"Non-Specific” Chronic Back Pain of Obscure Origins: Searching for Its Origins in Workplace Social Context”

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This presentation was recorded but not transcribed and added to the website at the time as the paper on which it as based had been submitted but not accepted for publication. It has now (April 2022) been published but the recording has been lost. The article can be found by following the link: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8961709/pdf/yjbm_95_1_153.pdf>

Discussion

*I was struck by your conceptualising of the social side of things which was still very much within that ontological frame, and still quite positivist? … involving measuring and standardising; and I wonder if that allows us to think about the structural issues in that model rather than the individual patient level.*

That is an important point. For example in the US right now there are very many people who have jobs but don’t like them … structurally we should give them better wages and work conditions but they still wouldn’t be satisfied with their jobs. So I do think there are still things to do at an individual level clinically but there are things that should be done at a structural level.

There are so many issues … one interesting finding by Pilowsky nearly 40 years ago was that a disproportionate number of kids who have major medical procedures and are isolated from their parents in the hospital have chronic pain in later life. That again is a social concept; but there are implications for hospital-based structures: how are you going to prevent the isolation from parents when they undergo these medical procedures involving hospitalisation? Another structural issue is that it has been found in the US that kids whose father has been in prison, often for a minor offence like drugs, disproportionately have chronic pain. A major issue in US now is the isolation of kids from their parents at the Mexican border – there are still more than 2000 of them. Are those kids going to grow up to have chronic pain? And what about those in refugee camps?

one interesting finding was by … nearly 30 years ago that a disproportionate number of kids who have major medical procedures and are isolated from their parents in the hospital have chronic pain in later life. Maybe the biomedical mechanisms have maintained priority because so much of the necessary research involves structural issues which can be so complicated.

*I am interested in your experiences in China. Talking about sociological factors – and looking at a very different model of society – did you learn anything that would help us there? – about differences between China and the US.*

Their acupuncture is remarkable. Whether they believe it is placebo is a different question . One thing I found about their attitude to biomedicine is that they have two answers: one is for English-speaking professors, but in their own terms acupuncture works. Placebo is not non-specific but their terms it provides anexplanation specific to pain. I don’t know if it would work in this society but it does in that society. The ambiguity in biomedicine regarding placebo - whether or not it is ethical to try to prove a practice better than a placebo - is not well tolerated. But people there are not afraid of needles and there is a feeling of intense relaxation in the clinic and that might be the mechanism by which it works. The clinicians know their patients and they come in to relax as all sorts of treatment is going on besides acupuncture.

What I have learned is that as we are coming out of the opioid epidemic here – at least I hope we are, although there is some apprehension of a resurgence – is that there are better ways to treat chronic pain than opioids. What I am concerned about in China is that following the West they may discourage some of these traditional treatments; opioids and blocks – e.g. epidurals – are becoming pretty big in China.

*In the UK we are saying goodbye to blocks . For many years facet joint injections and epidurals have been among the mainstays of treatment. They have now been determined as of very low efficacy and are no longer funded by the NHS so they are no longer performed, and within a year or so they have disappeared from clinical practice.*

They’re a quite good placebo I guess.

One of the things that surprised me in a study I did was that there was a subgroup of patients - maybe 10% - who were on opioids and were able to go to work and doing just fine. Most of those on opioids did not. Maybe some of the minority who did well were previously more active like my father-in-law [Ernie had previously shown a slide of his Chinese father-in-law who suffered from an intractably painful condition taking his grand-daughter to school on his tricycle which he did every day]

*There can be a difference between what the doctor sees as a good outcome and what the patient sees or what they want. They may say that the pain is still 10/10 but they can now do things like your father-in-law.[mentioned in the talk as being remarkably active and productive despite advanced age and persistent pain] It reminds me a little of one of my patients who was schizophrenic and went into hospital. On the consultant psychiatrist’s weekly ward round he would enquire about her hallucinations. On being told that she was still having them he would double the dose of her antipsychotic. This went on for several weeks and she was getting more and more dopey and could hardly walk. The woman in the next bed said: “ you’re not playing this right - you’ve got to tell them that everything is fine and they will start reducing the drug”. So she did this. The hallucinations continued but she felt so much better without the medication. Her desired outcome was not the same as the doctor’s: he wanted to stop her hallucinations but she wanted to get her life back.*

What I ask patient is: what do you want to do that you can’t do now? Another question is: what is *your*  idea of recovery? Some say want to go back to work; (if they are on Workers’ Compensation that is what they are supposed to say) But if you spend time with them as a sociologist or anthropologist most of them will talk about the daily activities they can no longer do. I talk to them for an hour or two; I never wear a white coat and my whole body language is not like that of a physician. They say things like “there has been a role reversal: instead of taking care of my children they take care of me because of my pain; my neighbour went with a boy scout troop outing but my kids wouldn’t even ask me.” Those are the sorts of things they want to talk about – it’s not the pain.

*I was wondering how those of you still in clinical practice change patient expectations. All my patients used to come to the clinic expecting me to do* *something when there were much more useful approaches. But if you don’t propose to do anything they jump to the conclusion that you think it’s ‘all in their mind’. How do you overcome this barrier?*

*It may be a slightly difficult perspective, but as a physiotherapist those are the conversations you have with people and maybe perception has something to do with that. Lots of people who come to us know that none of the interventions they have tried haven’t been very helpful and they are probably looking for something more realistic that matches their experience. The way we manage that conversation is as Ernie says is to start by listening to where they are coming from and what kind of knowledge they have picked up over time, which is often quite a rich and detailed examination of health systems and health care workers, and will tell you almost to a ‘T’ that this is not what they are looking for and want to know what other kinds of conversations they could have…*

… I don’t know if in this country [USA] they will have had such in-depth conversations with physical therapists …

*… I work specifically in chronic pain rehabilitation so I certainly do. But even in the musculoskeletal sphere there is a shift towards having that extended space to listen and pay more attention to non-biological markers mainly because they have found that ‘physical’ therapy is often not that helpful … it doesn’t change anything. I don’t think the situation is as bad as it sounds like it is in the States.*

*Has anyone come across John Stoner in Edinburgh? He is into functional neurological disorders. He has a nice website and talks about the way he explains this kind of problem to his patients. You’re genuinely ill, you’ve got a really bad pain. As far as we can tell it doesn’t have an easily explained mechanism but it seems that your nervous system is sending you inappropriate messages even though we can’t seem to find anything organic to target our treatments on. But it is real. He stresses that it isn’t in your head, meaning your mind, but it is in your nervous system which is not functioning as it should. You have to emphasise that or people will think you’re accusing them of malingering.*

*Sometimes pain has an important purpose. For many people having pain is a valuable part of their life. For example we have patients who have repeated injections in the clinic and if you ever threaten to stop them they get very upset even though they say they have worn off long before\* they are due for a repeat. The fact that they stay in the clinic with regular follow-ups … perhaps it is beneficial in some respects for the family – the fact that they are taken to the high altar of the operating room and have an injection done by the consultant … for many people that is an important part of life. So by having pain life is different. I am sure there are a lot of social connotations by which pain can change life, obviously more often for the worse, but sometimes for better.*

*A typical patient I saw today who as a consequence of being immobile because of pain gets a lot of attention from her neighbours who take her to church every Sunday and to lunch afterwards. We tend to ignore the occasional big social advantage of pain ; particularly regarding benefits and things like compensation. These are all very relevant.*

And that’s a big problem with compensation in this country : you have to get a diagnosis to get medical compensation as well as wage compensation. John (Loeser) has done some work on this which suggests that the higher the wage compensation the longer the pain persists …

*There is a relationship between the ratio of what you are getting when you are disabled to what you were getting when you were employed - that ratio predicts the duration of your disability to a large degree. The problem is that when you are sitting in your office with a patient in front of you it’s really hard to apply sociologic theory. If you want to get a patient mad at you, you tell them the major cause of their back pain is that they are unhappy with their boss or their workplace.*

*\*Often exactly six weeks before the next appointment so the inexperienced (as I once was) is tempted to make the interval before the next injection shorter… and the next time shorter still …*

*…until it gets down to two weeks … Ed.*

*That is not an acceptable model for most patients. They have a mismatch between what we know intellectually and what we can do practically. You can’t write a prescription for getting a better boss. Maybe if we could move the locus of health care into the workplace we might have some better control over that. But the way health care is organised, at least in the US, as a provider of health care you have no leverage on the sociologic factors.*

That is indeed a problem. When people ask me the ‘so what’ question … my point of view … I have problems with that.

*Getting rid of chronic pain may not only be unrealistic but perhaps the wrong target. . Sometimes it seems to be helpful to get pain relief off the agenda. If you see someone who has had back pain for 17 years and have not worked for 15 of them and in receipt of benefits; they have tried every drug in the book, every kind of injection and a spinal cord stimulator and still have chronic pain, it is wholly unrealistic that anything is going to make a difference to their pain, and perhaps then … we are very bad at saying to people: you have chronic pain, it is not going to go and I am not even going to discuss any further treatment for it. So where can we go from there? And sometimes a valuable discussion does come out of this situation. You may indeed start talking about social factors: family issues, alternative work – if you can’t go back to heavy work could you do something else? - and try to move things forward.*

If you ask them what they would do if they didn’t have pain that they can’t do now; in your experience do they say they just need to get rid of the pain before they can consider any other activity?

*If you take the bio bit out it does open opportunities for discussion about psychological or social factors. Often people will say “ well, actually I know where I am now; I will have to change my life, my spending habits, look at another job that I can do”. Because you are closing the door to getting rid of the pain you are opening another door to the social factors etc because there is nothing else. It may be an uncomfortable discussion but it can be valuable.*

I used to say: people who have something better to do don’t hurt as much. Pain intensity is considered a good indicative of success in the pain clinic world but I do think that if people pay less attention to their pain, eventually the pain ratings will go down; it won’t be sudden or total. I’m not a pain clinician and I just go by what I read in the journals.

Pain isn’t going to go away but there is a critical difference between pain going away and catastrophic …. You can dial down the experience … like my father-in-law you can still take your grand-daughter to school. You can still do what you want to do

*I would argue that everything goes back to the bio. Both the social and psychological factors have a biological effect which affects the experience of pain but I would also argue that there are different ways you can have that conversation to help people understand their pain so they can start to move forward. I often explain to people that pain emerges as a result of a complex conversation involving everything that goes on within you and around you – people, your work etc. And then you can start asking questions like ‘have you noticed that the pain is worse when … etc.?’ And then you can explain that the structure of your back or your knee is exactly the same but it’s the context that has changed. And then people begin to understand that everything goes into that complex conversation, and then they can start to see that actually the biomechanical approach probably isn’t the best way forward. But this is not to discount it because it can sometimes contribute to that conversation, as do other things like general fitness.*

*I started doing programmes for people with long-term pain rather than Pain Management Programmes with an emphasis on taking the focus away from symptoms to help improve quality of life. The content was very similar to PMPs but the approach was from a different perspective. A big part of that was starting off with the assertion that change is possible – not talking about getting rid of pain but changing your life.*

*We don’t say that enough. The message that too often comes across is that there is nothing we can do for your pain, and there is nothing more demoralising than telling someone that they will have it for the rest of their life. Far better to stress that change is possible, and this is what you can do about it.*

I don’t disagree with you about the biology. For example we do see tremendous increases in chronic pain with unemployment. But you are right about the complex interactions and you can’t ignore those.

In the US we are still in the midst of an opioid crisis. The physicians I know who prescribed opioids - I do think they were well intentioned in trying to obliterate the patients’ pain. It seems to me instructive for patients to know about the association of pain and unhappiness and that you can’t medicate for unhappiness. Their pain may diminish but they can expect pain because that is the natural history for people who have back pain; if you follow up people for years and years the odds are that they are still going to have back pain be it persistent low intensity or recurrent episodes. It may be useful for patients to know that if it lessens their tendency to catastrophise with each flare-up. The principle ‘First do no harm’ is important to bear in mind when prescribing opiates for people who can still do things …

*That all goes into that complex conversation. The adage that hurt doesn’t equal harm has to be qualified in a way because if things go on as they are harm may be created in other areas. For example both movement and avoided movement, may create harm in that area. That is the sort of message we want to get across about harm as opposed to hurt; if someone has chronic pain then in some areas of their lives there is harm happening.*

Hurt doesn’t equal harm in the context of chronic pain, but pain remains a useful signal.

*We can get people to look at pain along a continuum from the people who don’t feel pain and who don’t survive to someone whose pain dominates their life. So we should focus on moving them down that line, persuading them that they wouldn’t survive without pain and that it is a normal part of life; and getting the message across that we don’t want to get rid of pain because it is essential but that they need to learn to use it to protect more appropriately.*

*[ partly inaudible contribution regarding patient and professional acceptance of alternative explanations] Does medicine as a whole with its strong biomechanistic focus reject these psychosocial explanations? … I don’t think that patients coming to … rejection … suggestion that pain is not real … much wider …*

*So how do we legitimize … make these explanations as legitimate as physical trauma or something on an MRI …? People see their environment as completely separate from their biology… [how to lead them to] recognition and acceptance that social factors and past trauma are legitimate explanations for pain … how do we change perceptions … clinicians attitudes*

Physicians have great prestige in society. But in some cultures many others are involved in the sick person recovering. For instance in Chinese society there is more involvement of group rituals where they draw the sick person back into the healing group.

I keep quoting the historian Rosenberg about the immense prestige of biomedicine. I think all us of need this authority in some situations, for instance with the Covid virus.

It’s an important and difficult question I think it’s good to focus on and keep raising it .

In JAMA they had a recent series on relating to the patient and their story. Changing healthcare practices in the West is a total lottery – I don’t know what it’s like with you. I think there is going to be a lot of individual variability: some physicians do listen to the patients’ stories; others are fixated on biomedical intervention. John (Loeser) and other people have tried to train people in the at the University of Washington pain clinic to listen to the patient story and tried to find out what lies behind the bio mechanisms. I see the demise of the traditional pain clinic with rehab psychologists as a trend in the US There are pain clinics but they are increasingly biomedically oriented.

*I agree that there are huge variations in clinical practice in America and I suspect in the UK also. The industry of pain management has unfortunately invaded the original concept of pain medicine and that is an economic statement about the way we do health care in the US. It’s always interesting to hear you talk as I see myself 40 or 50 years ago and recall what we said and tried to do. This was transiently successful but in the US economic voices have driven multidisciplinary pain management into the background. If we can get more prepaid healthcare and less fee for service we may see it come back because is certainly is more effective. Healthcare in the US is not a system; it’s completely chaotic; the variations from place to place and doctor to doctor are huge. I don’t know what the future is going to hold.*

What is the trend in the UK?

*There is a great deal of that going on. Another background is the NICE guidelines which is crossing off many of the treatments that we have previously used, and that dictates the funding we get from the health purchasers. For example acupuncture has been approved for back pain, on fairly shaky grounds, provided it is administered by relatively low-grade clinicians; otherwise it ceases to be economically viable. Most of the injection treatments like facet joints and epidurals have been crossed off. As regards neurostimulation, there has been pressure from industry to get NICE to approve these technologies; NICE does tend to reject things that are ineffective but even NICE is not immune to such pressures. We have argued before in this group that NICE should look at social interventions as well as medical ones as otherwise the idea is reinforced that pain is a medical condition that needs to be solved.*

I don’t have any easy answer … take abuse as an example … I don’t think there is an intervention for abuse … or economic dependence …

When I did my series of one to five hour interviews, one reason why I couldn’t write it up was that I heard about such terrible abuse - these were women coming in for surgery and on opioids, going back into the same abusive environment.

*That is something that is sadly happening in the media …that there has been acceptance of the problems … like those that have been publicised in this country where we have schoolgirls highlighting the sort of problems like things that would have previously been accepted as teasing from boys but which are now seen as abusive – I think entirely appropriately. This is all coming out and needs to be dealt with so maybe in the future … child abuse is now following the biggest change. The exposure in 2013 of Jimmy Saville, a media presenter, who was up to all sorts of horrible misbehaviour with children he was responsible for, led to a widespread understanding and it is very difficult not to confront those problems now.*

There are many studies showing a relationship between child abuse and chronic pain in adults

*It’s rather popular to talk about how adverse childhood experiences, from physical to psychological abuse and poverty lead a variety of adult illnesses including chronic pain. But what do you do about it? The problem is that we have identified potent predisposing factors but … I would love to say that I have contributed to eliminating child abuse but it wouldn’t be true.*