour of individuals with persistent pain. Mostly though, we observe distress during clinical encounters as a consequence of societal judgements and iatrogenic stigmatisation.

Over 20 years ago, the discrepancy between objective indices and the subjective nature of pain led Kleinman¹ to recognise that the authenticity of a patient's chronic pain experience is frequently disputed by both health professionals and family members. More recently, emerging research findings have revealed that the individuals who experience chronic pain, irrespective of its pathology, have frequently described perceptions of not being believed during encounters with health professionals, especially in the absence of an objective cause of their pain being identified.^{2–13} Perceptions that chronic pain is fictitious or purely psychosomatic are associated with unhelpful emotional and social consequences. Distress, frustration, anger, shame and self-doubt have been experienced by patients.^{2,4,6,8–10,13} For other individuals, such perceptions have threatened their dignity and integrity as a human being⁵ or led them to seek social isolation to avoid the shame of further judgements.⁶

The dichotomy between how individuals feel compared to how they look^{2,6} has been cited as an explanation for being confronted with scepticism. To visibly demonstrate the credibility of persistent pain to health professionals, individuals have reported consciously altering their behaviour and appearance.^{14,15} It has thus been proposed that the physical and emotional effort required to demonstrate the validity of chronic pain diverts attention away from adopting helpful behaviours.¹⁵

In contrast, the literature tentatively suggests that a perception of being believed is not only highly valued but may be influential, first, in the process of acceptance of chronic pain and, second, in adjusting to the transition process of living with chronic pain. Consequently, a descriptive phenomenological study on a sample of eight participants was undertaken to elucidate the meaning of being believed for patients experiencing chronic non-malignant pain.¹⁶ The

meanings that emerged from the narratives within this study highlighted the significance of chronic pain being validated by others. Perceptions of being believed were highly valued by the participants and were associated with pain becoming more tolerable, enhanced emotional well-being, adoption of helpful coping strategies, improved relationships and restoration of social status.

In this study and from observations on clinical encounters, the legitimisation of persistent pain by others is not a static event but fluid within time and entwined by perceptions of encountering disbelief. A question then that arises is whether a patient's perception of being disbelieved might be entirely justified. Within clinical practice, it is not uncommon to witness health professionals inadvertently stigmatising individuals with chronic pain particularly where no diagnosis has been made. How many times have you heard patients with persistent pain being

Does a diagnosis in pain medicine promote disability?



labelled by terms such as ‘mad’? It could be asked why this might be so.

One possible explanation centres on a paradigm shift in the understanding of chronic pain being experienced by western culture, which results in diverse understandings. Ware¹⁷ from a medical anthropological perspective, proposes that the biomedical paradigm that is rooted within western cultural tradition accounts for such experiences. The basic assumption that has historically underpinned the biomedical model relates to the division of mind and body, otherwise known as dualistic thinking.¹⁸ The second assumption is the presence of a direct link between symptoms and pathology.¹⁹ Furthermore, objective findings have traditionally been emphasised at the expense of subjective findings.

Recently it has been suggested that health professionals may fail to appreciate that both their clinical reasoning and behaviour may be entrenched by dualistic thinking.²⁰ Clinical reasoning based on body/mind dualism tends to separate the causes of chronic pain as residing either in the body or in the mind. In the absence of objective findings, health professionals may therefore inadvertently label patients as having a ‘disturbed mind’.

Cohen et al.²⁰ also reminds us that dualistic thinking is in contrast to the ‘scientific revelations in neuroplasticity that provide neurobiological explanations for sensory and motor phenomena that would once have been dismissed as residing in the mental domain.’ Consequently, differing assumptions relating to the causes of chronic pain, upheld by health professionals and the general public, may account for some patients revealing an ever-shifting perception of the legitimacy of their pain. Cohen et al.²⁰ hope that stigmatisation and negative stereotyping towards individuals with persistent pain may vanish with a fundamental change in the dominant paradigm underpinning pain medicine that is still upheld by many clinicians.

How then might we influence the dominance of the dualistic paradigm in the UK? Without doubt, the suggestion from the Pain Summit Report 2011²¹ to use ‘the media to increase awareness and to help people understand that just because you cannot see pain, it does not mean it is not there’ will hopefully shift attitudes within society. With health professionals, apart from providing comprehensive education in pain management, there needs to be teaching on the current understanding of

neurobiological mechanisms underpinning pain. I suggest that we also need to increase awareness of the iatrogenic distress resulting from the behaviour of health professionals and develop educational strategies to reduce it. Recently, Green²² in an editorial in *Pain*, reminds us that communication between patient and a health professional can be laden with misunderstandings and that the art of medicine may lie with actively listening to patient stories.

In summary, validating or not a patient’s symptoms of chronic pain may potentially represent an important social determinate. It may affect expressions of pain behaviour and influence psychological adjustment, and needs further investigation. An early diagnosis appears to be critical as it validates symptoms and may minimise the risk of iatrogenic suffering resulting from perceptions that chronic pain may not be legitimate. Furthermore, factors contributing to stigmatisation and negative biases towards an individual with persistent pain need further exploration. I wait with eagerness for research to help us understand why we behave as we do towards individuals with persistent pain. Time will tell whether empathy biases, attachment theory or whether the conceptual frameworks upheld by health professionals to understand pain hold some of the answers.

I leave you with two thoughts:

- Have we been experiencing a cultural blindness with regards to the invalidation of persistent pain by health professionals, particularly towards those individuals where no structural cause for pain has been found?

And of more concern:

- Does the behaviour of health professionals towards individuals with chronic pain represent a risk factor for poor recovery outcomes?

(References not published but can be obtained from the author by email to christine.waters@wsh.nhs.uk)

A barrister's view

A barrister's view

Marcus Grant *Temple Garden Chambers*

Adversarial litigation: how does it impact on the study of chronic pain?

I bring a barrister's perspective to the study of chronic pain. Pain is a potent source of incapacity. Incapacity is the foundation stone of compensation. Chronic pain litigants are those whose recovery patterns do not follow expected norms (as a matter of clinical expectation) following trauma. Save in exceptional cases such as complex regional pain syndrome (CRPS) where there can be objective physical signs, it is rare to encounter objective scientific evidence to substantiate a chronic pain claimant's subjective report of incapacitating pain.

The absence of such objective evidence elicits the worst characteristics of our adversarial fault-based injury compensation system. The well-publicised abuses of the 'no-win no-fee' compensation culture of the last 15 years have harnessed an unhealthy distrust that has stained communications between injury claimants and compensators (usually insurance companies or emanations of the state). Cases where there is no objective evidence of incapacity are viewed by compensators through a prism of disbelief.

Disbelief is a potent maintaining factor of a chronic pain patient's symptoms. Often such patients approach the medical profession for explanations to help them understand, and to make those around them believe in and understand the aetiology of their pain. Many claimants tell me that the most valuable experience they take away from pain management programmes is the relief that they have met other patients with identical symptoms and that the phenomenon of chronic pain is real.

One central difference between the medical and medico-legal professions is the former's emphasis on treatment and looking forwards, and the latter's focus

on the likely cause of the condition in the first place.

I work with claimants with a wide spectrum of chronic pain complaints. Aside from chronic pain, there is one common thread that joins them: the inability to achieve deep restorative sleep, especially during the early stages following trauma. They wake each morning feeling unrefreshed. Many road accident victims experience acute neck pain; lying down, or changing their posture in their sleep often aggravates their pain, resulting in disturbed sleep. Trauma that is subjectively shocking can induce anxiety symptoms that intrude on both waking and sleeping thought processes, which in turn impairs sleep. Enforced lifestyle adjustments brought about by incapacity following trauma can trigger secondary impaired mood disorders (the 'psycho-social consequences'), which in time may result in early morning waking, another facet of poor sleep hygiene.

In approaching the medico-legal question of causation, namely 'On a balance of probability did the accident cause the chronic pain condition?', often

the pertinent question to address is 'What caused the inability to achieve deep restorative sleep?' Almost by definition, chronic pain patients fall within a small patient group (as a percentage by reference to the general population) who are vulnerable to developing chronic illness. In litigation, doctors are asked to distinguish between the causal potency of the index traumatic event and its consequences and preceding or other coincidental life stressors.

One ever-present stressor for claimants post trauma is the compensation process. Meeting lawyers and doctors is stressful in itself. Having strangers pry into almost every aspect of one's life, following a forensic trawl through intimate medical and financial records, is invasive. The compensation process indubitably focuses on the negative: i.e. what the claimant cannot do, what he/she has lost etc ... there is an inverse correlation between a claimant's health and their wealth (through their claim). The fact that the process is adversarial with the claimant having to prove their disability in the face of scepticism and often innuendo or worse



from the compensator often results in the claimant having to assume the mantle of disability in order to prove his/her case. Litigation provides oxygen to the flame that drives the vicious circle of the bio-psycho-social model of chronic pain.

What is the solution? Reforms are underway to tackle the worst excesses of the compensation process. These may speed up the process and reduce

the cost. However, our adversarial system of compensation will remain. I suspect that the litigation will continue to be a confounding factor in the treatment of chronic pain patients. Any insights that the medical profession can provide on the causal nexus between trauma and the development of chronic pain will be welcomed by the legal profession. It would seem that a good

place to start would be greater clarity about the physiological changes that take place in a human body subjected to deprivation of deep restorative sleep. It seems to me that focusing on the causes of sleep disturbance is the key to addressing medico-legal questions of the causes of chronic pain. A similar focus may play an important part in the future practice of preventative medicine.

Professional perspectives

Social Media and Pain are now friends.

Like. Comment

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There is no reason in the world anyone would want a computer in their home. No reason.

Ken Olsen, Chairman, DEC, 1977

'Social media' is the gestalt of our societal mores. Its lexical ambit is quite wide. The byzantine array of platforms on which it is played out too could be bewildering. It is akin to the undulating drone of cicadas buzzing in the densest of forests. My exploratory urge to pick out the rhythms of the multiple buzzings was rooted in my fledgling desire to utilise it for advocacy efforts. To spot the harmony in the rhythm would need a lion cub. Contemplation, awareness and agility were a prerequisite to stave off hunger. I was a house cat. Content with the knowledge that dinner would be served on time, whether I catch the mouse or not. The beginning of the attempted metamorphosis was a *Sisyphian* journey. I felt at worst a *Schrödinger's cat* and, at best a *Pavlov's dog*.

Relationship status: It's complicated

In India, issues of pain advocacy are best left to those who did not aim for the

academic stratosphere, thus triaged to professional organisations, patient groups, social workers and religious organisations. The consequence – on the internet, under the rubric of 'alternate medicine' or 'holistic medicine', manifold vested interests operate, touting commercial nonsense for the management of pain. Eighty per cent of internet users, or 59% of US adults, look online for health information.¹ Pain sufferers would like to know 'what is wrong?' and 'what to do?'. Some have gone online after consulting me, to check if I knew what I was talking about. Some have come armed with Wikipedia, Google search and unsolicited emails peddling herbs, flowers, pills and potions. India has recently been crowned the 'spam capital' of the world.² For moral and ethical reasons, the credulity and gullibility of the natives are tested alongside global netizens. Twixt Tweedle-dum and Tweedle-dee!

Facebook, because time isn't going to kill itself

The central tenet of social media is to engage others in conversation. It's the tittle-tattle of life that makes the world go

round. We are social beings and our world is cocooned in the interests and minutiae of everyday social life. From business contracts to bumbling poetry, a social context exists for all written works. If only human pain could be made intelligible through social media, it would be the apogee of technology. A billion people simply cannot be wrong. That's the number of active Facebook users,³ as well as the size of India's population. Twitter, a fast-growing micro-blogging site, where 140-character messages stream by as thoughts, ideas or interesting articles, is another powerful platform. WordPress, Blogspot, Posterous, Tumblr, Flickr, websites and countless other idiosyncratic variants exist. Kindergarteners learn on iPads. A new member joins LinkedIn every second. YouTube is the second-largest search engine. You just have to be where your potential audience chooses to be. At times I have felt like an Indian Oscar Wilde suffering from too many parties.

Good God and 4 other friends like your status

Social media is hard to describe when it is the ocean and we are the plankton.

Social Media and Pain are now friends. Like. Comment

At its depth, it is about people, relationships and communication. Forty-one per cent of patients look for medical content from social media sites and 94% of those patients turn to Facebook;⁴ 76% of patients trust peer recommendation. The need to congregate, to collaborate, to commune, drives humanity at a basic level. The traditional word-of-mouth dissemination of information on social occasions has largely been replaced by social media. Empowered with information and knowledge, a genuine intercultural polylogue takes place through pain self-advocacy groups. The increasing visibility of pain-related issues in the community has given patients the courage to assert their interests, to express their desires and to speak up for their rights. Physicians leading an anchoritic social media life would be surprised to find their online reputation written for them. We are early adopters of enabling technology, but languid to use it to communicate and collaborate effectively. It would be a Bergmanesque tragedy (OK, not quite) to show blithe disregard to the conversation about us, thereby missing out on redemption.

Hard Labour on Farmville!

As a collective chronicle of humanity, social media lends itself to cross-cultural curiosity. In India, both cultural homogenisation (mainly Americanisation) and heterogenisation (new ideas appropriated to fit with the cultural horizons) co-exist. One would be wrong and perhaps Precambrian if the term 'going viral' conjures up images of computers crashing. India had perfected 'going viral' through mass-forwarded emails (mainly of the Divine Wrath variety) well before the wet-eared geeks at YouTube got wind of it. A combination of Google Alerts (content change-detection and notification service), Google Reader (checks favourite news sites and blogs for new content) and aggregating platforms such as HootSuite and TweetDeck could be used to synthesize and share information. It works as a networking amplifier, where a single



message could be populated in multiple social media platforms. The vast and enthusiastic audience thus garnered might be interested in recent advances in pain and a meaningful evidence base for their treatments. Furthermore, it helps simplify the complex, convoluted healthcare system, so that pain sufferers could use their clinic visits effectively and efficiently. In social media, elegance and fastidiousness endears us to patients – not Svengali-like persuasive skills.

Pain is new to Facebook, you should suggest people he knows

The *Pareto principle* of economics (80% of the effects come from 20% of the causes) holds true for social media. Thought leaders and key influencers wield the baton in this symphony. Journalists, celebrities and elected representatives are the conductors. They do not always, from their exalted positions, communicate with upstarts. One wouldn't expect Beethoven to play commercial jingles either. Developing a targeted media list of local news outlets, radio talk shows, morning programmes and specialty blogs would help surge your efforts. When

developing stories, journalists assemble information from wide-ranging sources, including blogs. A well-written blog that captures memories, images and feelings might pique their curiosity. A national newspaper once contacted me for an article on cancer pain, leaving me like a captivated cherry being dropped into a bowl of covetous ants. Mind you, those ravenous ants too could be going around on a *Möbius strip* trying to break out of monotony. Importantly, the efforts could be synchronised with a network of pain advocates and professional organisations such as International Association for the Study of Pain (IASP), to serve as a voice for people in pain.

You have unread messages

Just as rational thinking and severe pain do not go hand in hand, the enormity of the task in social media might cause restless dissatisfaction that has us oscillating between a variety of preferences. It takes considerable discipline and time to get the advocacy efforts off the ground, starting with registering on different platforms. Technology has made it easier for us to set up our own social media presence,

but we still would have to write and communicate. Then, there is the fear of negativity in doctor review websites and possible public relations disasters. Blog content typically does not have a peer-review process. Editors with self-assertive arrogance, and neither deliberation nor judgement, could post content instantaneously, overseeing accuracy. Glaring mistakes with exuberant theatricality come to light after the content is transmitted through multiple channels. The tumultuousness of the World Wide Web is such that just as anyone can publish material, anybody could modify or plagiarise it too. The ephemerality of internet publishing warrants a scrupulous watch against content that is unfocused or not used judiciously. Beginners notably might feel frustrated and whipsawed by the lack of tactical guidelines for negotiating social media and sharing healthcare information. In the USA, the Health Insurance Portability and Accountability Act (HIPAA) and its regulations protect the privacy of an individual's health information. Reticence is a virtue where privacy is concerned.

Control your default privacy

To the extent that we are healthcare professionals, our observations are refracted through the prism of theory. Within the dispassionate carapace we outwardly present is the axiomatic truth of a helpful soul. Despite the refinements of culture, that is where altruism resides. No stiltedness. No superficiality. Social media permits our patients to have a peek at it. It helps bridge the gap between patients, physicians and healthcare organisations. Engaging safely and ethically with our audience along with curating online content is our social responsibility. Educational materials such

as short videos, infographics and e-brochures presented with clarity and candour are invariably cherished by pain sufferers. 'The universe is made of stories, not atoms,' poet Muriel Rukeyser proclaimed. Everyone has a compelling story to tell. Their prosaic and ploddingly unimaginative exterior (mine is one) might belie their benevolent and warm experiences. Enabling our colleagues and staff members to contribute does wonders to the esprit de corps. Certain avoidable misadventures in social media suffer the Parisian '*c'est un scandale*'. What wouldn't be discussed in a hospital elevator, shouldn't be published – the 'Elevator Test'. Behests in social media, inconveniently, could range from the banal to the divine. One would be ill-advised to accept a patient as a 'friend' on the personal page. When social media activity is work related, letting the employer know beforehand is prudent. Groping for the right words, when reprimanded by the employer for indiscretion, could thus be avoided. A disclaimer and a comment policy are indispensable. I prefer *Plain English*, you might opt for *Legalese*. For an ink squid, a chameleon is an amateur.

Pain and 3 other friends changed their profile pictures

The brain's 90 billion neurons linked by 100 trillion synapses far surpass the Web's 20 billion web pages connected by a trillion links.⁵ And, that's only the individual. Collectivity is the driving force of human advancement. When in pain, quixotic thoughts seem perfectly reasonable. Wisdom is possible too. On closer inspection, we could decipher that the wisdom is borne out of healed pain. Social media has helped chisel away the cultural parochialism and the structure of expressions that existed previously. It is a

florilegium of stories, poems and songs of pain sufferers. As people of science and champions of patients' rights, our role in social media is to distil these into a lucid narrative. More than stories, pain sufferers are looking for an interactive experience – a propitious experience of unprejudiced listening, attentive reassurance and hopeful optimism. Not to mention their yearning for recent scientific advances that might alleviate their predicament. Erudite physicians understand these intangibles and an increasing number of them are appearing on the digital media stage. Pain sufferers need a political voice too. The incongruity between health care and its bureaucracy and politics has driven a chasm between the provider and the benefactor. Social media, by engaging, educating and empowering our patients, can provide an emphatic voice to their rights to pain relief, and grapple back the symbiotic relationship we once enjoyed and cherished. The innovative resourcefulness of social media has engineered a *Pygmalion effect* in health advocacy. Other specialists have taken to social media with aplomb. Among the Ferraris of heart surgery, Bentleys of plastic surgery and Jaguars of brain surgery, mine is the Lada of pain medicine. It is the interior exuberance that counts. My very own *Faustian bargain*.

Palanisamy Vijayanand commented on his own status. He tweets as @painfreeindia

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The editor sincerely thanks all your views and feedback about the articles; we request your contribution to the "Letters to the editor" column also.



Survey of current UK practice in use of fluoroscopy, contrast material and steroids in neuraxial injections

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Patients with chronic pain have received steroids in neuraxial blockade for many years. There has been recent controversy about their efficacy but also about the possibility of neurological complications associated with the use of particulate steroids such as methylprednisolone, triamcinolone and betamethasone. In particular, inadvertent intra-arterial injections of particulate steroids are thought possibly to lead to spinal cord ischaemia by blocking small arterioles and causing catastrophic neurological and other complications. The use of contrast has also been suggested to minimise inadvertent intravascular injection. The aim of this study was to investigate the current UK practice of the use of fluoroscopy, contrast medium and non-particulate steroids in neuraxial injections.

Objectives

- To find out how many physicians performed facet joint injection (FJI), medial branch block (MBB), transforaminal epidural steroid injection (TFESI) or nerve root block (NRB) and interlaminar epidural injection (ILEI) in the cervical, thoracic and lumbar spinal levels, respectively.
- To find out how many physicians always used an X-ray image intensifier to confirm the position of the needle in the above procedures.
- To find out how many physicians always used a contrast medium to confirm position of the needle while performing the above procedures.
- To find out how many physicians used methylprednisolone, triamcinolone, betamethasone and dexamethasone in injections in the cervical, thoracic and lumbar spinal levels.
- To find out how many physicians would reconsider and use contrast

and non-particulate steroids after reading a given set of literature that emphasised the occurrence of inadvertent intravascular injection in cervical and lumbar injections and paralysis following use of particulate steroids in cervical and lumbar transforaminal epidural injections.

Method

Clinicians were asked a set of questions about their practice of neuraxial injections in chronic pain. These questions were followed by a second set if the respondents chose to change their practice after reading abstracts of five articles focusing on the use of contrast-enhanced fluoroscopic guidance to prevent inadvertent intravascular injection and the use of water-soluble steroid preparation such as dexamethasone to prevent spinal cord infarction. There were 135 completed responses of which 85.8% (115) were by consultants.



Results

More respondents performed injections in lumbar spinal level (around 85%) than in cervical or thoracic level (40%–60% depending on the type of injection).

We then derived the percentage of clinicians who used fluoroscopy and contrast material for a specific procedure at a spinal level. One hundred per cent of

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Table 1

Type of steroid used by clinicians at different spinal levels

	Methyl-prednisolone	Triamcinolone	Beta-methasone	Dexa-methasone	Number of physicians responded
Cervical	31	36	1	62	105
Thoracic	52	53	2	27	110
Lumbar	69	76	2	24	131

respondents who performed FJI, MBB, TFESI or NRB at any spinal level always used X-ray image intensifier to position the needle. Only 80%, 76% and 67% used image intensifier for ILEI in the cervical, thoracic and lumbar spinal levels, respectively.

While more than 90% of clinicians used a contrast medium to confirm the position of the needle for a TFESI or NRB, less than 75% did the same for ILEI.

For the sake of simplicity, the clinicians were asked if they would use methylprednisolone, triamcinolone, betamethasone and dexamethasone at cervical, thoracic and lumbar levels instead of a specific procedure. They could choose more than one steroid at any spinal level (Table 1).

These results indicate that fewer physicians were injecting at the cervical and thoracic level at the time of the questionnaire. Since the clinicians could indicate more than one steroid used at a level of the spine, all one can surmise is that respondents were more likely to use dexamethasone in the cervical region (about 50% of total responses) than in the thoracic and lumbar region (about 20% of the responses). Due to the way this particular questionnaire was conducted it was impossible to tell whether, for example, respondents were currently using dexamethasone for NRB and particulate steroid for the MBB or FJI. This will be corrected in future study.

After the first set of questions, the respondents were asked to read the abstracts of the following publications:

1. Baker R, Dreyfuss P, Mercer S, Bogduk N. Cervical transforaminal injection of corticosteroids into a radicular artery: A possible mechanism for spinal cord injury. *Pain* 2003; 103: 211–15
'This observation warns operators to always perform a test injection of contrast medium, and carefully check for arterial filling using real-time fluoroscopy with digital subtraction.'
2. Derby R, Lee S-H, Date ES, Lee J-H, Lee C-H. Size and aggregation of corticosteroids used for epidural injections. *Pain Medicine* 2008; 9: 227–34
'Until shown otherwise, interventionalists might consider using dexamethasone or another corticosteroid preparation with similar high solubility and negligible particle size when performing epidural injections.'
3. Brouwers PJAM, Kottnik EJBL, Simon MAM, Prevo RL. A cervical anterior spinal artery syndrome after diagnostic blockade of the right C6-nerve root. *Pain* 2001; 91: 397–99
4. Sullivan WJ, Willick SE, Chira-Adisai W, Zuhosky J, Tyburski M, Dreyfuss P, et al. Incidence of intravascular uptake in lumbar spinal injection procedures. *Spine* 2000; 25: 481–6
'The overall incidence of intravascular uptake during lumbar spinal injection procedures as determined by contrast enhanced fluoroscopic observation is 8.5%. Preinjection aspiration failed to produce a flashback of blood in 74% of

cases that proved to be intravascular upon injection of contrast dye.'

5. Lyders EM, Morris PP. A case of spinal cord infarction following lumbar transforaminal epidural steroid injection: MR imaging and angiographic findings. *American Journal of Neuroradiology* 2009; 30: 1691–3

The respondents were then asked if they would reconsider the use of contrast and steroids based on the information provided by the above articles. Only 21.5% (29) respondents changed their responses to the previous questions. Seven respondents who already used a contrast medium would now use it for other procedures as well. Three others who did not use a contrast medium before would consider using it for specific procedures in the future. Fourteen respondents said they would use dexamethasone only for procedures they performed; out of these, 11 had not used dexamethasone before. Of the nine who would use dexamethasone in addition to other steroids, five had not used it before.

Discussion

Scanlon et al. (2007) noted that in the USA between 1998 and 2003, the number of cervical and thoracic TFESI almost doubled. They noted that at the time of their writing, 27 cases of brain and spinal cord infarction following TFESI were reported; their survey revealed a further 78 cases following a survey of around 1,400 physicians despite a response rate of approximately only

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21%. Depomedrone, a particulate steroid, was seven times more likely to have been used in cases where there was evidence of brain and spinal cord infarction than either triamcinolone or betamethasone. No cases were reported with dexamethasone; it could be argued this simply reflected a frequency of use rather than a propensity to cause problems. Tiso et al. (2004) showed that methylprednisolone and triamcinolone were more likely to aggregate than dexamethasone or betamethasone, sometimes up to 100µm in diameter on microscopic slides, which has the theoretical ability to block small arteries.

Limitations

Only 135 clinicians responded to this survey, so the results of this survey are by no means a complete

representation of the practice all over the UK. In order to get a good number of responses, the questionnaire was simplified. We did not include caudal epidurals in the list of procedures, did not ask if real-time fluoroscopy was used and did not specify the procedures for choice of steroids. It is possible that the respondents could have interpreted the online questions differently, which would then affect the results. Multiple answers to several questions complicated data analysis.

Conclusions

These brief results show that there is already a growing awareness of the possible problems associated with particulate steroids, which may explain the differential use of dexamethasone between the different areas of the spine. However, we can surmise that significant

numbers continue to use particulate steroids in the cervical region, including for TFESI or NRB, i.e. those procedures most implicated in causing problems.

The relatively small number of catastrophic neurological cases compared to the very large number of injections being performed, along with some laboratory and animal studies, has led to considerable controversy over whether clinicians should be using particulate steroids at all in their injections. However, the clinical efficacy of dexamethasone as an alternative non-particulate steroid has been questioned by some.

Should we be changing practice now or wait for clearer evidence of harm or otherwise from particulate steroids? Clearly this subject will continue to lead to clinical controversy and litigation for some time to come.

Use of particulate steroids in neuraxial injections: a common but negligent practice?

Alice Nash *Barrister practising in clinical negligence at Hailsham Chambers*

The existence of a controversy over the efficacy and risks of a particular form of medical treatment raises the possibility that there may come a time when a practice that has been widespread is considered by the courts to constitute a breach of the clinician's duty of care to the patient. It seems likely that in the near future the courts will be asked to decide whether, in relation to the use of particulate steroids in neuraxial injections, that point has been reached.

Practitioners have a duty to keep up to date with developments in their field; they cannot cling blindly to a discredited practice. However, a clinician is not expected to read every article, nor immediately to put into practice every suggestion propounded therein.¹ In *Gascoine v Ian Sheridan & Co*² the judge

held that the defendant gynaecologist had a duty to keep himself informed of changes in practice through 'mainstream' literature, examples of which were 'leading textbooks' and the *Journal of Obstetrics and Gynaecology*. Demonstrating that a practice ought to be regarded as discredited, therefore, is

likely to depend not only upon the existence of studies calling its safety or efficacy into question, but on the extent to which those findings ought to have been known to the practitioner, who is not likely to have the same level of knowledge as a research scientist specialising in the field.

Use of particulate steroids in neuraxial injections: a common but negligent practice?

If the small sample of survey respondents in this particular paper is representative of the pain management community as a whole, it seems that the use of particulate steroids is still widespread. That will sound alarm bells in the mind of any lawyer asked to advise a potential claimant. Although, as will be seen below, the touchstone of negligence is what *ought* to be done, not what *is* done, there are considerable obstacles to establishing that a practice espoused by many practitioners is negligent, not least because if so many individual practitioners are in fact carrying out the practice, one assumes as a starting point that they have some reasons for doing so, and that the defendant is likely to be able to produce at least one credible expert to testify to the acceptability of the practice.

A further interesting feature of the survey is that comparatively few respondents said that they would change their practice even after being asked to consider specific publications. We do not know their reasons, but again, it seems a reasonable starting point to assume that competent practitioners must have weighed the costs and benefits of continuing with their current practice in giving their answers. It appears, then, that a substantial number, even when presented with the literature that a claimant would presumably be relying upon as evidence that the use of particulate steroids is negligent, would continue to sanction their use. If this sample is representative, the literature published thus far has not *in fact* been sufficient to discredit the use of particulate steroids throughout the pain management community.

With consultants apparently prepared to sanction the use of particulate steroids in over 50% of cases, and many asserting that they would continue to do so even in the light of current doubts as to their safety, is there any prospect of showing that a decision in the past few years to treat a patient by this method was negligent?

It is axiomatic that a doctor, or any other person acting in the exercise of some professional art:

is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.³

However:

the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice ... the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.⁴

It is important to remember that an expert, or body of experts, may be reasonable and responsible, but its opinion on the particular question may not be: the question is whether the body of opinion on the particular issue withstands logical scrutiny.

Accordingly, while evidence that something is common practice may be persuasive evidence that it is not negligent, it will not be determinative, even if the defendant calls distinguished experts to support the practice. However, the House of Lords emphasised that:

it will very seldom be right for a judge to reach the conclusion that

views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence ... It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed.⁵

It is clear, however, that the courts may find a common practice negligent if presented with the appropriate expert evidence, and have been prepared to do so in a number of cases.⁶ In *Hucks v Cole*⁷ Sachs LJ said, in a passage approved in *Bolitho*:

If a lacuna in practice exists whereby risks of grave danger are knowingly taken, then, however small the risks, the courts must anxiously examine that lacuna – particularly if the risks can be easily and inexpensively avoided.

Any claimant will need to grasp the nettle of providing sufficient evidence to enable the court to undertake this 'anxious examination'. Such evidence will need to address at least the following issues:

1. How well known was, or ought to have been, the risk?
2. How big was the risk?
3. How serious are the consequences?
4. What are the benefits of the treatment?
5. What are the alternatives?

The studies to which survey participants were referred appear to show that the risk of complications from the use of particulate steroid is small, but the consequences of the risk materialising are catastrophic, and can be avoided by the use of dexamethasone. The court will want to know how reliable these findings are and how widely they were promulgated, by reference to the

Use of particulate steroids in neuraxial injections: a common but negligent practice?

standing of the publication and/or the extent to which its findings were publicised elsewhere.

Defendants will want to emphasise that the area remains one of controversy: the court should not attempt to resolve a debate upon which eminent specialists cannot reach agreement. In particular, however credible the evidence of risk from particulate steroids, if defendants can provide equally credible evidence of the comparative inefficacy of the alternative, it will be difficult to argue that the use of particulate steroids cannot be justified.

There is potentially another route to recovery for claimants. Clinicians have a duty to warn of any significant risk that would affect the judgement of a reasonable patient;⁸ that duty may, in some circumstances, extend to informing the patient that an alternative, less-risky treatment exists.⁹ It may be easier, in an area of controversy, for the claimant to succeed in an 'informed consent'

argument than in persuading the court that the procedure should not have been offered at all; and if so, the claimant may be able to recover damages even if they cannot show that they would *never* have undergone the more risky procedure.¹⁰ In the light of the doubts now raised in a number of studies as to the wisdom of using particulate steroids at all, failures to offer the patient a less risky alternative may provide a fertile battle ground for litigation.

References

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- 7 [1993] 4 Med Law LR 393 at 397; a case from 1968, but not reported until much later.
- 8 *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P53, approved in *Chester v Afshar* [2004] UKHL 41
- 9 *Birch v University College London NHS Foundation Trust* [2008] EWHC 2237, where the actual performance of the impugned procedure was held not to have been negligent because the literature demonstrated that there was no consensus at the time as to which was the better method.
- 10 In *Chester*, note 9 above, the claimant was held entitled to recover when her surgeon negligently failed to warn her of a small but significant risk, the operation was carried out without negligence, and the risk materialised.



The Pain Toolkit – why has it become successful?

Pete Moore and Dr Frances Cole *Co-authors of the Pain Toolkit*

How the Toolkit started

In 2004 Pete was asked to write a chapter for a pain educational learning site and while writing it, the idea of the Pain Toolkit came into his head. Just as the car mechanic or gardener who needs a selection of tools to help them maintain cars or gardens, people with pain also need a selection of tools or skills. Pete collaborated with Dr Frances Cole, Bradford Pain Rehabilitation Programmes,



who supported the concept and suggested additions and trialled its use in Bradford's pain rehabilitation service. Other healthcare professionals (Mr Neil Berry, Southampton and Dr Patrick Hill, Birmingham) also contributed to help shape this self-management tool to its current version. Early audits of the toolkit in clinical settings showed its value for both patients and clinicians. The Long Term Health Condition team at the Department of Health recognised its value and have given extensive support in the distribution of the Pain Toolkit over the last two years. This has meant it has reached

thousands of patients in the UK and been included in numerous local and regional pain- or self-management-related websites.



How does the Pain Toolkit support patients and healthcare professionals?

The Toolkit promotes simple ideas or tools for people with pain and healthcare professionals work together more as a team and promote pain



The Pain Toolkit – why has it become successful?

The Pain Toolkit Tools

- Tool 1. Accept that you have persistent pain ... and then begin to move on
- Tool 2. Get involved – build a support team
- Tool 3. Pacing (daily activities)
- Tool 4. Learn to prioritise and plan out your days
- Tool 5. Setting goals/action plans
- Tool 6. Being patient with yourself
- Tool 7. Learn relaxation skills
- Tool 8. Stretching and exercise
- Tool 9. Keep a diary and track your progress
- Tool 10. Have a set-back plan
- Tool 11. Teamwork
- Tool 12. Keeping it up ... putting into daily practice tools 1–11

self-management more effectively. Its main message is teamwork between the patient and healthcare professional to address patient-led agenda. Practical examples in its use follow the example from a physiotherapist who shares a copy of the Toolkit with the patient. This physiotherapist encourages the patient to read the Toolkit between sessions and circle three of the most important tools they would like to work on with help from the physiotherapist. An example of teamwork in action – and once the patient is confident with those three tools, they then choose another three. Simple and effective, isn't it!

Other healthcare professionals have sent comments as to how the Toolkit is effective for their patients and they can be seen on the Pain Toolkit website (www.paintoolkit.org).

Evaluation of the Pain Toolkit – is it useful?

An audit of the value of the Pain Toolkit in facilitating self-care for more than 200 patients from the patient's perspective was carried out by Bradford Teaching Hospitals Pain Rehabilitation Programme Service in 2011. This drew on patient self-reports from numerous pain management programme services around the UK.

The audit found that in excess of 90% of patients found that the Pain Toolkit provided knowledge about key tools and useful information to enable self-management of their pain and direction to other resources. For many it helped to improve the partnership with their clinician.

The top key tools that patients found most useful in helping them to self-manage pain better were:

- Tool 1. Acceptance
- Tool 3. Pacing
- Tool 5. Setting goals
- Tool 6. Patience with self



The least important was surprisingly Tool 11. Teamwork – with healthcare professionals and others. So we think there is some work to do in this area.

How the Pain Toolkit has been useful outside the UK

The Toolkit has over the years become a valuable resource for other healthcare

professionals in Europe, where it has been translated into French, German and Italian. There will be Spanish and Dutch versions in 2012. We have also adapted it for Australian, New Zealand and Canadian pain organisations. There is also an animated DVD version, in English and Urdu.

**The Pain Toolkit and new ways of linking to clinicians and patients**

In 2010 we asked those who read the Toolkit what other resources they needed to help and support them in pain self-management. Overwhelming feedback was a need for a website and more skills and training, so we have developed the website and:

- a one-day workshop for healthcare professionals
- a half-day workshop for people with pain.

There is more information about these at www.paintoolkit.org/workshops

For more information about the Pain Toolkit, contact Pete Moore

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Mobile: 07811 222 044

Website: www.paintoolkit.org/contact



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A Systematic Approach to Pain Service

MedICUs – Data Collection System for Acute, Chronic & Paediatric Pain Teams

MedICUs Chronic Pain

MedICUs Pain Services (Mela Solutions) is a PC-based data collection system that provides a cost-effective method of recording and analysing patient care. The programme contains a fully customisable field and menu system, allowing the capture of data in an easy and efficient manner. Reports and analysis the data can be performed at the click of a button and the resulting information can be used to identify successful interventions and treatments, while highlighting those cases of concern.

“The flexibility of data collection within MedICUs allows our team to gather only the information we require. The system offers us the opportunity to locally define the fields of interest and to comply with minimum datasets, such as the National In-patient Pain Survey (NIPPS).”

Sue Millerchip - Lead Nurse - Walsgrave Hospital.

Flexibility is built-in

The system is flexible and can be adapted to suit individual needs. In this way, local information can be recorded simply by customising the system. MedICUs contains many other useful features. For example, printing costs can be reduced by producing patient literature on-demand at the point of use. This removes the need to stock large volumes of hard copies that may go out of date. In addition, the system can record which leaflets have been given to individual patients, helping to prevent duplication of information.

“The standard of support offered by the Mela Solutions team is excellent and any issues we have are dealt with quickly and professionally. The regular program updates ensure our system is continuously improving and furnished with the latest requirements.”

Jacquie Trim - Pain Nurse - Southampton General Hospital.

Accurate, intelligent pain assessment

The inbuilt assessment service allows for touch-screen completion of pain-rating questionnaires during the patients spell in the waiting room. As the information from the questionnaires is immediately saved to the system, the patient's progress report is available for the assessment to take place.

“The touch screen questionnaires have proved an invaluable tool; the fact the system facilitates their completion prior to assessment means patient-doctor time is no longer compromised by the filling in of paper documentation. Moreover, this straight-forward protocol can be completed on every follow-up appointment, allowing comprehensive analysis of patient progress”.

Rachel Butler, clinical audit assistant, The Walton Centre for Neurology and neurosurgery.

Data Analysis

Reporting and analysing the data can be performed at the click of a button in one of two ways: users can either employ one of the predefined library reports, or tailor reports to their own specifications by selecting specific fields of interest. The resulting information can be used to identify successful interventions and treatments, while highlighting those that have been less successful. The analysis will also help report on best practice; therefore, improving overall patient care.

Conclusion

Pain Services is not just about pain management. The current landscape focuses on increased efficiency while maintaining the highest healthcare standards. An integrated database such as MedICUs can facilitate communication between team members and driving efficiencies.



MedICUs

PAIN SERVICES

Data Collection Systems for Acute, Chronic & Paediatric Pain Teams

Includes:

Demographics

Diagnosis

Assessment

Adverse events

Modalities / Procedures

Questionnaires

Treatments

Outcomes

Auditing and analysis

Handheld data collection

NIPPS (National In-Patient Pain Survey) for Acute Pain



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The (cost) effectiveness of pain clinics: who are we kidding?

This is a transcript of a lecture given in the Philosophy and Ethics SIG meeting by **Ian Yellowlees**; Peter Wemyss-Gorman has reproduced this lecture. These are neither the views of the *Pain News* nor the Society. A full transcript of these and previous lectures are available on request from Peter Wemyss-Gorman at £7.00 including P&P payable to the BPS. It can also be downloaded from the Philosophy and Ethics SIG page on the BPS website. Please support the next meeting of this SIG to be held at Rydal Hall on 2–5 July 2012. (Enquiries to Diana Brighthouse at dbrighthouse@aol.com)

The answer to the question 'Is rationing of pain services necessary?' is so obviously YES that I won't actually talk about it much, but will instead talk about life – yours – what are you going to do with what's left of it? Does it matter? You might say it doesn't much, provided you don't do harm to others. It might be better if you actually do some good, and a lot of people in medicine think that's what they are doing. Volunteers often think that too. My son has been working in Zanzibar where he lived for eight months in a shed in a mud hut village with no running water, trying to teach physics to a class of 65 with nothing but a piece of chalk. Why do people volunteer, or go in to medicine? I would suggest that they do it to a large extent for *themselves* and if they do a little bit of good that's the icing on the cake.

Who decides things – us or 'them'?

In the NHS where most of us work there is a difference: you are *paid* by the rest of us to do good for some of us. There is an implied imperative to try to maximise the good we do per pound spent. But how do we do that? Who

decides how to maximise the public good? Maybe you think it's the job of managers; certainly it's what they are paid for. It's what politicians are elected for too. So maybe this is OK. Perhaps we can safely assume that if someone has created a job as a pain specialist or pain nurse, this implies that somebody has thought through whether this is a good thing for the NHS and the money is well spent.

If you take this attitude, that politicians and therefore managers are responsible, then that's good because everything becomes 'somebody else's problem'. So let's follow this through: if you think that it's all their responsibility, you also have to accept that their other decisions have some validity. So if they decide to reduce your budget, that's fine. If they decide that your service is not affordable, you shouldn't argue. And what other physicians do isn't your problem either, and the managers decide to fund their expensive treatments – fine, not your problem.

But then, what about whistle-blowing? In this scenario, management and politicians are going to make decisions about how the money is spent, and we are supposed to be doing well, so how do we handle it when things go wrong?

What are we going to do about situations that get out of control because of politicians and managers? What if they are going against professional standards?

I don't think it is possible to stand back and say: 'Yes, managers and politicians have the ultimate say.' There has to be a line somewhere. On the one hand, we are paying managers to decide how money should be spent in the NHS. On the other, we are saying we want to hold back a bit on that power. Where are we going to draw that line? We could draw the line at a basic human rights level. But even there we run into trouble. We approve of freedom of speech, but what about freedom of speech that causes upset to others, or incites violence? Maybe it's how we see our patients treated that decides whether we stand up to the managers who are trying to govern our service. Or should it be the GMC or NICE? Perhaps it comes down to how good the managers are? Who's going to decide that?

Are we kidding ourselves?

In the end it is going to fall largely on our plate. So why are we involved in pain?

The (cost) effectiveness of pain clinics: who are we kidding?

This is where I think we probably kid ourselves. You can persuade yourself that you are doing it for all sorts of good reasons, but maybe, just like the volunteers, you personally have a lot invested in what you are doing (in much more than the financial sense). So following our train of thought from our obligation to do good for some, and our agreement that we didn't want all the decisions to be made by managers and politicians, we seem to have ended up with the conclusion that maybe it's really just about us. It doesn't feel very comfortable and perhaps we'd rather not think about it too much. But it gets worse.

I was slightly disturbed to see on the front page of the programme (SIG meeting) the suggestion that people in pain medicine need to be involved 'heart and soul', as well as have expertise. We think we're in it to do good. Do we actually know that? Well, no. Quite a lot of what we do is actually harmful for patients but we like to ignore that bit. But presumably we enjoy what we are doing and think it worthwhile and we would stand up and defend our budget in the face of cuts. That means that we really believe that our work should have priority over some other aspect of clinical spending. Whose? Or perhaps we believe that there shouldn't be any restrictions of resources anyway?

So let's see if we can come up with some justification for what we are doing. At a very rough estimate, the total cost of pain services in the UK is about £80 million per annum. That would pay for ChildLine, for example, for about four years, or about 11,000 hip replacements. There is evidence that about 20% of the population suffer pain 'needing' treatment (this includes all causes of pain, including OA hip, cancer, etc). We actually see somewhere around two in 1,000 (0.2%) in most pain clinics. That implies that if there are about 20% of the population who need us, 99 out of a hundred are not presenting. Are we really suggesting that we have to provide for all



of these and that lack of resources is preventing 99 out of 100 people coming to a pain clinic?

Are we effective?

We kid ourselves if we think we are. We do a lot of good for a few individuals, but overall? Not really.

The outcome literature suggests that only a minority of patients with chronic non-cancer pain show measurable benefit from ANY of the treatments commonly given for this condition.

IASP News, January 2011

But let's be generous. An NNT of about five is maybe quite good for a pain therapy and this might provide 50% pain relief for a while (for about 0.04% of the population). The cost per patient helped works out at about £7,500 – about the same as a hip replacement. Alternatively, that would buy a nice holiday for the patient, which might be much more effective! The average time that people had pain before going on a Pain Management Programme (PMP) some time ago was *eight years*. The follow-up time for most PMPs was, if people were lucky, about six months.

Are you still feeling good? I'm not. I hope you can defend your treatments – but I doubt that I can. I think there is probably little ethical justification for claiming that that our little speciality

should have any priority for resources over others.

Rationing

So we're back to rationing. All that I've said applies to most branches of medicine. It seems to me that the only way forward, if you've got limited funds that are getting smaller, is to ration across the board. 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.

I'm just as guilty as you as I'm a pain doctor; I don't like this conclusion and I didn't really want to do this talk. But if we are really honest with ourselves we would have to concede that the real reason why we do what we do, like the volunteers, is that it is mainly about us, and if we get some benefit for some patients some of the time that's icing on the cake. So I suggest we face up to this and then, like most people in most walks of life, we get on with business as usual.

The Editor reminds readers that these are the approved views of the lecturer as transcribed by Peter Wemyss-Gorman; these are neither the views of Pain News nor the Society. The Editor welcomes your valuable comments and views on this topic; interesting letters will be published in the next issue.



The Tao of Pain

William Notcutt

This was presented as a lecture in the Philosophy and Ethics SIG; the author has kindly written the summary to suit our newsletter pattern.

Taoism is an eastern philosophy and the Tao is perhaps easiest described as the 'way' or – a way of life. However, it is more:

Tao is a thing that is both invisible and intangible.

Intangible and invisible, yet there are forms in it;

Invisible and intangible, yet there is substance in it;

Subtle and obscure, there is essence in it;

Tao Te Ching, chapter 21(1)

By putting this with the IASP definition of pain:

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

we can get:

Pain is felt by all but it cannot be touched. It cannot be seen or directly measured, but its patterns can be recognised. Elusive and ill defined, yet it has substance and specific characteristics.

In 1995, *Pain Reviews* published my initial thinking on this idea, which was based on the seminal work of Fritjof Capra, *The Tao of Physics: An Exploration of the Parallels between Modern Physics and Eastern Mysticism*.

Recently, I decided to revisit this after reviewing the later work of Wall, Melzack and others.

Thinking about pain has come a long way in the last 30 or 40 years, but the old Cartesian approach is still very prevalent in much western medicine. Pain is still too often seen as a target that we locate with the words of our questions or the radar of our scanners, bomb with chemicals, stab with steel and cauterise with fire and ice. Other therapies can also be used with similar vigour. Yet most chronic pain syndromes defy explanation in terms of peripheral sensory change and present a challenge to current understanding of pain.

Capra's paradigms

In his book, Capra identified six paradigms of scientific thinking that covered all of science. As I continue to struggle to fully understand pain, I decided to use his framework to explore the subject and this brief paper is a summary of a much longer one and its associated oral presentation.

In his first paradigm, Capra states: 'Knowledge of the structure does not predict function.' In the past we have thought that if we break things down to the fundamental parts then we will understand the system. In recent times we have used a three-dimensional model of the pain elements – Sensory/Discriminative; Affective/Evaluative; Cognitive Behavioural – to describe these elements. It does have a simplicity and

convenience but fails to give a full appreciation of the complexities seen. Melzack described the Neuromatrix theory of pain, which proposes that pain is a multi-dimensional experience produced by characteristic neuro-signature patterns generated by the body–self neuromatrix in the brain. By opening these dimensions out, we can broaden our view of the 'structural' elements.

The neural dimension

The brain is a massive complex neural network incorporating some 100 billion neurons, each with thousands of connections. It is not surprising that Patrick Wall didn't like the original Gate Theory diagram, because he knew that it would become a simple wiring diagram to explain pain without much further appreciation of other factors.

The chemical dimension

It is estimated that there may be some 250 molecules or more that are associated with pain. This leads to a complex chemistry of interactions within the neuron, the glia, in the synapse, the extracellular fluid and peripheral tissues. When we introduce a single chemical (medicine) into the nervous system, perhaps the amazing thing is, that it ever works!

The psychological dimension

Every patient has a different psychological make-up with different

ways of coping (or not) with their illnesses or pain. To this may be added the problems of behavioural disorders, anxiety, depression, and other psychiatric and cognitive disorders.

The social and cultural dimension

Social factors including environment, family, work and past experiences have a profound influence on pain. Cultural factors may influence reaction to pain with great differences across the world in response to pain of illness or injury, from apparent indifference to florid demonstrations of distress.

The time dimension

The longer pain persists, the harder it is to cure or control. Neuroplastic changes in receptor sensitivity and receptive fields, new synapses, changes in gene expression and so on, occur over time. Past traumas may also have an impact particularly on the psyche.

The genetic dimension

Melzack identified the neuromatrix as having a structure and function that is genetically determined. We also know that there are gender-determined responses to pain. Pharmacogenomics is now opening up the genetic determinants of the responses to medicines.

The dimension of unpleasantness

Fields HL explored the concept of unpleasantness, which may be quite distinct from the experience of nociception (or any other sensation). Post-herpetic neuralgia is an exquisitely unpleasant and painful experience. A painful massage may not be particularly unpleasant. For others pain can even be pleasurable!

The immune dimension

Pain is directly linked to the functioning of the immune system, both at the tissue level enabling the essential task of the recognition of tissue damage, and also within the hypothalamus in the response to stress.



The metaphysical dimension

Many will identify a spiritual dimension to their lives and thereby find a meaning in their pain, for good or bad.

The healthcare system dimension

Long waiting times, *limited resources*, lack of education, and inappropriate and ineffective treatment can influence a patient's pain.

How then can we tease out a single element and assume it is the whole cause of the pain. By using a 10-dimensional approach to the structures of pain, we acquire a realistic although incredibly complex description of the elements we are working with. Unsurprisingly, the problems patients present are often so difficult to comprehend and manage.

Capra's second paradigm defined 'Process' as being primary, and that this would determine structure. The process of 'Evolution' is a classic example. Neuroplasticity is a process whereby ongoing pain is changing the structure of the nervous system over time, and sometimes gets out of control, as with complex regional pain syndrome (CRPS). So too the psychosocial disasters of some chronic back pain patients. Melzack

developed the theory of the Neuromatrix of Pain, now supported by the developments within fMRI imaging. He suggested that pain is an iterative process at work within the nervous system that could be dependent on sensory inputs or may be generated independently of them.

Capra drew his third paradigm from the physicist Heisenberg's principle that you cannot separate the observed from the observer. In observing our patients we may induce changes in him or her, through our empathy (or lack of) etc. However, the patient is also observing me observing them, which may induce change in me as well. Therefore, all our relationships with patients are dynamic, two-way, complementary, ongoing, for better or for worse, but never static. All those researching into pain recognise this as a major problem in evaluating outcomes.

Capra's fourth paradigm recognised that there are no fundamental equations to explain anything. Pain being a subjective biological experience has no exact definitions and there are no hard measurements to use to construct tidy theories that we can use to plan pain therapy and predict the response to it. However, doctors and nurses still believe in predicting pain levels and using rigid prescribing criteria, for example.

Paradigm 5 recognises that all descriptions are approximations. The old Cartesian approach was based on the belief in the certainty of scientific knowledge. We now realise that science always deals with limited and approximate descriptions of reality, whether we are talking about quantum physics or medicine and biology. Back pain is a classic example; we may look at the scans and surgeons may operate because they observe a disc protrusion or a slipped vertebra. But is that necessarily the reason they have back pain? It may have been part of it, but trying to work out the contribution of any particular pathology is always an approximation.

Capra's final paradigm, the sixth, proposes a shift from an attitude of domination and control of nature to one of cooperation and non-violence, caring for the world, the environment and the

The Tao of Pain

person. If, for example, we don't take care with treatments involving immuno-suppression, for example, we are going to cause damage. Leprosy demonstrates what happens when pain sensation is lost. We still use a lot of violent, military language, and talk about painkillers, nerve blocking and nerve destruction. We have our armed camps: the 'needle jockeys' and the 'tea and sympathy brigade'. Doctors tell patients 'You'll be in a wheelchair in five years' time', 'You have the spine of an 80 year old', 'Your spine is crumbling.' Many of our words and actions may be harmful. We know the dangers of NSAIDs, but doing nothing may also lead to the patient despairing.

The essence of Tao

The essence of Tao is described as *Wu Wei* – 'Action through inaction'. This

doesn't mean 'Do nothing and wait for everything to get better' but rather the practice of the minimum necessary action to enable things to improve, to which we might add '*Primum non nocere*'. Pain isn't a simple wiring diagram through which an alarm signal is transmitted. How we understand pain is going to depend on whether we see it as a sensation, a symptom, an experience, a disease, or a combination of all of these in multiple dimensions of complexity. Pain is never simple.

Some points from discussion

- The more we discover about pain in molecular terms, the further we seem to be from solving its problems: we are just more aware of its complexity.

However, this opens many doors to influence pain.

- Biomedicine may induce a sense of mastery, but we must acknowledge our ignorance, our impotence and our capacity to do more harm than good.
- We are dealing with a small but complex corner of the pain world, and we mustn't forget that some treatments in orthopaedics, in pain or palliative care can be very successful.
- The art of medicine is difficult to define but is a powerful area and it's to do with the language that we use and the depth and quality of listening.

The full version of the *Tao of Pain* is published in Wemyss-Gorman P (Ed). *Pain, Suffering and Healing: Insights and Understanding*. London: Radcliffe Publishing, 2011

Informing practice

IAPT and Pain Psychology Services

Hilary Rankin *Centre of Pain Education, Epsom and St Helier University Hospitals NHS Trust*

Helen Curr *Sutton and Merton IAPT, SW London and St Georges Mental Health Trust*

The authors outline how local IAPT and Pain Services are working together to develop the psychology services to help people suffering with chronic pain.

In a previous edition of *Pain News*, Neil Berry explored some of the concerns of pain clinicians about the role of Improving Access to Psychological Therapies (IAPT) in the management of chronic pain.¹ In this article we describe how local services in a London borough are addressing some of these concerns and are working together to establish a care pathway for people with chronic pain and associated distress.



Features of IAPT	Features of Specialist Pain Services
<ul style="list-style-type: none"> • Easy access to high-volume assessment and signposting to specialist services such as COPE/physiotherapy • Easy access to low-intensity brief therapeutic work allowing early intervention • Guided self-help, group-based interventions and individual therapy for pre-existing anxiety and depression • Interventions for common mental health problems not directly related to pain, but impacting on pain coping (e.g. PTSD, social anxiety). • Group-based and individual interventions for anxiety and depression associated with difficulties in coping with pain • Basic advice about coping with chronic pain such as pacing activity, recognising the role of stress in exacerbating symptoms, stress management strategies, presenting a modified CBT model 	<ul style="list-style-type: none"> • Specialist expertise and education about pain mechanisms, medication use, physical movement, exercise and the pain nervous system • Access to medical records and investigations, e.g. MRI scan results with expertise to interpret and to challenge unhelpful beliefs about pain, e.g. pain means damage • Identifying and challenging evidence base for core beliefs associated with disability • Psychological strategies are part of integrated MDT working to address fearful avoidance of movement, ineffective medication use, etc. • Validation of pain experience through MDT working for people fearful of pain being seen as 'all in your mind' • Flexible longer-term input to address engagement difficulties and to help maintain changes in the face of flare-ups of chronic pain

Introduction

IAPT is a centrally funded government initiative designed to significantly increase the numbers of people who can gain rapid access to evidence-based psychological therapies for common mental health problems.

Last year IAPT reaffirmed its commitment (and funding) over the next four years to improving access to people living with long-term physical health conditions (abbreviated as LTC).² Many local IAPT services are therefore exploring options of care for people with LTCs, and looking for guidance from specialist services about appropriate care pathways and interventions for this group. IAPT Positive Practice Guidelines³ note the high prevalence of chronic pain in the population at large, and the significant costs associated with it, as well as the high prevalence of anxiety and depression in chronic pain populations. It concludes: 'The opportunity presented to pain services by IAPT is clear; Commissioners need to ensure that delivery of IAPT integrates with and augments current pain services.'

Local IAPT and chronic pain services

Sutton & Merton is a large London borough serving a population of

approximately 400,000 people. The IAPT service, provided by South West London & St George's Mental Health Trust, began in October 2009 as a 'second wave' IAPT site and has expanded rapidly with a current capacity to see 4,500 people a year. The service has taken a specific interest in the development of approaches for people with LTC. Locally, IAPT interventions adopt a cognitive behavioural therapy (CBT) focus on behavioural activation, setting graded goals and using pacing where required, as well as challenging assumptions about health and illness common to a range of LTCs to alleviate low mood.

The Centre of Pain Education (COPE) is a small specialist service for an acute trust serving a wider catchment area, providing specialist nursing, physiotherapy and clinical psychology input and liaising closely with medical colleagues in the pain clinic. The service offers an education session, multidisciplinary assessment, group pain management programmes and flexible individual interventions with the capacity to see 200 referrals per year.

With a population of 400,000 in Sutton & Merton, the arithmetic is not hard to do. At the most conservative estimates, 40,000 residents are living with chronic pain and 4,000 of them are likely to be depressed.

While COPE continues to present the case for expansion of its service, there is a huge gap between what the service can provide and the number of people who could benefit from psychological input to their pain management. There was clearly much to be gained from working with the local IAPT service to identify the strengths and limitations of both services and be able to signpost people to the service that they need.

Initial concerns

Both services, however, recognised a number of concerns and challenges to developing this work. The team at COPE were concerned that at IAPT, a lack of access to and integration with necessary specialist knowledge and expertise of other health professionals, e.g. physiotherapy and pain medicine, meant that there was a danger that people may be inappropriately directed to a service that did not have the required competencies to assess or manage them.

In addition, it was feared that referral to a psychological therapy service could feed into people's suspicion that the pain is seen as 'all in your mind' and increase the perception of being disbelieved and misunderstood. This could result in lack of engagement and potentially, anger

Vignettes

IAPT guided self-help approach

Jane was referred to IAPT with an 18-year history of chronic headaches. In IAPT she was assessed, and she presented with moderate levels of depression and irritability, which was impacting on her day-to-day life. She was offered guided self-help to better understand the impact of her headaches, and to improve her mood and confidence in coping. Within IAPT she was offered four sessions of guided self-help, which provided a preliminary formulation of how her thoughts and behaviours could exacerbate her low mood, and gave her a range of practical strategies she could test out. Allowing Jane to separate out the different problems she was dealing with, and apply more appropriate solutions to different situations, supported her to feel less overwhelmed. She reported significant improvement in mood, and felt she coped better with her headaches when they occurred.

COPE Pain Management Programme approach

Clare was referred to the pain clinic by her orthopaedic surgeon, who in turn referred her to COPE. She had a 10-year history of knee pain and a two-year history of low back and shoulder pain. She told us that she needed a knee replacement and that she had extensive damage in her back. She was terrified of exercise and movement that might cause more damage and was becoming progressively more limited physically and fearful of the future. Clare found our initial education session in which the role of threat perception in 'winding up' the pain nervous system was described, helped her to question the role of stress and fear-avoidance in exacerbating her symptoms. The supervised graded exercise element of the Pain Management Programme helped her to overcome her fear of specific movements. She was also able to see how catastrophising about further damage, losing her job, house and family had contributed to a downward spiral of increased pain 'threat' and disability. She was recently reviewed by her orthopaedic surgeon and they have agreed that with the improvements she has made, it is now unlikely that she will need knee surgery in the foreseeable future.

Joint working

John was referred to the IAPT service with chronic back pain and post-traumatic stress disorder (PTSD) following a road traffic accident. At the time of assessment he reported significant difficulty managing his pain, reduced activity and movement, and high anxiety about future surgical options being considered. He reported having had little specialist input with regard to pain management and was concerned about how he would cope. He also reported symptoms of PTSD, including nightmares, irritability and avoidance. His attention and concentration was poor, and he felt he needed to manage his pain better as a first priority. In liaison with the pain service clinicians, the IAPT service asked the GP to refer John to COPE for initial pain management. Through attending the initial pain management sessions, and following an MDT assessment, John was able to stabilise his medication routine and regain confidence in his movement. He noted a significant improvement in mood as he was able to return to previously valued activities; however, he remained too anxious to drive, and continued to suffer nightmares and flashbacks about the accident. He was referred back to the IAPT service where he was offered individual CBT for PTSD, resulting in remission of these symptoms.

and hostility or renewed seeking of further investigations or treatment to validate their pain.

There were also concerns that cash-strapped commissioners might see an IAPT-type programme as an attractive low-cost alternative to multidisciplinary team (MDT) pain management programmes and that the presence of IAPT could make it less likely that appropriate levels of investment into multidisciplinary pain management would be made in the future.

Within the IAPT services it was also recognised that specialist knowledge and competencies were needed. The

IAPT workforce has been specifically trained to deliver NICE-recommended interventions for depression and anxiety, with limited training in approaches for people with physical health problems. Running condition-specific interventions would mean having to assimilate health information across a range of conditions and staying up to date on advances in medical care, psychology of health and patient views. In addition, most IAPT services are working with stringent limitations on waiting times and high-volume targets. People therefore need to be able to engage readily with the service and benefit from a brief, focused intervention.

Key strengths of IAPT and Specialist pain services

In this context we have worked together to identify key strengths and differences between both services. While this is an ongoing process, our initial thoughts are summarised in the table above.

Addressing our concerns

The exploration of our differences and the explicit acknowledgement that we are services that are not in direct competition but that we each have an important and different part to play in the chronic pain care pathway has allowed both services to explore openly what we are able to offer, and consider where

areas of overlap or exclusion would need to be.

Locally the IAPT service has taken a clear position that it will not attempt to develop specialist knowledge in pain, or deliver interventions that are specifically designed to address pain, without the support of pain specialists. Pain is *not* conceptualised as a medically unexplained symptom. People's stories about their pain are accepted so that IAPT can focus on the mood elements that people may be struggling with.

The presence of COPE allows IAPT to discuss and refer on patients who may make contact with IAPT, but who might need an MDT approach. This gives confidence for the IAPT service to open its doors for patients with distress in the context of chronic pain, knowing that those who are clearly seeking help

to manage their pain can have access to specialist advice and support, and those whose beliefs about pain need specialist input can also be referred on.

Very low waiting times specified for the local IAPT service offers the opportunity for good simple advice to be given early in the patient's journey, even where there may be a need for more specialist pain advice in the future. It also supports specialist clinicians to refer for specific issues, knowing that their patient will be assessed and progress to treatment rapidly, allowing effective integration with specialist care.

Conclusion

We hope that our description of the approach taken in one local area will be helpful to other services that may be weighing up how to proceed. However, many questions and concerns remain.

In our local area we will be continuing to work together to develop and refine our care pathway. It will be crucial to carefully examine clinical outcomes and patient experiences to further guide us and develop a joint approach to advising our commissioners. We hope that this will lead to the best use of our combined expertise and resources to improve outcomes in an area where development is sorely needed.

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Informing practice

The INPiC pilot project

Matthew K Makin *Chief of Staff, Cancer Clinical Programme Group, Betsi Cadwaladr University Health Board, North Wales*

What is the role of cordotomy in mesothelioma-related pain? Notes from the INPiC Consensus Conference: Royal Society of Medicine, 10 October 2011.

Background

Liverpool has had a long and strong tradition of pain and palliative care specialists working closely together for the benefit of patients. Following the formation of the Marie Curie Palliative Care Institute Liverpool in 2005, Professor John Ellershaw asked Dr Matthew Makin to set up a group to explore the interface between pain medicine and palliative care.

The Pain Group initially wished to investigate the role of neurodestructive procedures in cancer pain; there was clearly inequity in the access and

provision of such interventions and although there were many case series describing successful outcomes, there was a paucity of robust evidence of their effectiveness and associated adverse outcomes. As a consequence, there was a lack of clarity on where, if at all, neurodestructive procedures should fit in a cancer patient's clinical pathway.

Initial work focused on reviewing the totality of the literature associated with neurodestructive procedures, identifying where, and by whom, these procedures were performed, and measuring (as well

as developing) consensus on their role in clinical practice. These interventions are performed infrequently and it was the view of the Pain Group that traditional approaches such as double-blind randomised controlled trials, sufficiently well powered, and designed to expose potentially worthless treatments, would be impractical.

On the advice of the National Cancer Research Institute's Pain Subgroup (chaired by Professor Marie Fallon), the Pain Group focused its work on cordotomy for mesothelioma-related pain and was successful in winning an NCRI

The INPiC pilot project

SuPaC Lung Cancer Research Grant, which was approved in June 2008. The rationale for focusing on this specific area was that there are around 1,800 new cases of mesothelioma annually in the UK. More patients die of mesothelioma than cervical cancer, malignant melanoma or endometrial carcinoma. The incidence of mesothelioma is still rising. The National Mesothelioma Framework (2007) suggested that patients should have access to services that offer cordotomy as a palliative intervention to provide relief from challenging pain syndromes. We recognised a great inequity in the provision of services offering cordotomy; as new services were being established, others services have closed.

INPiC Pilot study and consensus conference

This led to the INPiC Pilot study, 'As much a test of the methodology as the technology'. The novel idea behind the study was to triangulate quantitative and qualitative information from a formal systematic review, a service survey, an online Delphi survey and a consensus conference to inform the development of an intervention registry. We thought consensus methodology had particular utility in this field as it not only provides a means of collating information and expert opinion (where little or contradictory evidence exists), but also allows a wider range of study types to be considered than is usual in statistical reviews, permitting a much greater role for the qualitative assessment of the evidence. The intervention registry will be used to capture each procedure (in this case cordotomy) and its associated outcomes; this provides a framework of governance and a platform to generate further research.

A formal systematic review of the literature was undertaken by Cardiff University under the supervision of Dr Marlise Poolman, although over 2,000 articles were identified with reference to cordotomy. Following systematic identification, screening and exclusion, only a small number of studies met the inclusion criteria to progress to the

Figure 1

Needle just anterior to dentate ligament

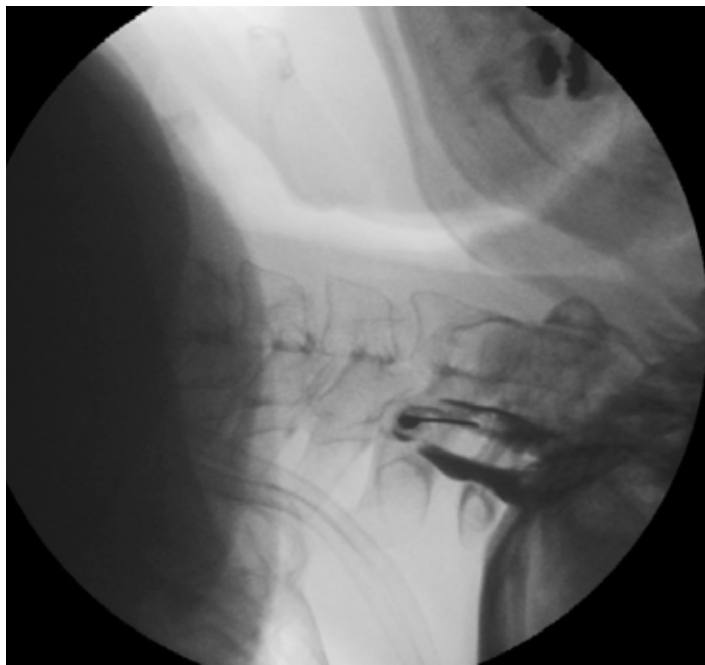
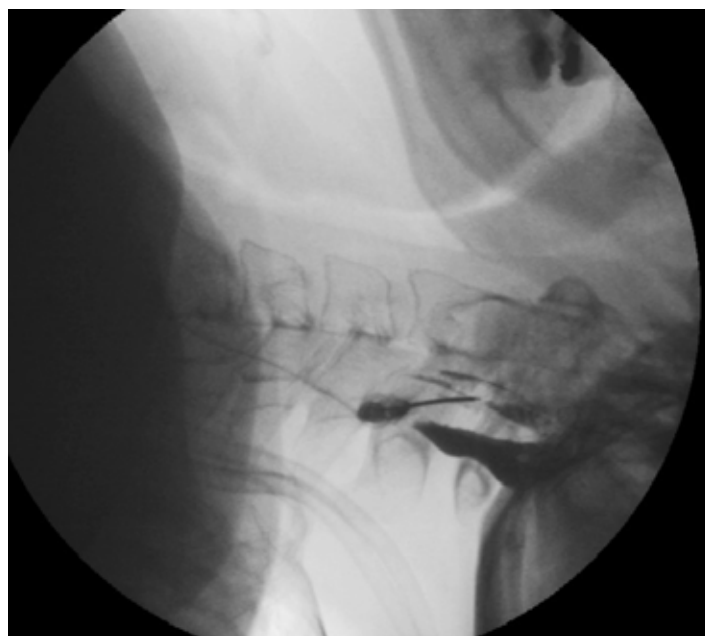


Figure 2

Cordotomy probe introduced through spinal needle into anterolateral quadrant of spinal cord



narrative synthesis and meta-analysis. Only one global outcome measure (pain relief two days post-procedure) could be used as there were insufficient studies/data for the remaining outcomes. Key findings of the systematic review were that the evidence base for the use of cordotomy in mesothelioma-related pain is small (all case series), and that there are multiple techniques to perform cordotomy but X-ray guided techniques are most commonly used. The team also found that studies demonstrate good pain relief in most patients and that life-threatening complications were rare; however, minor side effects (mirror pain, temporary weakness, numbness or dysaesthesia) were more common.

One hundred and sixty participants took part in the service survey with 136 giving consent to take part in the online Delphi consensus study. The service survey identified three main sites – Liverpool, Portsmouth and Oldham – that were providing percutaneous cordotomy regularly (>10 procedures per year). Other sites, such as Warwick and Coleraine, performed cordotomy regularly but less frequently, and only two sites in the UK offered open neurosurgical cordotomy.

The web-based Delphi consensus approach enabled participants to quantify the extent of their agreement or disagreement with a number of statements. The iterative process allowed opinions to mature and develop through the 'rounds' of the Delphi process, and also gave an opportunity to 'capture' outlying opinions through the recording of a 'free text' narrative.

The statements/questions are listed below with the results of the Delphi study:

Cordotomy has a place in the management of mesothelioma-related cancer pain **CONSENSUS REACHED: YES IT HAS**

The potential benefits of cordotomy far outweigh the risks of the procedure **CONSENSUS REACHED: YES THEY DO**

The evidence-base for the use of cordotomy in mesothelioma-related pain is robust **CONSENSUS REACHED: UNCERTAINTY ON THE ROBUSTNESS OF EVIDENCE**

To what extent, in your opinion, are patients with mesothelioma in the UK who would potentially benefit from the procedure referred for cordotomy? **CONSENSUS REACHED: NO THEY'RE NOT**

In your opinion, are patients with mesothelioma in the UK who would potentially benefit from cordotomy referred at the appropriate time? **CONSENSUS REACHED: NO THEY'RE NOT**

Cordotomy should only ever be considered for mesothelioma-related pain **CONSENSUS REACHED: NO**

An invited audience of experts also joined the INPiC investigators for a conference at the Royal Society of Medicine on 10 October 2011. The conference delegates were able to consider the results of the study. They also heard from a number of eminent clinicians in the field of pain medicine, palliative care and oncology presenting 'the case' for particular approaches, and took part in an interactive voting session leading to debate and consensus on a number of themes:

- That selected patients should be offered disease-modifying therapy with either combination chemotherapy and/or radiotherapy and close liaison with between primary and secondary care, oncology, pain and palliative care specialists is imperative.
- In patients suitable for disease-modifying therapy, this should be offered prior to cordotomy.
- Given the limited survival of these patients, getting the timing right for cordotomy is important; there was agreement that cordotomy should be considered in patients requiring strong

opioids, and/or when symptoms persist or escalate following systemic oncology interventions.

- The importance of patients being seen by both palliative care medicine and pain specialists, as patients often have other uncontrolled symptoms such as dyspnoea; early joint review enables all options to be considered along the patient journey.
- For patients who may have to travel long distances, an initial telephone consultation with supporting patient information (web-based/hardcopy) can be helpful.
- That there is a need to look at the health economics of cordotomy, as the view from delegates was that it can be cost-effective given the high cost of some of the modern analgesic regimes.
- That there was a need for providers of cordotomy to educate other specialists on patient selection and timing; the view being that in general patients are often referred too late to benefit from the procedure.
- There was agreement to share patient and professional information literature.
- There were potential synergies with the Sheffield group who have recently been successful in securing funding associated with asbestos-related disease research.
- Potential future research – looking at clusters of patients around 'cordotomy-focused' locations and 'non-cordotomy-focused' locations.

There will be a meeting of the INPiC Pain Group at the Palliative Care Institute in Liverpool to review the results and outputs of the research. A group will be established (INPiC Registry subgroup) to take forward the data set for the registry (meeting to be booked early 2012, venue to be agreed).

Pictures kindly provided by Dr Manohar Sharma, Liverpool



Action on Pain Resource and Information Library (A.P.R.I.L.)

Silma Ramsaywack *Deputy Chair of A.P.R.I.L., www.aprilnewforest.org.uk*

A.P.R.I.L. is a charitable organisation, whose purpose is to provide help and support for those affected by chronic pain. The A.P.R.I.L. office is manned by volunteers, who also have chronic pain, and is based in New Milton, Hampshire, within the Leonard Cheshire Disability building. As Leonard Cheshire has now decided to sell this building, A.P.R.I.L. is actively seeking funding in order to purchase or run the building ourselves.

A.P.R.I.L. first came into existence in 2006. The idea stemmed from members of a pain support group meeting, which was organised by the Southampton Pain Service. It had been recognised that people with long-term pain are often isolated and lack useful information about the nature of their condition and how best to manage this pain. As a result, they frequently looked to the NHS pain services to provide support, even though they recognised that they did not wish or need ongoing treatment or investigation. There was a clear need for a patient support group. Therefore, monthly meetings were commenced in New Milton to help provide this.

Being able to meet with others who had chronic pain, as well as receiving information from specialist speakers in the field, enabled individuals to have some kind of control in the management of their pain. However, this was still only providing a service for a limited number of people. Leonard Cheshire agreed to rent a room to the support group, in order to establish a walk-in centre. This was the first of its kind in the UK, with a specific focus on persistent pain and its associated disabilities. A support telephone line was also put in place. We wanted to set up and equip a resource and information library for people and



carers whose lives are affected by persistent pain. The library needed to be equipped with both books and leaflets, relaxation aids and such, as well as a computer with internet access and a printer. This would enable members without the use of these facilities at home to access the many useful websites on the management of pain.

In 2007, with help from clinicians at the Southampton Pain Clinic and the Southampton pain support group, we successfully received an award from the National Association for Patient Participation (NAPP) to create a resource and information library. In the first year A.P.R.I.L. gave help and support to over 500 people.

A.P.R.I.L. became a registered charity in its own right in November 2008. As previously stated, we operate the first walk-in centre of its kind in the country. We have ambitious plans to expand into other geographical areas, primarily in the south. The charity is manned and managed entirely by volunteers, many of whom are, or have been, affected by chronic pain themselves, and consequently have a first-hand understanding of what it is like to live with constant pain. While the volunteers are not qualified to give medical advice, they can offer practical advice and support, based on their own experiences. Individuals are able to just 'pop in' for an informal chat with someone who understands their situation. They can also be directed to other organisations that could be of help.

Visitors can browse through a wide selection of books and leaflets in the comfort of our offices with a complimentary tea or coffee. Or take them away to study in more depth at home. No appointment is necessary, but we advise people who are travelling from outside our immediate vicinity to phone beforehand to check that the office is open. Alternatively, they can call the support line and talk directly to one of our volunteers. It may occasionally be necessary to close the office at short notice, if one of our volunteers is having a 'bad day' with their pain management. A.P.R.I.L. is reliant on fund-raising and donations for its work. We received no funding from the government.

The pain support group meets every second Thursday of the month at the Leonard Cheshire disability resources centre from 1 p.m. to 3 p.m. This is a free service offering light refreshments, the opportunity to share ideas, make new friends and listen to invited speakers, in an informal atmosphere. There are also times when we all just meet for fun. What is important is that we have enjoyable distractions to help us deal with the pain.

Over the years, A.P.R.I.L. has received client referrals from pain clinics in the immediate area, such as Southampton, Hythe and Poole, as well as local GP



surgeries. A.P.R.I.L. views chronic pain as being both physical and mental, as per the definition of pain from the International Association for the Study of Pain (IASP). We have also accepted referrals from community-based psychiatric facilities and mental health charities such as Rethink.

The relaxed, non-pressured environment that we have been able to provide at the A.P.R.I.L. office has enabled individuals, if only for an hour or two, to experience being in an office/work environment again. For some, it gave them the courage to attend training courses, seek part-time work, or even to start up their own business. This was obviously what was needed. The trustees of A.P.R.I.L. decided that we had to formalise this service and to apply for funding from the Lottery in order to do this. In April 2010, we were awarded almost £10,000 in order to fund our buddy programme.

As a result of pain, sufferers could lose their jobs, have far less money, give up their social activities, lose their friends and fall out with family members. It became evident to us that many of the residents of the New Forest and

Waterside area of Hampshire lived in isolated houses and small villages, as well as the larger towns. The area lacked a much-needed service that offered one programme in one accessible building, that addressed the problems of pain management, mood and negative thinking, and helped improve the life situation of individuals living with long-term pain. As part of the buddy programme, clients are assigned their own A.P.R.I.L. buddy, who supports them through the programme of activities designed to help them self-manage, build confidence, gain a sense of self-worth, identify their own individual problems and set their own achievable targets. The list of activities included: individual assessment and induction; individual counselling and life coaching; group therapy sessions consisting of mindfulness, exercise, therapeutic craft; to name just a few.

The buddy clients are individuals who personally suffer from long-term physical or mental pain, and come from the rural communities spread throughout our region as well as large towns. The programme is designed to strengthen the lives of these individuals (which

Action on Pain Resource and Information Library (A.P.R.I.L.)

would in turn strengthen their families) and enable them to once more be in a position to make a contribution to society. The programme has raised awareness of common pain issues and its impact on the NHS services available in the New Forest and Waterside area. Patients returning to the NHS simply for information and support can now be referred to A.P.R.I.L. for a place on the buddy programme. This has in turn freed up valuable NHS resources in the area.

The programme is designed to help break the recognised cycle of pain and distress that has an impact on everyday

life. Being in the company of empathic people who themselves have chronic pain, and have regained their self-esteem and self-worth by breaking the pain cycle, is therapeutic in itself. We hope that this programme encourages clients/clinicians to set up pain support groups affiliated to A.P.R.I.L.

So, what of the future for A.P.R.I.L.? We are in need of funding in order to purchase the Leonard Cheshire building or to find some alternative arrangements that would ensure stability. The service we provide is vital to the many volunteers with pain who keep the office

operational, as well as to all the clients who use the service. We need to employ a part-time office manager, preferably someone who does not suffer from chronic pain, and we also need money for our day-to-day office costs and expenses.

We are grateful for this opportunity to raise awareness of our existence among those with an interest in chronic pain. The A.P.R.I.L. model is one that we would like to see replicated throughout the UK. We feel the benefits are enormous, and well worth the investment of time and money.

Knitting and pain

Betsan Corkhill *Stitchlinks, Bath, www.stitchlinks.com*

Knitting conjures up different connotations in our heads, but look beyond the word and you have a bilateral, rhythmic, psychosocial intervention that changes behaviour, attitudes and social confidence. Like chronic pain, knitting has physical, psychological and social dimensions. It may also change the knitter neurologically and physiologically, making it a powerful tool for improving well-being at little to no cost to your budget.



Knitting involves rhythmic movements; induces positive psychological states, such as pleasure, calm, flow and sense of fulfilment; and the knitting group is a nurturing, social event. Also, items knitted serve as gifts and charitable donations, so the mechanism by which knitting might 'work' has multiple levels from the neurophysiology of pain to the person's position, identity and perceived worth in society.

Many patients aren't motivated to carry out exercises or make lifestyle changes to self-manage, so we need to take a step back with these individuals. They first need to develop an interest in the world, social contact and an aspiration to improve their well-being to become motivated to self-manage.

My initial thoughts were that knitting could provide a rewarding, creative

occupation from the armchair, a springboard to other activities, but as I investigated further, I realised it went a lot deeper and could potentially change the way we approach long-term illness and general well-being. The psychological benefits of being absorbed in any activity are well documented, so I'll concentrate on the issues that make knitting different, the effect of the actual movements and the practical issues that make it an ideal tool for well-being.

Knitting provides an effective distraction from issues such as pain and depression. This ability to 'switch off' life's problems gives feelings of control that can change a person's perspective on life. However, there is a more generalised refocusing of attention: knitters plan, imagine and talk about future projects. Pain may still be present but it may not matter as much or

may move to a different place in the sufferer's mind.

Excitement, happiness, anticipation and pride are experienced. Mood is raised and as they look forward to the next project, they begin to look forward to tomorrow. This is enhanced by the visual and tactile stimulation of colour and texture. Work to date suggests touch and texture are significant in raising mood, grounding the knitter in the moment.

Rewarding rather than purposeful occupations should be our focus for improving well-being – those that fire off the reward circuit. Many patients feel guilty at not being able to contribute, so prioritise daily chores over experiences that trigger the reward circuit, which may decline as a result. Involvement of the reward circuit may explain why knitting is motivating and can be used to successfully conquer destructive addictions. Being successful encourages a desire to improve skills and try other activities. It reintroduces the *can do* feeling, and enabling success is an important first step in motivating patients.

Feelings of self-worth and value are nurtured through gift giving, but knitting also provides other causes to become involved in, such as socks for soldiers, chemo hats and baby clothes for children in need. There is a lot of symbolism and emotion involved in showing you care for someone by wrapping them up in something warm and cosy, so this benefits both parties.

Mastery of a skill boosts self-esteem, which is reinforced with every stitch, row or project. Importantly, knitting enables the progression of skill levels in a way that ensures success but challenges the individual, introducing regular novelty, which is known to be a cornerstone of neuroplasticity.¹ Other valuable life skills, such as perseverance, patience, planning and pacing, are also acquired. Mistakes can be undone – they're not catastrophic, and goals can still be achieved despite a few detours along the way.

Solitary confinement is a torture imposed on prisoners and the effects on the mind are devastating, yet this is a situation many people with long-term



illness find themselves in. The position of the hands during knitting increases personal space, providing a buffer to the outside world. Knitters use this to enable them to visit places they wouldn't normally feel comfortable attending when using public transport, to feel safe. This encourages knitters to socialise and attend groups.

The benefits of knitting are enhanced by attending a group. Knitting makes the group work by creating a social space that is accepting, safe, nurturing and healing. The rhythmic movements relax the individual, facilitating easy banter and laughter. Knitting enables eye contact, or not, so the individual is in complete control of their degree of participation. The option to 'just be' in the relaxed company of others is nurturing, but sadly missing, from the lives of many.

Continued attendance is ensured by the activity that provides a reason to attend, a point of

conversation and encouragement to learn and show pride in new skills. The common interest builds cohesion between people of diverse backgrounds, and a sense of belonging leads to supportive friendships resulting in greatly improved social confidence and a willingness to give new experiences a go. This environment encourages fun, play and laughter, and changes the context within which pain is experienced.

There is a lot we can do to change the context of pain and thereby change the



Knitting and pain



pain experience. The knitting group enables the clinician to hear the patient's story and thereby treat the whole person. As a portable take-home tool, knitting reinforces positive change and creative stimulation in the home, enabling individuals to work on projects between groups in anticipation of praise at subsequent meetings. Once motivated, the patient is more receptive to other activities and experiences.

The psychological benefits of knitting are many, but the physical movements could also be changing the brain chemically, even structurally. Bilateral rhythmic movements appear to facilitate a meditative state more readily than unilateral ones. They also appear to affect spatial and body awareness and sense of self. Most knitters knit three to five times a week, so brain maps could also be changing.

Performing a repetitive visuo-spatial task within a six-hour window of a traumatic event significantly reduces the risk of flashbacks.^{2,3} Knitters report relief from nightmares and post-traumatic stress disorder (PTSD) symptoms several years after the event. Soldiers suffering shell shock after the First World War were treated with knitting, so perhaps there is a link with eye movement desensitisation and reprocessing (EMDR). Repetitive movements in animals are known to enhance the

release of serotonin.^{4,5} In my view, it is the rhythm of these movements that is important. It facilitates a meditative-like state and could enable a wider population to experience the benefits of meditation at low cost. The relaxation achieved teaches the feeling of relaxation in those who may have forgotten what it feels like to be truly relaxed.

The automaticity of the movement patterns encourages movement often without triggering the pain system. I've also observed that when the brain is occupied with a background automatic movement, conversation becomes more intimate quickly. This enhances the nurturing quality of the social experience, helps to integrate new members and encourages those who find it difficult to talk. Creativity is important for well-being and it is my belief that creative thought can act as an ongoing distraction, and that improving creative ability improves self-management skills and psychological flexibility. Knitting enables us to develop creative ability within a safe framework, where reward is achievable with a little effort, progressing to projects where patients are happy to experiment, learn from mistakes and to be actively creative as opposed to being passive recipients of a destructive force.

From the clinician's viewpoint, knitting is deliverable in kit form to the armchair, it's not messy, it crosses cultural, language, age, disability and intellectual boundaries,

and requires no artistic talent, so is suitable for most, including marginalised populations.

The learning process involves no wasted materials and it can be practised and reinforced at home using DVDs, books and YouTube, so it is cost-effective in terms of time and materials. Groups run by a clinician who can answer health-related questions are beneficial for the patient and clinical unit, providing an accessible, cost-effective 'self-management with support' approach. Using it personally could help you manage the stresses of clinical work. Therapeutic knitting can also be used with a specific aim in mind, and it's much easier to engage men with this approach, to achieve a meditative state or improve sleep patterns, for example.

There is a lot we *can* do for patients with long-term pain. We should carefully consider activities that up-tune parasympathetic activity and influence top-down modulation of nociceptive signals in a nurturing, social space. The portable, creative, meditative and social benefits of knitting make it a good place to start at little to no cost to your budget.

To find out more about therapeutic knitting groups please contact me (betsan@stitchlinks.com). You will find information on setting up groups on the Stitchlinks website (www.stitchlinks.com). Your patients are also welcome to use the website and forum for self-management support at all times.

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The CARE campaign

Caroline Hacker *The Patients Association*



The Patients Association is a healthcare charity that for nearly 50 years has advocated for better access to accurate and independent information for patients and the public; equal access to high-quality health care for patients; and the right for patients to be involved in all aspects of decision-making regarding their health care. The Patients Association Helpline assists thousands of patients and relatives every year, answering concerns and queries about any aspect of the healthcare system.

Our helpline either directly advises the public on how to resolve their health or social care problem, or puts them in contact with other organisations that may be able to help. We do not provide medical advice, but focus on advice regarding non-clinical matters such as accessing medical records, living wills, how to complain and how to interact with doctors, dentist or other healthcare professionals. Our helpline receives over 5,000 enquiries each year, and along with our database of over 14,000 cases, we are able to monitor issues and trends as they emerge. Over the last decade, we have received numerous calls to our helpline regarding the issue of pain management, particularly in regards to older patients.

"Whilst in Intensive Care, the BIPAP mask was left on my mum throughout the night. On one occasion when we came in to see her in the morning, she was hoarse and could barely speak. When we asked her what was wrong, she said that she had been left to scream all night, in pain and alone. The BIPAP mask had drowned out her pleas and so she had been left alone by the nurses.

[When admitted to hospital] I was taking paracetamol for the pain until a nurse saw and removed the tablets. She said a doctor would have to approve their use. I then asked three nurses (blue uniforms) and five Healthcare Assistants (grey uniforms) for pain relief. It was eight hours before I was given a paracetamol."

For the last three years, the Patients Association has produced an annual patient stories report, which details the appalling accounts of poor hospital care that we have heard on our helpline. In November 2011, we launched our third report 'We've Been Listening, Have You Been Learning?' As with our previous two reports, 'Patients Not Numbers, People Not Statistics' (2009) and 'Listen to Patients, Speak up For Change' (2010), this report contains some shocking accounts of care received by patients in hospitals across the country, focusing on four key fundamentals of care: communication; access to pain relief; assistance with toileting; and help with eating and drinking.

The accounts show that patients continue to be failed in these key areas. In particular, one account was of Sally Abbott-Sienkiewicz, who was admitted to Glenfield Hospital in November 2010 as a cancer patient with a terminal

diagnosis and contracted double pneumonia. Her daughter Samantha complains that throughout Sally's time at the hospital her family repeatedly had to request more pain relief for her as it became apparent that her life was coming to end. Samantha describes her mother's pain as being, at times, 'horrendous and horrific':

"What happened that night was both unnecessary and horrific. As mum's pain and discomfort increased, my stepfather tried unsuccessfully to console her. After numerous discussions with the staff, at approximately 1.30am, the nurse in charge paged a duty doctor to authorise more appropriate medication. One hour and forty minutes later the doctor arrived."

The same elements that form the basis of poor care are heard with depressing frequency by our helpline. We know that if a patient or relative contacts us because nurses take forever to answer their call buzzers (or don't answer at all), they are likely to also have had problems with one or more other key indicators – pain relief, eating and drinking, or toileting care. In one of the most developed countries and health systems in the world, patients should not be left starving or thirsty, they shouldn't be left in pain and they shouldn't be forced to urinate or defecate in their bed because the nurse designated to them says it's easier for them to change the sheets later than to help them to the toilet now. Yet this is what is happening around the country every day.

The saddest thing is perhaps that in our patient stories reports, and indeed the calls we receive to our helpline, it is often a relative who is available to speak



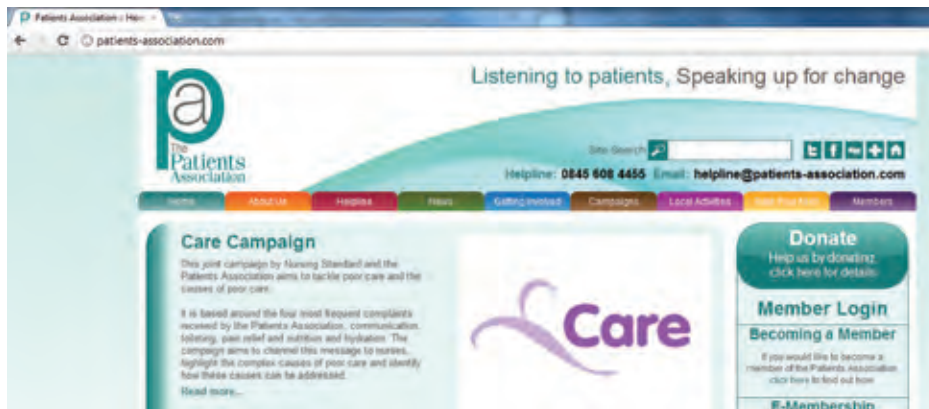
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The CARE campaign



up for the patient. Yet there are many patients who have no one to speak up for them, and no relatives to challenge the care that the nurses are giving them. It is for those patients that changes need to be made in the future, which is why, along with the *Nursing Standard* magazine, Angela Rippon OBE, vice-president of the Patients Association, launched the CARE campaign on 9 November 2011.

The CARE campaign aims to drive improvements in patient care across the UK. The campaign recognises that everyone who goes into hospital or a care home is entitled to these fundamental aspects of care – they are a human right.

CARE stands for:

- C – communicate with compassion
- A – assist with toileting, ensuring dignity
- R – relieve pain effectively
- E – encourage adequate nutrition

The CARE slogan is simple, easy to remember and also useful. We hope patients, relatives and nurses will use this CARE slogan as a care checklist. Patients can use it to challenge poor care; if a zero-tolerance approach to all four of these concerns were adopted, it

would transform patient experience in the UK. Relatives would feel less concerned for their loved ones while they were being cared for and recovery would be enhanced.

We recognise that there are many good healthcare workers who care passionately about providing a good-quality service to their patients. What makes this campaign unique is that nurses and patients are coming together to tackle this issue. We want nurses and patients to be at the heart of this debate and help us pinpoint the cause of these care failures and help identify the solutions.

To launch this two-year campaign, the Patients Association and *Nursing Standard* hosted a meeting in London in October 2011 to discuss the causes of poor care and its solutions. The meeting was chaired by Dr Phil Hammond and attended by many of the UK's top nurses, policy experts, patient champions as well as doctors and managers, and all of them backed the idea of nurses and patients forming a partnership to tackle poor care concerns.

Our joint aim in hosting the emergency meeting was to open up a dialogue between patients and the healthcare profession and agree some urgent priorities for action. At the meeting, we developed the campaign aims:

- For nursing staff in hospitals to adopt the CARE Challenge, based on our four-point tool
- To highlight obstacles nurses face in delivering the CARE Challenge
- For organisations to sign up to the CARE Challenge
- For patients to recognise the CARE checklist and use it to challenge poor care
- To support nurses who expose failures to deliver the fundamentals of CARE

The UK's four chief nursing officers are backing the campaign, as are the Royal College of Physicians (RCP), the Queen's Nursing Institute (QNI) and the Nursing and Midwifery Council (NMC). Indeed, NHS South West director of patient care and nursing/workforce development Liz Redfern says she would be surprised if the campaign did not get 100% sign-up.

We have written to every nursing director, chief executive and non-executive director of NHS trusts in the country and asked them to sign up to the CARE Challenge so that 'Care' becomes a universal expectation for patients. The response has been phenomenal. Not only have we had sign-up from nursing directors, ward sisters, nurse specialists and staff nurses from around the country, but also students and nurse lecturers, carers and care home managers, GPs and practice nurses have joined our drive to improve fundamental care for patients.

For the next two years, the CARE campaign will instigate discussion and debate. We recognise that a solution needs to be found. *Nursing Standard* will continue to highlight good practice and give publicity to measures that nurses and others are taking to enable nursing to be the best it can be. Our joint ambition is to see an end to poor patient care. To read more about the campaign, please visit: <http://nursingstandard.rcnpublishing.co.uk/campaigns/care-campaign>



From presentation to journal publication: the journey of our Society's ASM abstracts

Dr Neeraj Saxena, Dr Shefali Kadambande and Dr Sharmila Khot Cardiff

The Editor wishes to inform that the Council Meeting of the British Pain Society in December 2011 decided to publish all the abstracts of our Annual Scientific Meeting in our *British Journal of Pain (BJP)*. *Pain News* congratulates the editor of *BJP* Felicia Cox for her hard work and efforts to achieve this.

Presentation of abstracts at scientific meetings provides an opportunity for clinicians and researchers to showcase their work and gain informal feedback and critique. It also allows the audience to gain useful, timely knowledge and information, potentially long before it is published. Since conference abstracts undergo a less-rigorous review process for acceptance as compared to scientific journals, this allows for the presentation of preliminary research work, research methodology protocols and non-research work such as clinical audits, service evaluations and case reports.

Such presentations are an integral part of scientific meetings, a valuable attraction for attendees and also promote the interests of the learned societies. The British Pain Society (BPS), the main British multidisciplinary society including various pain-related disciplines, regularly invites abstracts for its annual scientific meetings. Accepted abstracts are invited for presentation as posters with the best-rated ones to be presented as oral presentations.

However, following this informal peer review at society meetings, all abstracts do not progress on to full-text publications in scientific journals. This 'presentation to full-text publication conversion rate' may be considered as a quality benchmark of these scientific meetings.¹ The aim of this study was to



determine what proportion of abstracts presented at a BPS Annual Scientific Meeting (ASM) subsequently resulted in full-text publications in peer-reviewed journals.

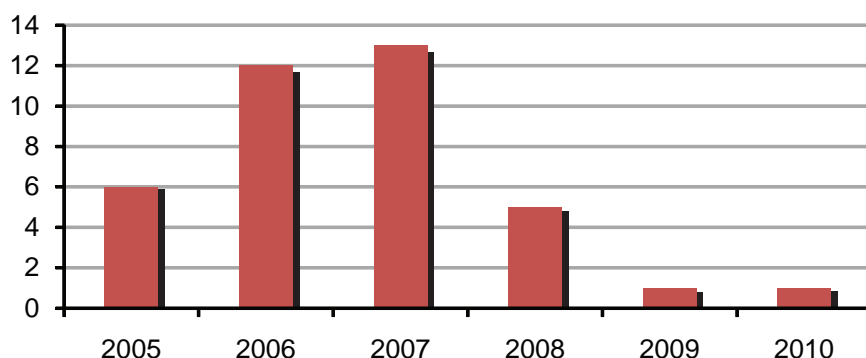
Methods

All abstracts presented at the BPS ASM in 2005 (chosen to allow a six-year follow-up period) were considered. The titles and authors of the abstracts accepted for presentation were collected from the BPS ASM (2005) conference

proceedings. *Ovid Online* (through Cardiff University) was used to search various databases including EMBASE, MEDLINE, OLDMEDLINE, PsycINFO, CINAHL and AMED. Database searches were done using the first author's name, with a period limit (2005 to 2011). If numerous citations appeared, the search was further narrowed down using the last author's name. The resulting titles were searched through for a matching title and the abstracts read to compare with the conference abstracts. If a definite match

Figure 1

Number of publications found during respective years (2005–2010) from the abstracts presented at the BPS ASM in 2005



was not found, further searches were done using other authors' names and keywords from the abstract titles. Finally, Google Scholar was also used to search using the titles and authors' names. Publication in peer-reviewed journals as full-text articles or non-peer-reviewed publications (such as authors' personal websites, company brochures, etc.) as a full article, abstract or any other reference were also recorded.

Following this search strategy, if no citations were found, it was considered that the abstracts had not led to a full publication.

Results

There were a total of 97 abstracts accepted (but one withdrawn) for presentation at the BPS ASM in 2005. Thirty-eight abstracts (39.6%) resulted in a full-text article publication in a peer-reviewed journal with no change or some change from the original abstracts. At least five other abstracts appeared on internet searches on authors' or their institution's websites, either as abstracts or titles in their lists of presentations. The other 53 abstracts (55.2%) could not be accessed in any format on the web. All the full-text publications were achieved within five years following the presentations, with the most being published within the first three years (Figure 1).

Discussion

We were able to identify full-text, peer-reviewed publications of only about 40% of the abstracts presented at the BPS ASM in 2005, in the following six years. While there is no previous study looking specifically at presentation to full-text publication conversions of abstracts presented at multidisciplinary pain conferences, evidence from other biomedical areas show a conversion rate similar to our results (44.5%).^{2,3} This may be considered a healthy presentation to publication conversion rate supporting the high standards of the review process of BPS scientific committees and the performance of its presenters. However, over half of the abstracts presented at the BPS ASM do not appear in the public/scientific domain after this initial presentation.

While a successful publication in an indexed journal is indeed a sign of scientific importance of such work, there are numerous factors that limit the abstracts to the presentation stage only. Higher publication conversions include those presentations with 'positive' findings, basic sciences research (in contrast to clinical research) and acceptance for oral (as opposed to poster) presentations. The various reasons cited for failure of subsequent publication include inadequate quality, lack of time by researchers (or clinicians), lack of 'significant' results, work not

considered as research (case reports etc.), authors' considering low priority and anticipated rejection.^{2,3}

Case reports and clinical audit constitute a large proportion of abstract posters failing to complete their journey to publication. Clinical audits and service evaluation projects are targeted at local issues and therefore may be considered important only to the population directly involved. However, dissemination of these findings is useful to the audience as it may provide inspiration for transfer of good practice, and would avoid unnecessary duplication and even potentially 'useless' change in practice. These factors are relevant even for research-related data that may not get published eventually due to various reasons including publication biases.

All scientific work involves valuable resources including time, effort and money. The failure to disseminate their hard-earned data to other interested clinicians/researchers restricts the full potential of valuable information and its application to patient care. In research areas, such failure may be considered as scientific misconduct as patients would have consented for use of their data or time for the benefit of other patients.⁴

This highlights the need for presenters to press on and attempt to publish their results as full-text publications, in easily accessible (or indexed) resources. Some presenters may not want their work to be more widely available; however, this is unlikely. Considering the previously mentioned factors associated with difficulties in publishing, at the very least conference abstracts should be made as widely available as possible. The BPS (like many other learned societies) publishes its conference abstracts in CD or 'proceedings' format. Failure of scientific work to appear in indexed journal publications also limits its inclusion in systematic reviews and literature searches, which lead on to clinical and policy decisions by individuals and at local/ national levels.

There is, however, a potential risk of over-reliance on these scientific meeting

From presentation to journal publication: the journey of our Society's ASM abstracts

abstracts and poorly reviewed abstracts forming the basis of a significant change in clinical practice. It has been suggested that more-stringent acceptance criteria should be applied for conference presentations so that only high-quality work that can survive the peer-review process of journal publication should be accepted.⁵ Also, if abstracts' acceptance was considered on a par with peer-reviewed journal publications, some authors may not feel the need to submit their studies for further publication.

Despite these potential threats of 'importance' of abstracts, we feel that they play a significant role in medical progress and so should be made as widely available to the scientific community as possible. It is possible that given a choice, the presenters would prefer their abstracts to be widely available for their findings (even at an early

stage) to be acknowledged and cited in related work. Publication of abstracts in free-to-access web-based databases (or the society's own website) would make searching for them easier both for researchers and clinicians (and even patients). While there may be sound reasons for not doing this, including financial limitations or as a disincentive to non-members or even members to attend, it is a loss to the wider scientific community.

Conclusion

To conclude, we believe it is the collective responsibility of all presenters and the BPS to disseminate their scientific work to a wider audience. Steps should be taken by presenters to publish their work through peer-reviewed journals and by the BPS to publish their abstracts through their regular

publications (e.g. *Pain News*) or on their website and make them accessible to all.

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Informing practice

British Pain Society Annual Voluntary Seminar 2011: Pathways for Pain Management – Giving them Life

Geraldine Granath

This annual event organised by the Patient Liaison Committee was held on 14 November 2011. Delegates and speakers from a wide range of voluntary organisations concerned with aspects of pain gathered together to focus on the development of pathways, the benefits they could provide for patients and to debate the most effective ways of communicating information about them to patients. Communication is a key aim for the Patient Liaison Committee and a session in the afternoon focused on the work plan that it has developed.

Douglas Smallwood, Chair of the British Pain Society (BPS) Patient Liaison Committee (PLC), introduced the seminar by welcoming all the patients and professionals present to a briefing on key pain developments and the PLC work plan. The focus for the day was a mix of formal presentations and informal interaction, highlighting

two key pieces of work aimed at improving services and the experiences of people whose lives are affected by pain. The afternoon session would pick up these themes by looking at the psychological aspects of pain in more detail.

Dr Stephen Ward gave delegates an overview of the National Pain Audit,

sponsored by the BPS and carried out by Dr Foster. Preliminary results for the current phase gave a picture of current services; these showed considerable variation in current provision by geography and scope. Future phases will build on this picture with repeat surveys. Information was provided by primary care trusts (PCTs); 28 PCTs did not report any service

British Pain Society Annual Voluntary Seminar 2011: Pathways for Pain Management – Giving them Life

being available and further information will be sought about these areas.

Dr Martin Johnson RCGP, Pain Champion and member of the Primary Assessment group, gave an overview of the Pathways project. In summary:

- The pathways currently focus on five identified aspects of pain, primary assessment and management, spinal pain and musculo-skeletal pain that is non-inflammatory and not spinal.
- There is a BPS pathway implementation group chaired by Dr Andrew Baranowski.
- Comment is welcomed on the pathways; comments can be left and the pathways viewed in detail on the Pain Community Centre website hosted by Cardiff University (<http://www.paincommunitycentre.org>).
- Self-management needs to be integrated into all the pathways so it is mentioned consistently within the pathways rather than viewed as a separate issue.
- A reminder: 49% of GP consultations involve patients reporting pain as a symptom.

There is a common aim behind pathway development – to ensure that the patient is seen at the right time in the right place and receives appropriate care. There also needs to be awareness of the four Ds affecting patients with pain: Depression, Disability, Drug use and Distress. Self-management strategies such as Co-creating Health, an initiative to encourage supported self-management, can be of great benefit to patients. Questions followed this session and these included a discussion about how commissioning strategies can be influenced and the role of the National Institute for Health and Clinical Excellence (NICE) in promoting clinical indicators that cover pain duration and appropriate assessment. Given the prevalence of severe pain, delegates also noted the need to act on pain as a prevention issue.

Dr Stephen Ward then outlined the work of the lower back pain pathway. He outlined some of the challenges working

with small-scale research studies, as much of the evidence is weak. The findings tend to show small statistical significance and minor short-term improvement in function. The pathway uses a combination of 'red flags' and risk management to identify routes to treatment, ranging through medication and multidisciplinary assessment.

These presentations were followed by a workshop session giving a number of key messages for pathway implementation and some practical suggestions for taking these forward. A number of comments related to supported self-management and using the pathways to empower patients:

- Patients need this information – use media, patient stories, YouTube and a variety of media to promote the pathways.
- Patient groups can assist in getting this information out and get it into an accessible form – a patient version would be excellent.
- Use PAIN UK website.
- Link to self-management initiatives.
- Link to shared decision-making.
- Make use of existing information resources.
- Local ownership is critical; use national networks to access local bodies.
- Focus on prevention – e.g. ergonomics patient information leaflets – these need to be incorporated into pathways alongside dissemination of patient information at key stages.
- Involve occupational health services – opportunity is currently available through Department of Work and Pensions pilot.

The afternoon commenced with a thought-provoking session from Dr Claire Daniel, clinical psychologist at University College London, giving an overview based on recent research on the use and benefit of psychological input to assessment and pain management.

She described how the physical pain process links to psychological processes and how psychosocial factors affect the impact of pain on patients. These factors



The British Pain Society and Patient Liaison Committee Annual Voluntary Seminar

Monday 14th November 2011

Pathways for Pain Management – Giving Them Life

Programme

10:00-10:30	Registration & Coffee
10:30-10:40	Welcome and Introduction Mr Douglas Smallwood, Chair of Patient Liaison Committee
10:40-10:55	Briefing on Pain Audit Dr Stephen Ward
10:55-11:10	Background to the Pain Pathways Project Dr Martin Johnson
11:10-11:30	Pain Pathways – Introduction Dr Martin Johnson, Mrs Ann Taylor and Dr Stephen Ward
11:30-11:50	Tea & Coffee break
11:50-13:00	Workshop Session A Making the pathways work for patients
13:00-13:45	Lunch
13:45-14:00	Pain in Psychology Dr Claire Daniel
14:00-15:00	Delivering the Workplan of the Patients Liaison Committee Mr Douglas Smallwood
15:00-15:15	Coffee break
15:15-16:00	Feedback and summary session Mr Douglas Smallwood
16:00	Ends

were identified through a number of research studies and the understanding of their interplay has led to the realisation that multidisciplinary approaches are most likely to lead to a positive result.

This underlined the importance of self-management appropriate to the experience and severity of the pain. Approaches such as cognitive behavioural therapy (CBT) are often effective; however, NICE guidelines are not consistent in mentioning CBT with regard to pain pathways and there is a risk that pain is treated as a purely psychological rather than physical symptom when in reality they are interrelated. Comments from delegates stressed that pain should be viewed as real – not being believed can have impact on future care and benefits and can adversely affect the individual.

The final session of the day was small group work on the PLC Plan, its objectives and how participants or their organisation could contribute to it. This was also an opportunity to hear about the Patient and Carer Reference group and how to become more involved. On this positive note speakers and delegates were thanked for attending and for their contribution to the day.

**Pain, Suffering and Healing:
insights and understanding.
Edited by Peter Wemyss-Gorman**

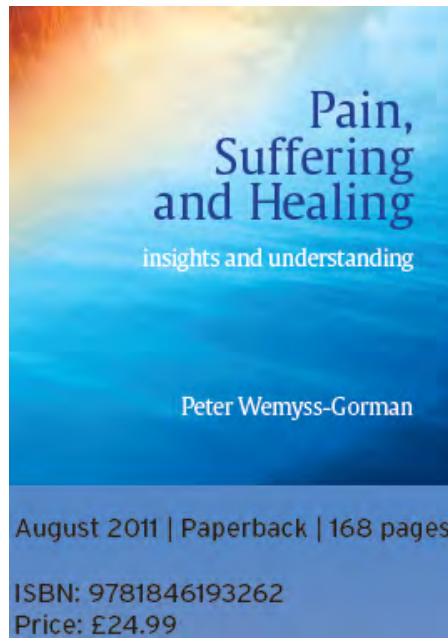
Reviewed by Mary Midgley

*Moral Philosopher and formerly
Senior Lecturer, Newcastle University*

This book is about the meaning that prolonged pain has for those who suffer it, something which, for most of us, is a quite unmapped territory. Modern tradition has flatly told us – and indeed our doctors – to regard illness reductively as simply physical malfunction, and medicine as just the physical machinery that corrects it. This model has, however, always been unconvincing and it has already been radically shaken by the invention of hospices, which showed us clearly how small a part the mere physical mechanism plays in the crucial business of dying. By now, most of us have begun to grasp that people who are near death need to be understood as well as operated on. The issue of how to treat them has thus ceased to be a taboo subject for medicine. But, as this book points out, no similar public spotlight has yet been turned on the equally embarrassing topic of pain.

Since the doctors who write here work largely in pain clinics, they often confront long-term pain that has not yielded to ordinary treatments. As they point out, these cases call for a much wider kind of thinking, a background conceptual map that must be very different from the blank division between mind and body that informs the accepted dualist approach. When the obvious physical remedies have already been tried, a new paradigm is needed – one that really takes on the person as a whole. As they show, understanding that person's problems can sometimes directly relieve the pain. And, even where it does not, it may still make it possible to manage it more effectively.

For instance, a pain is sometimes closely linked to past bad experiences such as torture, abuse or bereavement.



It may also have been intensified by resentment caused by earlier casual or unimaginative treatment. Since these things have often not yet been properly aired, a full discussion of them can sometimes make them much more manageable. This kind of indirect relief is often helped, too, by finding myths, stories or metaphors that place the current trouble against a wider background, relating it somehow to the pattern of the rest of life. This whole imaginative, symbolic way of approaching life, which is lost from our current narrowly literal culture, must be called on to deal with these extreme experiences. Patient and physician can work on this together – always provided, of course, that they are given adequate time, something which, throughout medical practice, is now too often sacrificed to unrealistic demands for efficiency.

The crucial part played by this imaginative component is witnessed by the effectiveness of placebos, which, as Peter Wemyss-Gorman points out, has now been shown to be solidly real, although the dualist paradigm still has no room for them. Placebo effects make it



THE BRITISH PAIN SOCIETY

clear that *what suffers is the whole person*, a person who lives in the whole context – spiritual, emotional and social, as well as simply physical. He or she therefore needs help on all these levels, which means that the emotional associations involved in placebo are every bit as relevant as the pills. In any case too, all medical intervention, including pills, carries a placebo element from the mere fact of being given as healing. This does not, of course, authorise deceiving people deliberately by providing a placebo because such deception undermines the patient's crucially necessary trust. But it means that this natural, reassuring phenomenon is a quite legitimate part of the treatment.

Help of this more holistic kind does, of course, often come from religion, but it works there in widely varying forms that may suit different kinds of people. Wemyss-Gorman usefully notes the difference between the relief drawn from submission to God in Christianity and Islam and the meditative kind envisaged in Buddhism or Taoism, which works by cultivating a more detached, less battling attitude to our troubles. As he points out, these are just two possible ways of dealing with the central paradox that always confronts us – the need to combine accepting the fact of pain with continuing our efforts to mitigate it, both in ourselves and others.

This is very like the paradox that arises over accepting death, and it is no easier to resolve. As Michael Bavidge remarks, the emphasis that is now laid on autonomy – on the need for individuals to control their own destiny – makes this clash more confusing in the case of clearly un-chosen troubles like pain. People need to somehow grasp that accepting them does not involve mere blank passivity – that there are still active choices to be made in the way one lives with them. There can be freedom of mind even where there is little freedom of action.

Paul Martin and Paul Bibby illustrate this kind of freedom interestingly by

drawing a comparison with the situation of alcoholics. Chronic-pain sufferers may (they suggest) come to regard their pain as an outside power that has them in an irresistible grip, just as an alcoholic regards their drinking. They may thus become fixed in their attitude and inwardly dependent on it in a way that can only be broken by finding some *other* power that

seems to them stronger still – perhaps God or perhaps the therapeutic group – to overcome this menace.

Pills, as they point out, cannot play this role, however useful they may be at their own level. However, Willy Notcutt meanwhile provides an interesting sidelight on the vexed issue of pills. In a discussion pleasingly entitled 'Bundling

With Big Pharma' he describes the problems of cooperating with the firms that supply the necessary medicines, and also the special difficulties that arise in researching the medical uses of cannabis.

Altogether, these essays are very illuminating. They cast a really useful and informative light on a vast and important subject.

Listening to pain: finding words, compassion and relief.
By David Biro

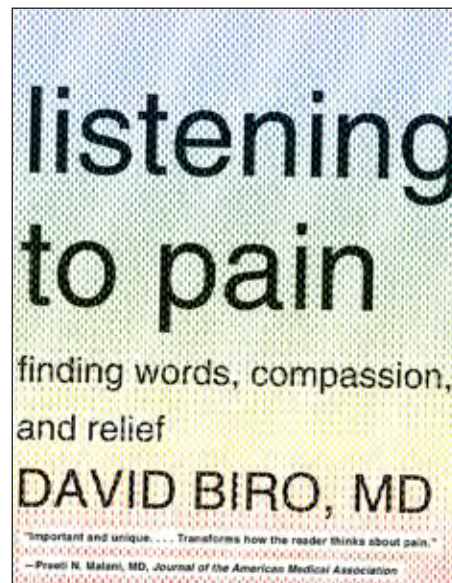
W. W. Norton Publishers
ISBN 978-0-393-34025-9

Reviewed by Arumugam Pitchiah
Advanced Pain Trainee, Wales

There are many books available focusing on different aspects of pain management, but how many books are out there that explore the reasons for the inexpressibility of pain and attempt to find solutions for the same?

Pain, by definition, has an emotional component to it. Like all other human emotions, there is a dearth of words in language to accurately express the actual meaning as experienced. The book, as the title suggests, aims to find words and phrases to improve the communicability of pain and its suffering. It is not only targeted at the healthcare professionals, but also at the patients who suffer from pain. It implores the physician to think 'out of the box' and try to perceive the patient's suffering and empathise, which will pave the way for effective management of the patient's condition. The author of this book is an associate professor in dermatology who practises in Brooklyn. He also has a doctorate in English literature from Oxford University and has two other books on pain and related topics to his credit.

This book is divided into two sections, the first focusing on the problem of difficulty in communication and the second on the solution to the dilemma faced. The first section, aptly referred to as the crisis, starts with the chapter on the personal experience of pain. This portrays the pain and the anguish perceived by various



people in pain, by using quotes and stories from various biographies. The subsequent chapters explore the reasons for the elusiveness of pain and the famine of words and ideas in communicating the emotion to the outside world. There is a comparison drawn to 'locked-in syndrome', which is intense in description, but quite successful in conveying to the reader the distress and helplessness experienced by those who suffer.

The second section of the book would probably have been more challenging for the author than the preceding section, as it strives to generate answers for the impossible task faced. Various metaphorical strategies are presented in this section in an attempt to simplify the complex concepts and ideas. The author believes that the pain expressions and metaphors are well intertwined and goes on to substantiate the use of metaphor as the only available option to fill the void in language in communicating pain.

The metaphorical strategies employed involve familiar objects and known themes such as the mirror, weapons, war, etc. The strategies, well supported by stories, are presented in simple language and effectively convey the meaning to the reader. The use of specific adjectives and the necessity to compare with particular situations to convey pain experienced in different medical conditions is well rationalised by the author. The origin of the adjectives used to describe pain in the original McGill questionnaire is also well detailed, emphasising the use of the same strategy by Ronald Melzack in the early 1970s.

In the preface, the author mentions his hospital admission and further recalls his experiences in the subsequent chapters. His previous book, *One Hundred Days: A Journey from Doctor to Patient*, chronicles his experience in more detail. The chapters have been written in a deliberate, logical sequence to ensure a smooth flow of reading and to help the reader grasp the concept presented. The vocabulary used in the book is rich, but yet simple, reminding the reader that the author is a professor in literature. Imaginary descriptions composed by the best writers and real words from 'real people' have been used to understand the emotion behind the suffering from all perspectives. The book also bears pictures of various famous paintings such as *The Scream* by Edvard Munch, *Mirror* by Frida and photographs from *Perception of Pain*, which support the argument laid down by the author in the corresponding chapters.

The background of medical knowledge, English literature and personal experience makes Dr Biro an

ideal candidate to take on the challenging task of finding a solution to a common, but complex issue – bridging the gap between the doctor and the patient. The author needs to be lauded for the mammoth effort

***Interventional Pain Control in Cancer Pain Management,*
Joan Hester, Nigel Sykes and
Sue Peat (editors)**

Oxford University Press
ISBN 978-0-19-921908-7

Reviewed by Dr Arun Bhaskar
*The Christie NHS Foundation Trust,
Manchester*

In recent times, there have been huge advances in the treatment of cancer with vastly improved survival outcomes and subsequently, the management of cancer pain is also changing, with better understanding of pain mechanisms and development of pharmacological and interventional options. This concise book with 13 chapters gives an overview of interventional management of cancer pain with emphasis on the practical aspects of managing patients with complex cancer pain, whose pain is inadequately controlled by systemic analgesics as proposed by the World Health Organisation (WHO) ladder. The case histories give the reader perspective while describing various situations and interventional techniques as they would have been in similar situations in their clinical practice. The book also demonstrates that the partnership of specialist pain services and palliative care services is far more fruitful in the management of these patients, be it in the hospital setting, hospice or at home.

In the first chapter, the problem of difficult cancer pains and the limitations of the WHO in this group of patients are discussed, setting a preamble for the contents of the following chapters. The history of cancer pain management and the development of the WHO pain ladder and palliative medicine as a specialty have resulted in the decline of the use of

undertaken and for having successfully managed to accomplish this daunting task with ease.

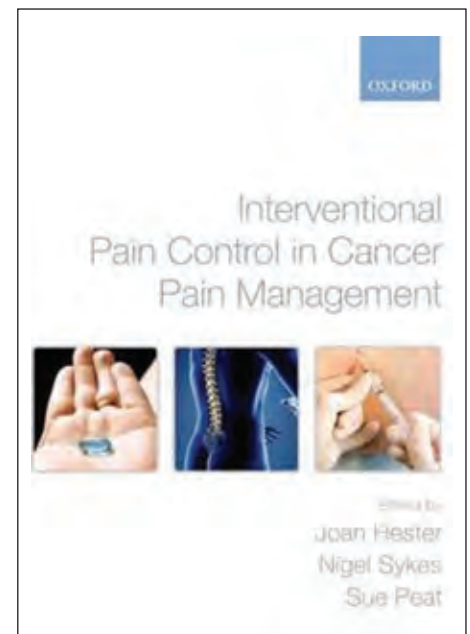
This is not a medical book and neither does it intend to be one. This is a book of medical philosophy, art and literature

interventional techniques that were previously widely used in cancer pain management. However, the authors highlight the role of interventional pain management in dealing with nearly a quarter of cancer patients whose pain control is not adequately met with systemic analgesics. This is particularly relevant as the collaboration between palliative care services and their corresponding pain services are about 5% of all the caseloads, while 23% of patients utilising palliative care services were not satisfied with their pain control. In the subsequent chapters, the authors try to cite examples of case studies in a palliative care setting that has benefited from various pain interventional procedures.

The next two chapters identify most of these complex pains and introduce the role of various interventional techniques that can be used in alleviating the painful symptoms. It also outlines the evolution of interventional techniques over the years and the importance of proper assessment of pain and the understanding of pain mechanisms. The chapter on 'Mechanisms of Cancer Pain' is well referenced and describes the pathophysiology of various cancer pains, particularly cancer-induced bone pain and chemotherapy-induced neuropathy.

More than a quarter of the book, chapters 5–7, are dedicated to epidural and intrathecal delivery of analgesics by various systems. There are detailed descriptions of various techniques and different drugs, as well as practical tips on troubleshooting and ensuring best practice, showing the wealth of experience of the authors. The pictures and the colour plates showing a step-by-step approach provides an easy guide for pain trainees and anaesthetists who are sometimes called upon to assist with these patients. The book clearly demonstrates the role of epidural

addressing a common medical problem. This is a must read for all healthcare professionals involved in managing pain and especially for the novice pain trainee who is attempting to 'learn the ropes' by listening to the patient's pain.



infusions and externalised intrathecal lines in managing terminally ill patients when fully implanted systems are not always practical due to costs and logistical reasons. The importance of after-care, particularly from a nursing perspective, is also very well explained.

The chapter on 'Specific Nerve Blocks' describes the commonly affected areas with cancer and the various interventional techniques that are currently being used to tackle these pains. There is a detailed explanation of the different approaches to the various techniques available, as well as potential complications and illustrations of the relevant anatomy of the region. Neurolytic procedures for intercostal nerves, peripheral nerve plexuses and intrathecal neurolysis are also discussed in this chapter. Although suprascapular nerve block is been mentioned, the use of it in mobilising the shoulder joint and in relieving the severe pain seen in patients following mastectomy/axillary dissection and post-radical neck dissection could have been

elaborated. The authors also share a case study demonstrating clinical pearls such as the use of EMLA for successfully managing painful metastatic rib fractures in a patient who was not in a fit state to undergo invasive neurolytic procedures.

The chapter on 'Blocks of the Autonomic System' gives a detailed account of various blocks used in the management of visceral pain or sympathetically mediated pains. Coeliac plexus blocks and splanchnic radiofrequency, used in the management of pancreatic cancer and other upper abdominal malignancies, are described in detail, both the classical technique and the modern imaging techniques. It is nice to note that in addition to blocks commonly used like stellate ganglion, superior hypogastric blocks and ganglion impar blocks, the very rarely performed blockade of the vagus nerve has also

been described. Percutaneous cordotomy is described in depth as a full chapter and the X-ray images and other illustrations would give the reader a better understanding of the anatomy and the procedure itself. However, the authors could have discussed newer procedures like vertebroplasty and radiofrequency ablations that are widely used in alleviating painful symptoms and improving quality of life in patients with cancer pain.

Neuromodulatory techniques are not commonly used in the cancer patient, mainly due to the costs involved, but also because most of these patients require regular follow-up MRI scans, particularly if they are on clinical trials, and this prevents the frequent use of the technology. The authors highlight that the current technology is still found wanting in the MRI scanner and explain the use of external

peripheral neuromodulation techniques that can be utilised in the cancer pain population. Patients and carers alike are favourable to therapies like acupuncture and this book gives adequate coverage to this topic, something that is not usually found in textbooks for interventional pain management. The book sums up with a chapter from a patient's perspective, leaving the most important message of treating them as a person rather than as a patient and that of not de-personalising the experience.

This book would be a valuable addition to any department as a reference guide, but should also be essential reading material for palliative care physicians, nurses and trainees in pain medicine and anaesthetic trainees to understand the usefulness and practise safely the various interventional techniques in cancer pain management.

The BMA Guide to Back Care

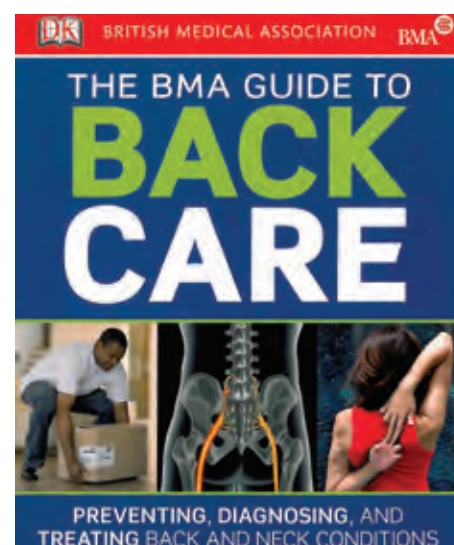
Dorling Kindersley
ISBN 978-1-4053-6429-4

I have longed for a book of this kind, written by a professional group to guide both the patients and the clinicians, directed towards back care. The British Medical Association (BMA) should be applauded for its great work to produce this interesting guide. This book comes in an attractive format with lots of pictures and easily understandable layman terminology. It also has lots of flowchart algorithms for each condition in a step-wise manner. It comes with standard patterns of anatomy, diagnosis and treatment, where to find help, how to maintain the structures, strategies for prevention, strategies for coping and rehabilitation exercises. Given that the BMA editorial group has diverse specialisations including a practitioner in musculoskeletal and sports medicine and a musculoskeletal physiotherapist, there is no wonder that this book is attractive and informative.

The first chapter deals with the anatomy of the back and neck; the

pictures are very attractive. The next chapter is on diagnosis and treatment. When many groups, including National Institute for Health and Clinical Excellence (NICE), have not given importance to facet joint pain, it is heartening to see a discussion of this and its treatment, including injection; however, it has to be appreciated that in any given described condition, the authors always describe multimodal multidisciplinary team management, starting with simple techniques first. However, they have classified treatment as for early, intermediate and advanced stages; this might be sometimes difficult as drawing boundaries can be difficult.

In the next chapter about causes of back and neck pain, many common conditions are well covered. (This chapter could have preceded the previous chapter, which describes these conditions.) The following chapter on where to find help is very informative, but it can be misleading as some might understand that they need to see an orthopaedic specialist after six weeks! More importance is given to



investigations and immediate injections, while traditional teaching is against this.

The following chapter is very useful – it deals with how to maintain the back and neck. Posture, exercises, stretching techniques etc. are vital learning points for all. The next chapter on how to prevent pain also provides practical information. However, more space could have been allotted to coping and pacing techniques. The final chapter on rehabilitation exercises

is different and a valuable addition compared to other books; the pictures are easy to understand and make these learning strategies much easier.

On the whole, I found this book a very useful, cheap addition to the back care armamentarium; every pain clinic or GP surgery should have a copy on its

shelves. The publisher's assurance of a cleaner and greener environment during the production of this book should also be appreciated.

End stuff

Course review

Aberdeen Interventional Pain Workshop

Dr Manish Chablani

Specialty Trainee in Anaesthetics

Having attended the Aberdeen Interventional Pain Workshop earlier this year, what did I feel about the course as a trainee? What did I gain from it? Was this the right course to go to when you were just thinking of taking up a career in pain medicine? These and many such questions had cropped in my mind before taking up the course. Before I go into these questions, let me start by introducing what the course aimed to do.

The course was aimed at teaching clinicians about the interventional management of lumbar facet joint and sacroiliac joint pain. The interventions taught were lumbar medial branch blocks, sacral lateral branch blocks and radiofrequency neurotomy (both thermal and cooled radiofrequency). Going by the published literature, these joints account for more than 50% of causes of lower back pain. So is it relevant to know about them? The only answer to the above question, if you are a pain physician or planning to be one is, yes.

The course was held at Aberdeen Royal Infirmary. Aberdeen has recently been voted as the best city to live in Scotland. It has something to offer everybody: from modern city life and romantic hideaways, to an imposing coastline and breathtaking scenery, to a host of adrenaline-packed

activities. It is the third-largest city in Scotland and is often referred to as the Granite City because of its architecture.

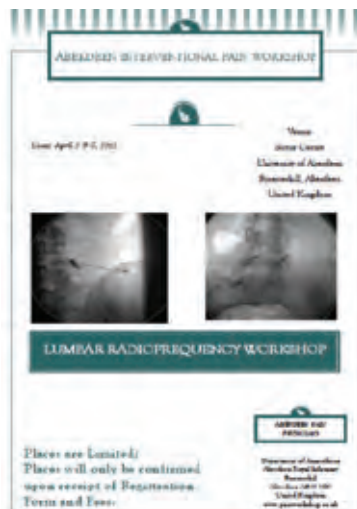
The course was spread over two days and had good mixture of lectures, live demonstrations and practical sessions. The faculty consisted of both national and international pain physicians spanning the UK, Europe and

the USA. The lectures were succinct and drilled into you the diagnostic points and challenges for diagnosing facet joint and sacroiliac joint pain. They also reinforced the applied anatomy of these joints and the steps for performing these spinal interventions. Each lecture was followed by live demonstrations, again reinforcing the radiological anatomy and the technique for performing these interventions.

The second day of the course provided 'hands-on' opportunities for practising these procedures on cadavers. We were a small group of four and rotated around seven stations. At each station, the faculty member reinforced the principles of the block before demonstrating the technique. Then we had the chance to practise the block. Although I got my hands wet on each table, there were few people who did not do the same due to lack of time. There were also stations to make you familiar with the equipment and radiofrequency lesion sizes on egg yolk. This was particularly interesting as it demonstrated the difference between sizes of lesion with different gauze needles, enhancing your understanding. What stood out was the patience of the faculty members to guide and teach every candidate, and their willingness to answer all queries. The food was superb, as was the venue. The discussions with the faculty during and after the end of the day were very stimulating.

So coming back to what I gained from the course: I became more confident in diagnosing lumbar facet joint and sacroiliac joint pain. My understanding of the radiological anatomy of the above joints increased by leaps and bounds and as a result during higher training I have been able to perform these blocks under supervision with a lot more confidence and very little need for direct support.

Was this the right course to go on and would I recommend it to trainees thinking of or pursuing a career in pain medicine? Most certainly, I would.



Letter to the Editor



THE BRITISH PAIN SOCIETY

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Royal Bolton Hospital, Bolton

Sir – I read the debate on ‘the dilemma of diagnosis in pain clinic’,¹ and feel that important aspects have been overlooked by all the contributors, and particularly the three authors who favoured the diagnostic role. There are two issues I would raise: the first is a question over their reasoning; and the second relates to an issue that all the authors failed to address – the training of a modern pain physician. Both lead to the legal problems faced by the individual(s) in the given scenario.

The first is their curious assertion that ‘we estimate that we do not make a diagnosis in a quarter to a half of our patients’, and further that ‘a lack of diagnosis can only lead to random treatments’ (with some associated comments about astrology).

This seems a fundamental failure to understand the problem that has faced pain physicians since the speciality began to develop in the 1950s: that it is essential to treat the pain, even when there is either no diagnosis, or there is a diagnosis but current measures that challenge disease progression have limited symptomatic benefits.

Many pain clinics implicitly – and perhaps it should be more explicit – accept patients on the basis of this and it falls outside their remit, and specialist knowledge, to investigate for causes. There are always times when we spot something, or request a new or repeat investigation that is positive, but it is not our role and it lies outside our training. Even accepting the figure of 25%–50% of ‘undiagnosed’ patients, which seems of unclear provenance, this does not mean that we have no clinical information or an array of symptomatic approaches to hand.

PROFESSIONAL PERSPECTIVES

Diagnostician, technician or physician: the dilemma of diagnosis in pain clinic

Rajesh Munglani has organised this interesting, thought-provoking debate with experienced elite professionals; it debates on whether pain clinicians should be diagnosticians.

<p>Should the pain clinic have a diagnostic role? A clinical scenario:</p>	<p>but the thoraco-lumbar pain had worsened. Clinical examination was unremarkable. As the patient was claustrophobic, a CT of spine was requested which showed significant</p>
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This leads me to the second and most important realpolitik issue: that of training. Training has changed radically over the last 20 years in the UK. The majority of pain physicians will qualify from medical school into a two-year foundation course training of six brief jobs, followed by seven years in anaesthetic training, only one of which will be in pain training at an advanced level.

Anaesthetics is, arguably, a symptom speciality. Our training, and our professional lives, are almost wholly guided to the reduction of pain, and consciousness, to allow *others* to provide diagnostic and therapeutic activities.

But I do not accept the label as technician for this role – my assessment, risk management, pre-operative optimisation, anaesthetic and post-operative care – any more than a surgeon would for operating for appendicitis or a general physician for an urgent stenting for a myocardial infarction. Our ‘diagnostic’ skills are simply different, as any anaesthetist who has been informed by a physician that the patient is ‘fit for surgery’ will attest to.

Under the guidance of the Calman report, the Postgraduate Medical Education and Training Board (PMETB)

and now the General Medical Council (GMC), training has fundamentally changed. Trainees no longer wander through a variety of specialities picking up useful skills they then bring to their final one, but are focused on their ‘final’ choices even before they have completed their foundation year. This is the reality, and pain physicians of a different era must recognise this.

I emphasise this last part because, to place a modern pain physician in the position of being a final arbiter of diagnosis will be to do a huge disservice to our current trainees and profession, leading to the success of medico-legal challenges as self-proclaimed diagnosticians fail to account for the training of others without their ‘privileged’ past.

To a certain extent there is no dilemma – ethical, professional or legal.

We are simply not a diagnostic profession. We must not let ourselves lose our focus on the undiagnosed. We should always keep up to date with the evolution of medicine to help focus our

WINTER 2012

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

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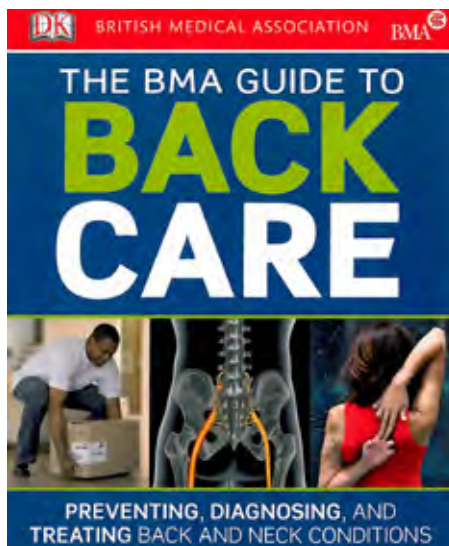
treatments, and we must never be placed in a position of defending ourselves for being 'accused' of something that we are not.

Competing interest: Dr B M Miller is a member of the Training Committee of the Faculty of Pain Medicine. This letter is a personal opinion.

References

- 1 Munglani R. Diagnostician, technician or physician: The dilemma of diagnosis in pain clinic. *Pain News* 2011: Winter; 19-22

Competition



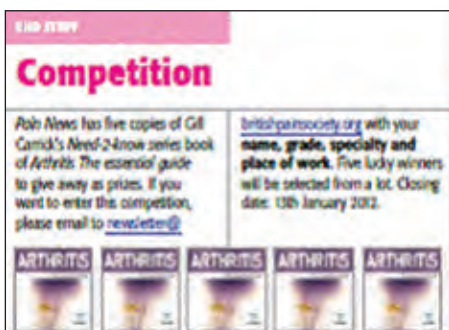
Pain News has 5 copies of *The BMA Guide to Back Care* (Dorling Kindersley, ISBN 978-1-4053-6429-4) to give away. To enter this competition, please send us an email containing your **name, grade, specialty** and **place of work** with **'Competition BMA book'** in the subject line. Ten lucky winners will be selected.

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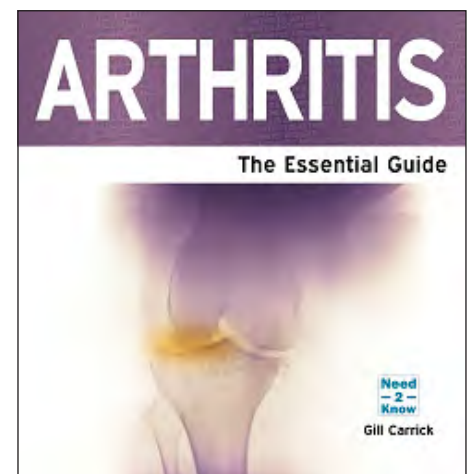
Only one person entered the draw last time to win a copy of this book. Congratulations to **Mrs Kathryn Nur**, Senior Clinical Nurse Specialist at Withybush General Hospital,

Haverfordwest. A copy of Gill Carrick's Need-2-Know series book of *Arthritis: The Essential Guide* will be posted to her soon.

We now have four more copies of the same book to give away in a second draw. To enter, please send us an email containing your **name, grade, specialty** and **place of work** with **'Arthritis competition'** in the subject line.

Email address: newsletter@britishpainsociety.org

Closing date: 10 April 2012





Ratified at the December 2011 and January 2012 Council Meetings

Name	Position	Institution
Dr Kanar Al-Quragooli	Associate Specialist in Anaesthesia & Chronic Pain	Trafford General Hospital
Mrs Geraldine Anthony	Study Co-ordinator / Research Fellow	University of Aberdeen
Dr Premila Arunasalam	Consultant Anaesthetist	University College London
Miss Emma Fisher	Research Assistant, Centre of Pain Research	University of Bath
Dr Shamin Haider	ST7 Anaesthetics	Hull Royal Infirmary
Dr Senthil Jayaseelan	ST5 Anaesthesia	Liverpool Heart & Chest Hospital
Dr Nicholas Marshall	Consultant Anaesthetist	Royal Cornwall Hospital
Mrs Julie Price	Nursing Sister, Unit Manager: Pain Management Clinic	Northampton General Hospital
Mrs Sarah Smith	Senior Staff Nurse in Pain Management	Northampton General Hospital
Dr Alison Twycross	Reader in Children's Nursing	Kingston University
Dr Rajinikanth Sundararajan	ST6 in Anaesthetics and Pain	Queen Elizabeth Hospital, Kings Lynn
Dr David McGavin	GP Partner PWSI Pain Management	West Kent PCT, Maidstone
Dr Ravi Manohar Kare	SpR Anaesthetics	Peterborough & Stamford Hospitals
Dr Katie Warnaby	Post-Doctoral Research Fellow	University of Oxford, John Radcliffe Hospital
Dr Serena Sodha	CT2 Anaesthetics	Royal Berkshire Hospital
Mr Suhapab Techamahaneerat	Post Graduate Research Student	School of Pharmacy, John Moores University, Liverpool
Mrs Polly May	Clinical Nurse Specialist	Poole Hospital
Dr Arindam De	Specialist Trainee	Leicester Royal Infirmary
Mrs Emma Ghulam	Clinical Nurse Specialist	Churchill Hospital, Oxford
Dr Christopher Green	Anaesthesia & Pain SpR	John Radcliffe Hospital, Oxford
Dr Sami Alawad	Advanced Pain Trainee	Barts and The London, London
Dr James Taylor	ST6 Anaesthetics, Pain Medicine	Seacroft Hospital, Leeds
Professor Marie Fallon	St. Columba's Hospice Chair of Palliative Medicine	Western General Hospital, Edinburgh
Miss Jacinta Nalpon	Acute Pain Specialist Nurse	Papworth Hospital, Cambridgeshire
Dr James Francis Wilson	ST5 Anaesthetics & Pain	St Peter's Hospital, Guildford
Dr Louise Millington	GP	Greyswood Surgery, Streatham, London
Dr Karen Frame	Consultant in Palliative Medicine	St Marys Hospital, London
Dr Jessica Eade	Principal Clinical Psychologist	Bryn-Y-Neuadd Hospital, Conwy, Wales
Dr Emma Baird	SpR Year Three	Royal Blackburn Infirmary
Dr Deepak Malik	Specialty Registrar (ST5)	Leicester Royal Infirmary
Dr Karthikeyan Thanigaimani	ST7 in Anaesthetics and Chronic Pain	Queen Alexandra Hospital, Portsmouth
Mrs Colleen Porter	Theatre Practitioner, Band 5 Recovery	Countess of Chester Hospital