

MARCH 2014 VOLUME 12 ISSUE 1

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



SIGN Guidelines
Picturing Pain
Good-Bye Pain
Yorkshire Health Study



THE BRITISH PAIN SOCIETY

ISSN 2050-4497



Start to unlock severe chronic pain with Palexia SR



Palexia SR (tapentadol prolonged release tablets) is indicated for the management of severe chronic pain in adults, which can be adequately managed only with opioid analgesics²

Tapentadol is a Controlled Drug, Schedule 2

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PALEXIA[®] SR Prescribing information

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

Presentation: 50 mg (white), 100 mg (pale yellow), 150 mg (pale pink), 200 mg (pale orange) and 250 mg (brownish red) prolonged-release tablets contain 50 mg, 100 mg, 150 mg, 200 mg and 250 mg of tapentadol (as hydrochloride) respectively. **Indication:** Palexia SR is indicated for the management of severe chronic pain in adults, which can be adequately managed only with opioid analgesics. **Dosage and method of administration:** Individualise according to severity of pain, the previous treatment experience and the ability to monitor the patient. Swallowed whole with sufficient liquid, not divided or chewed, with or without food. Initial dose 50 mg twice a day. Switching from other opioids may require higher initial doses. Titrate in increments of 50 mg twice a day every 3 days for adequate pain control. Total daily doses greater than 500 mg not recommended. **Discontinuation of treatment:** Taper dose gradually to prevent withdrawal symptoms. **Renal/hepatic impairment:** Not recommended in severe patients. Caution and dose adjustments with moderate hepatic impairment. **Elderly:** May need dose adjustments. **Children below 18 years:** Not recommended. **Contraindications:** Hypersensitivity to ingredients, suspected or having paralytic ileus, acute alcohol intoxication, hypnotics, centrally acting analgesics or psychotropics. Not for use when mu-opioid receptor agonists are contraindicated (e.g. significant respiratory depression, acute or severe bronchial asthma or hypercapnia). **Special warnings and precautions:** At risk patients may require monitoring due to misuse, abuse, addiction or diversion. At high doses or in mu-opioid receptor agonist sensitive patients, dose-related respiratory depression may occur. Caution and monitoring required with impaired respiratory function. Should not use in patients susceptible to intracranial effects of carbon dioxide retention (e.g. increased intracranial pressure, impaired consciousness or coma). Use with caution in head injury, brain tumors, moderate hepatic impairment and biliary tract disease including acute pancreatitis. Not

recommended if history of or at risk of seizures or severe renal or hepatic impairment. Care should be taken when combining with mixed mu-opioid agonists/antagonists (e.g. pentazocine, nalbuphine) or partial mu-opioid agonists (e.g. buprenorphine). Should not use with hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption.

Interactions: Use with benzodiazepines, barbiturates and opioid analgesics, antitussive drugs and substitutive treatments may enhance the risk of respiratory depression. Central nervous system (CNS) depressants (e.g. benzodiazepines, antipsychotics, H1-antihistamines, opioids, alcohol) can enhance the sedative effect and impair vigilance. Consider dose reduction with respiratory or CNS depressant agents. In isolated cases, serotonin syndrome has been reported in combination with serotonergic medicinal products (e.g. serotonin re-uptake inhibitors). Use with strong inhibitors of uridine diphosphate transferase isoenzymes (involved in glucuronidation) may increase systemic exposure of Palexia SR. Risk of decreased efficacy or adverse events if used with strong enzyme inducing drugs (e.g. rifampicin, phenobarbital, St John's Wort). Avoid use in patients who have taken monoamine oxidase inhibitors (MAOIs) within the last 14 days, due to cardiovascular events. **Pregnancy and lactation:** Use in pregnancy only if the potential benefit justifies the potential risk to the foetus. Not recommended during and immediately before labour and delivery. Do not use during breast feeding. **Driving and using machines:** May have major effect on ability to drive and use machines, especially at the beginning or change in treatment, in connection with alcohol or tranquilisers. **Undesirable effects:** Very common ($\geq 1/10$): dizziness, somnolence, headache, nausea constipation. Common ($\geq 1/100$, $< 1/10$): decreased appetite, anxiety, depressed mood, sleep disorder, nervousness, restlessness, disturbance in attention, tremor, involuntary muscle contractions, flushing, dyspnoea, vomiting, diarrhoea, dyspepsia, pruritus, hyperhidrosis, rash, asthenia, fatigue, feeling of body temperature

change, mucosal dryness, oedema. Other important undesirable effects: palpitations, heart rate increased/decreased (uncommon $\geq 1/1000$, $< 1/100$), drug hypersensitivity including angioedema (uncommon $\geq 1/1000$, $< 1/100$), respiratory depression (rare $\geq 1/10,000$, $< 1/1000$), convulsion (rare $\geq 1/10,000$, $< 1/1000$). No evidence of increased risk of suicidal ideation or suicide with Palexia SR. Consult the SmPC for full details. **Overdose:** Seek specialist treatment (see SmPC). **Legal classification:** POM, CD (Schedule 2). **Marketing Authorisation numbers, pack sizes and basic NHS cost:** 50 mg: PL 21727/0041, 28 pack (£12.46) and 56 pack (£24.91); 100 mg: PL 21727/0042, 56 pack (£49.82); 150 mg: PL 21727/0043, 56 pack (£74.73); 200 mg: PL 21727/0044, 56 pack (£99.64) and 250 mg: PL 21727/0045, 56 pack (£124.55). **Marketing Authorisation Holder:** Grünenthal Ltd, Regus Lakeside House, 1 Furzeground Way, Stockley Park East, Uxbridge, Middlesex, UB11 1BD, UK.

Date of preparation: September 2013. UK/P13 0073a.

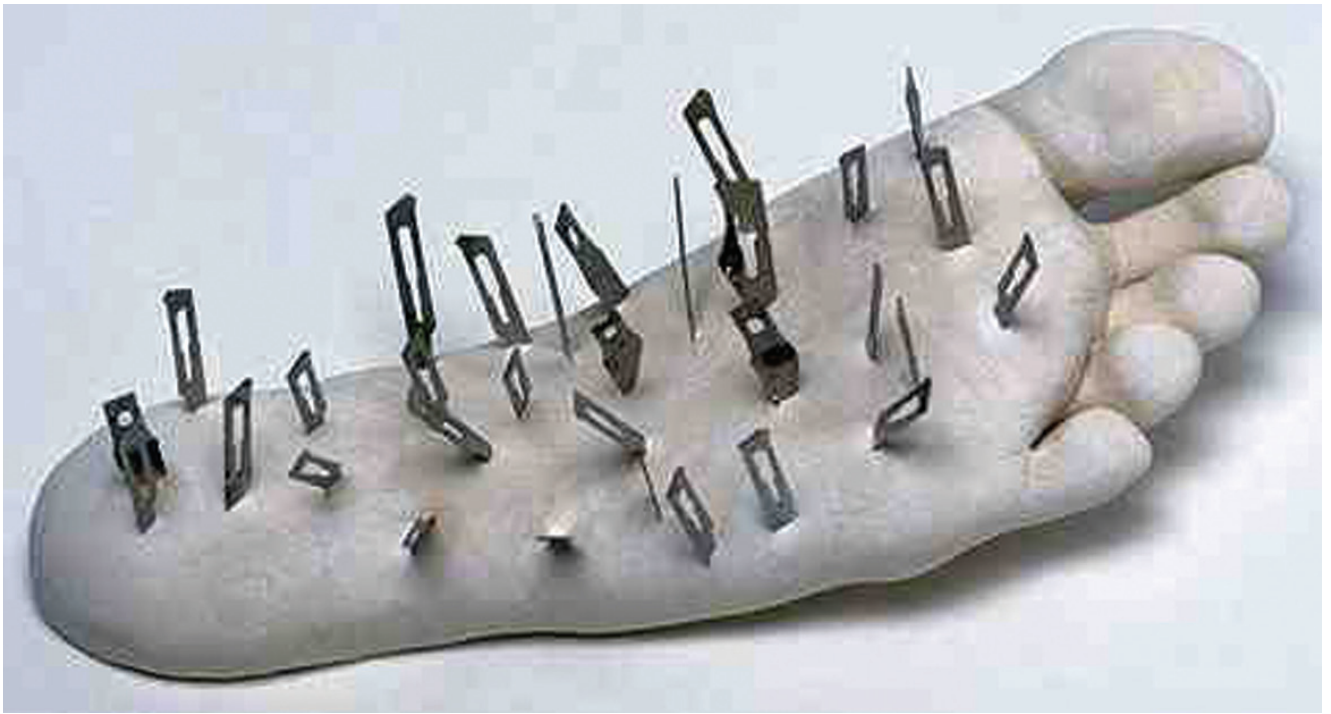
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Grünenthal Ltd (telephone 0870 351 8960).

References:

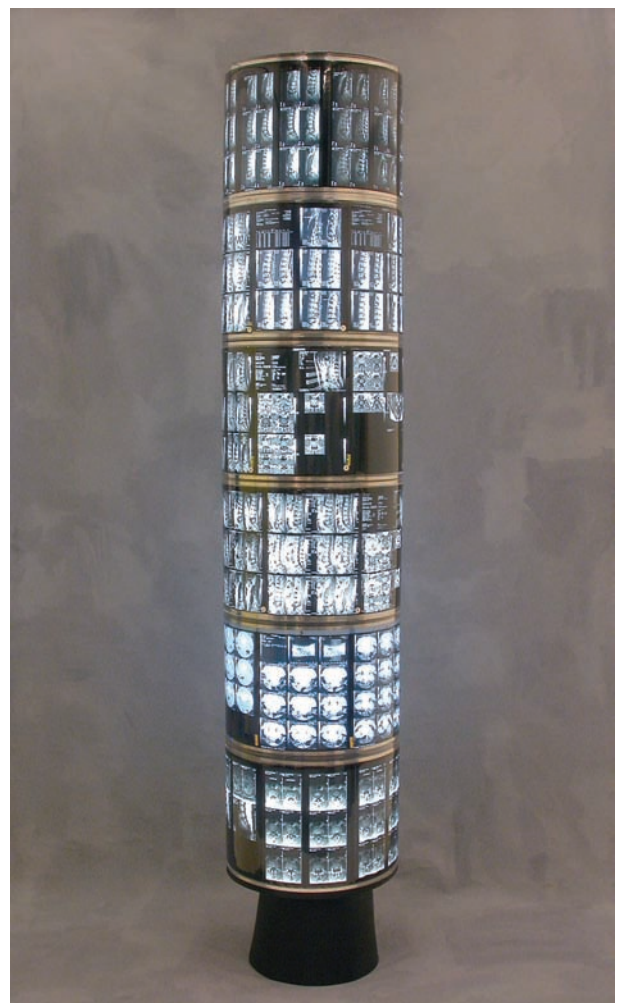
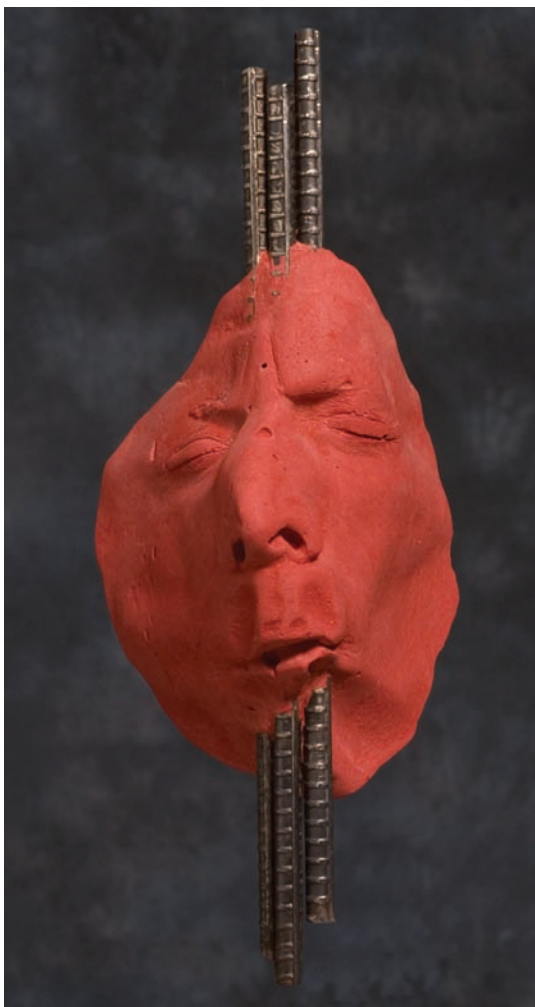
1. Tzschentke, T.M., et al. Drugs Today (Barc), 2009; 45(7): 483-96.
2. Palexia SR, Summary of Product Characteristics.

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Please see page 32-35 for Susanne Main's article on 'Picturing Pain' for more details; Picture courtesy: Mark Collen, www.painexhibit.org



Please see page 32-35 for Susanne Main's article on 'Picturing Pain' for more details; Picture courtesy: Mark Collen, www.painexhibit.org



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

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THE BRITISH PAIN SOCIETY
PAIN NEWS

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The opinions expressed in PAIN NEWS do not necessarily reflect those of the British Pain Society Council.

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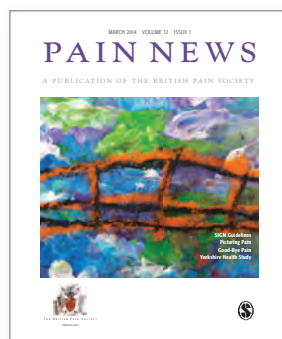
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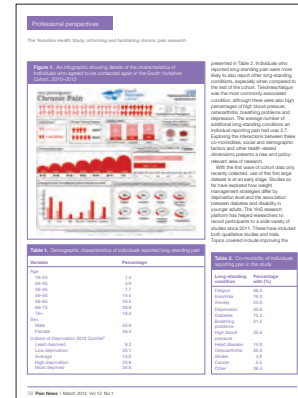
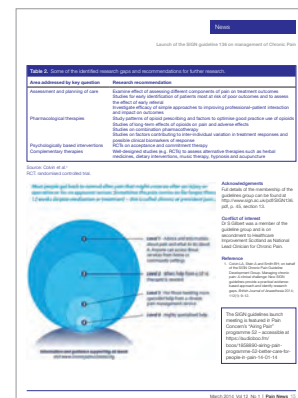
The editor welcomes contributions
including letters, short clinical reports and
news of interest to members, including
notice of meetings.
**Next submission deadline :
11th April 2014**

Material should be sent to:

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British Pain Society Calendar of Events

2014



Annual Scientific Meeting

Tuesday 29th April to Thursday 1st May
Manchester Central, Manchester

Musculoskeletal Pain (30th Study Day)

Thursday 15th May
Churchill House, London

Orofacial Pain (31st Study Day)

Tuesday 17th June
Churchill House, London

Philosophy & Ethics SIG Annual Conference

Monday 30th June – Thursday 3rd July
Rydal Hall, Ambleside, Cumbria

Cancer Pain (32nd Study Day)

Wednesday 23rd July
Churchill House, London

Interventional Pain Medicine SIG Annual Meeting

Friday 17th October
Manchester

Patient Liaison Committee – Annual Seminar

Thursday 23rd October
Churchill House, London

Pain Education (33rd Study Day)

Monday 24th November
Churchill House, London

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

Thank you!

Thanthullu Vasu



Dear Friends,

I hope you all had a nice Christmas and have started 2014 with all happiness. This is my last issue of the newsletter as the Editor, and I am happy to handover the responsibility to the wonderful team led by Arasu. You will read about this team and their plans to make more innovations in *Pain News* in the next few pages.

*I can no other answer make
but thanks,
And thanks, and ever thanks.*

Twelfth Night, Act 3, Scene 3

My conscience is firm that I was given responsibilities far more than my worth

by the Council and the Executive Committee of the Society. I hope I have done justice to their confidence in me. I also sincerely thank all the members of the Society for supporting me in the last three years with a variety of interesting articles. Without your contributions, *Pain News* cannot exist – thank you very much! I thank Mike Basler, my predecessor for giving me this responsibility and guiding me appropriately. I have enjoyed each and every moment of this role and am satisfied that I have left our newsletter with a better team in a better way.

I sincerely thank the Secretariat of the Society for all their help during my three years of Editorship; I have troubled Jenny regularly for *Pain News*, and she has never hesitated to help me in all possible ways. I am amazed at her incessant honest smile, energy and dedication in work. She has worked in many unsocial hours, including the weekends from home to cope with the deadlines for the newsletter – I am not sure how to thank for all her efforts! I also thank Leila (who left the office recently), Rikke, Ken and Dina for all their support. I thank Gurbukshaw from SAGE who had to bear with my obsessive compulsive nature of editing work. *Pain News* and *British Journal of Pain* have gone hand-in-hand and special thanks go to Felicia Cox for working hard to raise the profile of both these publications together.

This would not have been possible without the support of all my

colleagues at work in Ysbyty Gwynedd, Bangor; special thanks to my mentor and colleague Dr Rhian Lewis, who has encouraged me in every step of this career. My family has supported me enormously in the last three years allowing me to spend all the valuable time alone with my computer, especially doing editing work at odd hours to keep with the deadlines. My special thanks also go to my close friend Shyam Balasubramanian, Coventry, who has given me the much needed moral support in all the difficult times.



I welcome Arasu and wish him the best as the incoming new Editor; he is lucky to be supported by his Associates Margaret, Ethel and Christina, who will definitely bring in a huge amount of expertise and their experience to raise the standards and quality of our newsletter.



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Pain News

2014, Vol 12(1) 3–4

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SAGE

Editorial

Thank you!

In the last few years of my association with the Council, I have noticed that all our Executives, Council Members, special interest group (SIG) officers and the co-opted members spend a huge amount of their valuable time to help the Society and improve the specialty. Many of them do this in their own personal time at the expense of their quality time with family. Can I kindly request you to thank these individuals when you

meet them in our Annual Scientific Meeting (ASM) or other meetings please? They all deserve heart-felt thanks from all of us for their dedication to the Specialty.

Strive not to be a success, but rather to be of value

Albert Einstein

I hope I have been of value to the Society by representing all your views

honestly. Please accept my sincere thanks once again,

Kind regards,



Thanthullu Vasu
Bangor

Cover photo details



The cover photo illustrated in this issue is a photograph of the artwork produced by **Sushant Shyam**, age 6, *Monkspath School, Solihull*. Impressed by Monet's famous painting, he created this artwork in his school, which illustrates 'A bridge over a pond of water lilies'. However, given the fact that

his father is a member of the British Pain Society, he describes that this is a bridge between pain and hope - "*which could hurt but there is optimism*". The Editor was impressed by his artwork and the description. Hope our members could send us more works like this in future!



Change – it's just the way of things!

Arasu Rayen *Birmingham*



Change isn't good or bad. It's just the way of things. Nothing stays the same

Anonymous blogger

Everything changes with time: children, boyfriend, girlfriend, gadgets, opinions, climate, tax, colour of your hair, fashion and more. Change is inevitable. Change isn't good or bad. It is the way of things. In some instances, good things come of change, in some not. National Health Service (NHS) changes constantly. 'As ever the National Health Service is going through further revolutions', wrote Vasu, outgoing editor of *Pain News* in his first editorial in 2011. NHS 2014 is going through even more changes. Pain Management had a fair share of changes and challenges in the last three years. We, as an optimistic group, have taken these changes not as challenges, but as opportunities to move forward.

Friends, it is the time for change in *Pain News* as well. The editor in *Pain*

News is changing. For the first time, rather than the editor alone, we have 'true' multidisciplinary editorial team. In addition to myself as incoming editor, the Society has also appointed three associate editors – one from each major discipline represented in the British Pain Society (BPS). Christina Liossi, Senior Lecturer in Health Psychology; Ethel Hili, Clinical Physiotherapist; and Margaret Dunham, Senior Lecturer in Nursing will be joining the team as associate editors. Please see their interesting introductory articles elsewhere in this edition. I am excited to work with this talented team, and we hope that we bring quality and interesting materials in each issue, which we know matter to you.

While perusing through the previous *Pain News*, I bumped into Mike Basler's first editorial in 2008. He was concerned at that time that the articles in *Pain News* did not have true geographical and disciplinary representation. In the last six years, we have seen a sea of changes. Under Vasu's editorship, we have seen more contribution from all corners of Great Britain and different disciplines. Now, we have an Editorial team representing all the major disciplines of pain management and different geographical locations.

I was not aware that I had a small 'writer streak' in me until Vasu asked me to write a regular column in *Pain News*. I thank him for his confidence and trust in me to give me free will to write about what interested me, what was relevant and mattered to you all; without his confidence, patience and support, I would not have written *Rayen's column* for the last three years. Vasu's

dedication, organisational skill, hard work, innovation and unrelenting passion has seen *Pain News* go from strength to strength.

During the last three months, I have seen the support of Secretariat staff, including Jenny, Dina and Ken. Working closely with them showed me how much hard work they put in before the glossy booklet of *Pain News* reaches our hands, and I am thrilled and honoured to work with such an enthusiastic team.

Last but not the least, I have to thank my wife and daughter for letting me accept this challenge. Without their 'informed consent' and support, I do not think I would have accepted this post. *'Happy wife is Happy life'*

The BPS Annual Scientific Meeting is around the corner. Once again, the scientific committee has done a wonderful job. Come and show your support to their effort. If you are going to be there, I look forward to meeting you all in Manchester.

I sincerely thank all the past and future contributors of *Pain News*. Without your continued support, it would not have been (and will not be) so popular. If you are a 'literary virgin' and have not written anything yet, find the writer hidden in you. *Pain News* is an ideal medium for starting your literary journey. If you are a seasoned writer, please keep writing and remember to send your articles to us. If you have innovative ideas or burning issues that you want to write about, please let me know. We are happy to consider all your work for our publication.

Please remember, *Pain News* is for you, and possible **only by your support**.

Dr William Campbell



Low back pain

As I mentioned in the last issue of Pain News, Professor Charles Greenough (National Clinical Director – Spinal Disorders and Chair of the Pathfinder Project on Low Back Pain) is making good headway in bringing a wide variety of healthcare disciplines, commissioners and patients together, to produce a flowchart to manage low back pain.

Since the replacement for the NICE low back pain guidance CG88 will take at least two years to complete, it is hoped that the Pathfinder Flowchart will fill the gap for clinicians and commissioners alike until the new NICE guidance becomes available. It is hoped that the project will be completed early spring 2014. At the time of writing, it is difficult to see how this will be very much different from the

British Pain Society Pathway for Low Back Pain. The main issue here is that the heads of various professional organisations are seen to agree a common system to deal with low back pain under the auspices of an NHS lead. This will hopefully clarify the management of low back pain for commissioners, clear the way for an agreed way of managing this condition and hopefully result in a more equitable resource throughout the regions, for the patients benefit. We can but hope.

Commissioning

There is a degree of mystery and perhaps confusion about this matter. The Society has run Roadshows on this subject in London, Bournemouth, Birmingham, Manchester, Newcastle, Edinburgh and Belfast, organised through my predecessor Professor Richard Langford. He arranged funding and with the support of Dr Andrew Baranowski, Dr Martin Johnson and keen members of the Society in spring through to autumn 2013. Since then, there have been many meetings and privately run study days on this topic. Dr Martin Johnson, our Honorary Secretary and the Pain Champion for the Royal College of General Practitioners (RCGP), has taken a very active role in these presentations. Several major pharmaceutical companies supported the Commissioning Support Document, launched on the 16th January 2014. (they had no part to play in the writing nor editorial control of the final document which was released under the control of the RCGP and endorsed by the BPS) In addition as information becomes

available about commissioning this will be updated regularly on our website.

Annual Scientific Meeting. Manchester 29th April – 1st May

Last year it was agreed by the Chairs of the British Pain Society Special Interest Groups and the organisers of the ASM that we would run the ASM differently this year. The meeting starts at 10:15am Tuesday morning and is complete by mid Thursday afternoon. Only two nights stay but a lot packed into that time! We have excellent local and overseas speakers, with several SIGs grouping together to produce a themed programme (see the programme!)

Vote for new Council members

Vote early (but not often - as in some parts of the UK!) one vote per member.

It is that time of year when we must say goodbye to several Council members.

Professor Roger Knaggs (2011-2014)

Dr Raj Munglani (2011-2014)

Dr Mick Serpell (2008-2014) two terms each of three years.

Each has given many hours of their time not only responding to the multitude of email traffic but also volunteering to assist with subcommittees and meetings, as well as attending the regular Council meetings. Their significant contributions to the Society for the benefit of members and patients is greatly appreciated.

I haven't mentioned our Immediate Past President, Professor Richard



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From the President

Dr William Campbell

Langford ! He took up office four years ago. He achieved a huge amount during his time in office – overseeing the National Pain Audit (led by Dr Cathy Price), arranging the Commissioning Roadshows, the Pain Pathways, (Chaired by Dr Andrew Baranowski), as well as ensuring that the Pain Pathways

were made widely available via the Map of Medicine. In addition, he arranged outside financial support to run the last three of these projects. We will miss his bubbly nature and enthusiasm at Council, but of course wish him and the retiring Council members well for the future.

Members of The Society – we need you to vote now for three new Council members.

Please don't wait when the papers arrive in the post, vote and return as soon as possible.

I look forward to seeing you at the Annual Scientific Meeting in Manchester!

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From the Honorary Secretary

Dr Martin Johnson



THE BRITISH PAIN SOCIETY

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Happy New Year to you all! I really hope that you have all managed to avoid the adversity of the severe weather conditions. The start of the New Year means that the next Annual Scientific Meeting, this year in Manchester, is only a few months away. With the rearranged, more compact – but still exciting – programme and the new social events I hope that many of you will consider supporting the event. Remember that the ASM helps to support other BPS activities, which in turn are supporting your work.

Membership

Wide ranging multi-professional conversations are at present being co-ordinated by Council members to look at ways that we can make BPS

membership attractive for the various professions. If you have any thoughts around this area please don't hesitate to email me at the BPS Office.

Current membership numbers: 1378

Patient Pain Champion's

2013's Patient Pain Champion Jean Gaffin has created a government e-petition asking the Department of Health and the organisations responsible for setting standards of care to ensure that health and social care professionals help people living with pain by asking about their pain, measuring it, recording it, treating it and managing it at every opportunity.

Please consider signing the petition and circulating it amongst your networks. It can be accessed here: <http://epetitions.direct.gov.uk/petitions/58377>

The 2014 Patient Pain Champion has been announced as Pete Moore. Pete continues to make a massive contribution to the pain world both in the UK and internationally – many congratulations Pete – you fully deserve the award.

Electronic voting

We will soon be sending you voting papers for use for Council positions that are due to come vacant in April. May I encourage you to use your vote – unfortunately the last election had a very poor turn out.

Hopefully this will be the last paper vote. At the ASM in April I am going to propose moving to an electronic voting system, which will be considerably cheaper than the present system and, I

hope, will engage even more members in the voting process.

SIG Meetings

SIG's are the life blood of the Society and as such we encourage all SIG's to plan high quality educational events. However please note that the BPS office would urgently ask you to involve them at an early stage of planning of events. We now have guidelines for SIG's that are organising events especially with regard to 'educational grants' which are forming part of the overall budget; if these are set up incorrectly it could mean the whole Society is liable for VAT. It is recommended, where possible, that the budget should be worked out at least six months in advance (though we appreciate this is not always possible) and that advertising of an event starts at least three months before an event – the latter minimises the amount of work that the secretariat have to subsequently do, if advertising is too late!

Pain management and assisted dying/assisted suicide

Lastly, turning to a more serious subject, Council has recently considered how pain management health care professionals may be involved in the debate around assisted dying/assisted suicide. I considered writing a summary of the document within my column, however I believe that this would be a negative move. The excellent document, prepared by Sam Ahmedzai and Neil Berry needs to be read in it's entirety and can be found on the BPS website (http://www.britishpainsociety.org/secure/members_articles_submenu.htm).

For the management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain

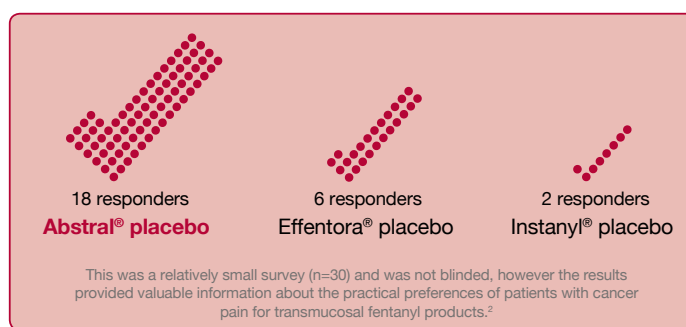
*The decision to use a specific opioid preparation should be based on (in particular)
the **patient's preference** for an individual preparation¹*

Association of Palliative Medicine

In a survey of user opinions of transmucosal fentanyl product placebos, **Abstral** was rated most preferred



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and more palatable than the other placebos.



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Abstral® Abbreviated Prescribing Information

Abstral® 100 micrograms, 200 micrograms, 300 micrograms, 400 micrograms, 600 micrograms and 800 micrograms Sublingual Tablets (fentanyl (as citrate))

Abbreviated Prescribing Information Please refer to Summary of Product Characteristics before prescribing. **Presentation** Sublingual tablets containing 100µg, 200µg, 300µg, 400µg, 600µg and 800µg of fentanyl (as citrate). **Indication** Management of breakthrough pain (BTcP) in adult patients using opioid therapy for chronic cancer pain. **Dosage and Administration** Only for use in patients who are considered tolerant to their opioid therapy for persistent cancer pain (i.e. using at least: 60 mg of oral morphine daily or 25 micrograms of transdermal fentanyl per hour or 30 mg of oxycodone daily or 8 mg of oral hydromorphone daily or equivalent). Administer directly under the tongue and allow to dissolve without chewing, sucking or swallowing the tablet. Adults: Initially 100µg, titrating upwards as necessary. Patients must be monitored closely by a health professional during the titration process. Once an appropriate dose has been established patients should be maintained on this dose and should limit consumption to a maximum of four doses per day. During titration, patients can use multiples of 100µg tablets and/or 200µg tablets for a single dose, but no more than 4 tablets should be used at any one time. During both titration and maintenance patients should wait at least 2 hours before treating another episode of BTcP. Elderly and patients with renal and hepatic impairment: Special care is needed in titrating elderly patients and patients with kidney or liver dysfunction; observe for signs of fentanyl toxicity. Children and adolescents: Must not be used in patients less than 18 years of age. **Contraindications** Hypersensitivity to any of the ingredients; opioid-naïve patients; severe respiratory depression or severe obstructive lung conditions. **Warnings and Precautions** Instruct patients and carers to keep tablets out of reach and sight of children. Ensure patients and carers follow instructions for use and know what action to take in case of overdose. Before starting Abstral, ensure long-acting opioid treatment for persistent pain is stable. Dependence may develop upon repeated administration of opioids. Risk of clinically significant respiratory depression. Particular caution needed during dose titration in patients with COPD or other conditions predisposing to respiratory depression. Administer with extreme caution in patients who may be particularly susceptible to the intracranial effects of hyperkapnia. Opioids may mask the clinical course in patients with head injuries. Use with caution in patients with bradyarrhythmias, hypovolaemia, hypotension, mouth wounds or mucositis. Monitor carefully use in elderly, cachectic and debilitated patients and patients with liver or kidney dysfunction. Possible symptoms of withdrawal on cessation are anxiety, tremor, sweating, paleness, nausea and vomiting. **Interactions** Fentanyl is metabolised by CYP3A4. Use with caution if given concomitantly with CYP3A4 inhibitors such as macrolide antibiotics, azole antifungal agents, protease inhibitors or grapefruit juice. Concomitant use of other CNS depressants, such as other morphine derivatives, general anaesthetics, skeletal muscle relaxants,

sedative antidepressants, sedative H1 antihistamines, barbiturates, anxiolytics, hypnotics, antipsychotics, clonidine and related substances may produce increased CNS depressant effects. Respiratory depression, hypotension and sedation may occur. Concomitant use of alcohol or partial opioid agonists/antagonists (e.g. buprenorphine, pentazocine) is not recommended. Not recommended for use in patients who have received MAO inhibitors within 14 days. **Pregnancy** Safety in pregnancy not established. Use only when necessary. Long-term treatment may cause withdrawal symptoms in newborn infant. Do not use during labour and delivery since fentanyl crosses the placenta and may cause respiratory depression in foetus or infant. **Lactation** Fentanyl is excreted into breast milk and should only be used if the benefits clearly outweigh the potential risks for both mother and child. **Driving, etc** Opioid analgesics are known to impair mental or physical ability. Advise patients not to drive or operate machinery if they become dizzy, drowsy or experience blurred or double vision. **Undesirable Effects** Typical opioid undesirable effects are to be expected. The most serious adverse reactions associated with opioid use are respiratory depression, hypotension and shock. The most frequently observed adverse reactions from clinical trials with Abstral include typical opioid adverse reactions such as nausea (very common), constipation, somnolence and headache (common). Other commonly observed adverse reactions include: dizziness, dyspnoea, stomatitis, vomiting, dry mouth, hyperhidrosis and fatigue. Other serious but uncommonly reported adverse reactions include: hypersensitivity, tachycardia, bradycardia, hypotension and drug withdrawal syndrome. See SPC for details of these and other undesirable effects. **Overdose:** Immediate management includes removal of any remaining tablets from the mouth, physical and verbal stimulation and an assessment of the level of consciousness. A patent airway should be established and maintained, and assisted ventilation initiated if appropriate. Adequate body temperature and parenteral fluid intake should be maintained. Consider the use of opioid antagonists. **Pack Size and Basic NHS Price:** Abstral 100-400µg 10 tablets: £49.99 Abstral 100-800µg 30 tablets: £149.70. **Marketing Authorisation Numbers:** PL 16508/0030-35 **Legal category:** CD POM. Further information is available from the **Marketing Authorisation Holder:** ProStrakan Ltd, Galashiels, TD1 1QH, UK © Registered Trade Mark. **Date of PI Preparation:** March 2013.

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References: 1. Davies AN *et al.* *EUR J Pain* 2009; **13**: 331-8. 2. England R *et al.* *BMJ Supportive & Palliative Care* 2011; **1**: 349-51. ©Effentora is a registered trademark owned by Teva UK Ltd. ©Instanyl is a registered trademark owned by Takeda Pharmaceuticals International GmbH.

Margaret M Dunham



THE BRITISH PAIN SOCIETY

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As a lecturer in pain management, I am passionate, obviously, about pain management and in particular the neglected health care needs of older people. I started nursing at a time when the treatment for pain was by the clock and not by how much pain was being endured. This was also at a time when Omnopon and Scopolomine were the favoured, and frequently the only, options for pain relief. I have maintained my enthusiasm to advocate for adequate pain relief throughout my career. However, in recent years through personal loss, I have noticed that older people often get the worst deal in health care.

I trained as a registered general nurse and worked in various different areas

including vascular surgery, but finally settled as a Clinical Nurse Specialist in Pain Management. I worked as a pain specialist for six years before taking a secondment to teach, with the support of Pat Schofield (now Professor at Greenwich), the pain management courses at the University of Sheffield. I am currently a senior lecturer at Sheffield Hallam University where I am employed in an academic and teaching role. I contribute to the teaching of pain management across both undergraduate and post graduate curricula.

I am convinced that current pain research must directly inform the education of all health care professionals. I am especially interested in the individual's experience of health care services. My broad research interests include pain and its management, older people, cancer and palliative care; areas where there is still some work to be done to ensure the voice of service users has sufficient representation. I have presented my work at many national and international nursing and multidisciplinary conferences, and have written and contributed to academic papers in pain management. I am currently undertaking a part time PhD study into the experiences of older people with cancer pain. At the time of writing, I am in the stages of gathering data which involves visiting various local hospices and meeting with the day hospice staff, the specialist palliative care teams and their clients. By the time you read this, I am

optimistic that I will be doing the data analysis and writing up my findings.

I have been a member of the British Pain Society for over 12 years now. I keep in touch with my practice through active membership of the Trent Pain Network and the North Trent Acute Pain Special Interest Group. I am also a member of the International Association for the Study of Pain IASP, the RCN Pain Forum, the Palliative Care Research Society and the British Society of Gerontology. I have had some reviewing experience over the years having had an editorial role for the pain supplements in the journal, *Professional Nurse*. I have also been a regular peer reviewer for Whurr Publishers and for the Joanna Briggs Institute for Systematic Reviews.

I live in North Derbyshire and so have the convenience of all Derbyshire and the benefits of the city of Sheffield close at hand. When not working or studying, I enjoy gardening, singing, walking, swimming and holidaying in France. However, my most challenging role is and has been as mother to three children, themselves very supportive of my career choices. An unexpected benefit of having children is that as they get older, they make invaluable (unpaid) proof readers for most of my academic writing.

I look forward to working with the new editorial team for *Pain News* and also learning about a whole range of our member's interests in future issues.

Christina Liossi



I write to introduce myself as a new Associate Editor of *Pain News* and to provide you with insight about my vision for our newsletter. I am a paediatric psychologist, senior lecturer in health psychology at the University of Southampton where I am also the programme director for the MSc in Health Psychology. I hold an honorary consultant paediatric psychologist contract and work with children and adolescents with chronic pain as part of the multidisciplinary pain management service at Great Ormond Street Hospital for Children NHS Trust. In the past, I have worked in academic and health care institutions in the UK and abroad and cared for children with various chronic medical conditions including cancer, cystic fibrosis, chronic kidney disease and sickle cell disease.

I believe that there is a need for good evidence to guide care and I am

committed to the promotion of evidence-based practice in the NHS. I believe passionately in the synthesis of science with clinical practice and fully subscribe to the scientist practitioner model. In my view, the scientist-practitioner model is not a bipartite one, but rather comprises an integrated philosophy in which the scholarly and research roles of psychologists and other health professionals are inextricably linked to their clinical and applied roles.

My research on pain focuses on three intertwined themes:

- a) the cognitive and affective neuroscience of pain,
- b) the development of theory driven psychological interventions for the management of acute and chronic pain in children and adults,
- c) the evaluation of the efficacy and effectiveness of psychological interventions in paediatric and adult pain management.

Other research interests include paediatric psychology in general and psycho-oncology and neuropsychology specifically. In my work, I integrate methods from a range of perspectives such as cognitive-experimental paradigms, randomised controlled trials, a cognitive-neuroscience approach and qualitative methods.

My vision for *Pain News* is straightforward: to process and review manuscript submissions in a timely fashion, and to encourage the

submission of thought-provoking articles written on subjects of current clinical interest by specialists in that field. I aim to foster intellectual and scholarly debate and hope to expand our international outreach. I welcome the more “experimental” ideas of younger colleagues and I am committed to guide and support them in the planning and development of their papers.

I am confident that the new Editorial Board, under the leadership of our Editor Dr Arasu Rayen, will continue the success of *Pain News* and take the publication to the next level. Future issues of the newsletter will continue to provide important and clinically relevant information that can be used by practitioners, to express the views of our multidisciplinary membership and to make our members aware of the excellent work done by the Executives, Council and in fact the whole membership. The editorial board and society staff will be working hard and we are dedicated to the publication and to continue the success of the outgoing Editor Dr Thanthullu Vasu. All of us will be an integral part of the publication's future success, but nothing will happen without the innovators, scientists and clinicians who will submit their work for publication, and you, the readers of this newsletter, who will take this knowledge and allow it to inform and inspire your clinical work and thinking.

I am delighted to be Associate Editor of *Pain News* and I do hope to meet and work with as many of you as possible in the next three years.



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Hello and welcome to this issue of *Pain News*. It is with great pleasure that I write this brief introduction to myself as one of the three new Associate Editors for *Pain News*.

I qualified as a Physiotherapist from the University of Malta in 2005, following which I worked as a physiotherapist in a large residential home for people with physical and learning disabilities. I joined the Maltese health service in 2006, where I

worked in the Physiotherapy Outpatients' Department and on the Orthopaedic wards, before moving to the UK in 2008. Once in London, I resumed my studies at King's College London on the MSc in Advanced Physiotherapy (Neuromusculoskeletal Rehabilitation). This was essentially my first real venture into the world of pain neuroscience, management and rehabilitation – a glimpse that rapidly developed into a passion.

I was fortunate enough to land jobs in pain management and senior outpatient physiotherapy roles after this, all of which paved the way to my current job of Clinical Specialist Physiotherapist in Chronic Pain with the Community Chronic Pain service that forms part of Kent Community Health NHS Trust. The service, which operates from outpatient locations across the whole of East Kent, is multi-disciplinary and aims to support people with chronic pain to achieve long-term self-management by developing strategies, enhancing qualities of life and decreasing dependency on healthcare services. This post has given me the opportunity to continue to develop my skills in pain management while increasing my passion for pain education amongst patients and clinicians alike.

I form part of the British Pain Society's Pain Education SIG committee and contribute to the Patient Education sub-committee. Through this, I have also had the opportunity to participate as author and reviewer on several e-learning projects about pain and pain management.

I would like to thank the BPS Executive Committee, the current Editor and our future Editor for this wonderful opportunity. I feel privileged to be offered the position of Associate Editor of *Pain News* and hope to use this experience to help continue to raise the profile of Physiotherapy in pain management, while continuing to support the development of excellent clinician and patient education.

I am looking forward to contributing to the continued improvement of the BPS' flagship publication. However, I am even more excited about receiving all your news from around the UK. I would like to encourage you to put pen to paper and let us know all about your experiences, your projects and your discoveries as you work with people suffering persistent pain. So get cracking! I look forward to hearing from you.



Launch of the SIGN guideline 136 on management of Chronic Pain

Dr Steve Gilbert



December the 12th 2013 saw the launch of the Scottish Intercollegiate Guidelines Network (SIGN) guideline on the management of Chronic Pain. This guideline provides recommendations based on the current evidence for best practice in the assessment and management of adults with chronic non-malignant pain in non-specialist settings, including self-management, pharmacological, psychological, physical, complementary and dietary therapies.

The guideline development was lead by Lesley Colvin, using SIGN methodology to identify and evaluate the available evidence. The launch meeting was held in Edinburgh to publicise the content of the guideline as well as being combined with practical workshops on how the work of Scottish Pain Management Service Improvement Groups can help to put the evidence into practice.

The conference was introduced by Denise Coia, Chair of Healthcare

Improvement Scotland, and Lesley Holdsworth, who gave an overview of the work by Healthcare Improvement Scotland and the Chronic Pain Steering Group towards implementation of the Scottish Service Model for Chronic Pain.

There are service improvement groups established in all 14 Scottish Health Boards now, which are working on improving pain management in the community and primary care as well as in Specialist Multidisciplinary Pain Management Services. A new national pain management website has been launched – <http://chronicpainscotland.org> – with quality-assured information for patients and public, healthcare professionals and for the service improvement groups.



Michael Matheson, Minister for Public Health, spoke on the Scottish Government's support for implementing the recommendations of the Getting Relevant Information on Pain Services (GRIPS) Report. Chronic Pain has been included in the Local Delivery Plan of the National Health Service (NHS) Boards, which will ensure that progress can be monitored. Lesley Colvin, Peter McCarron, John Wilson, Blair Smith and John Hardman covered the main points of the guidelines.

The full guideline can be downloaded at <http://www.sign.ac.uk/guidelines/fulltext/136/index.html>. The main guideline is accompanied by a patient version and the following three treatment pathways:

- Chronic pain assessment, early management and care planning in non-specialist settings;
- Patients with neuropathic pain;
- Using strong opioids in patients with chronic pain.

Susan Scott and Marion Beatson, who have lived with chronic pain, gave a patients' view of their experience of the journey through the medical system, which gave a valuable insight into how essential better understanding and early management is.

The morning session was concluded by Steve Gilbert who outlined the progress that has been made since GRIPS in 2007 and the work that still has to be done to improve knowledge and skills in pain management

Launch of the SIGN guideline 136 on management of Chronic Pain

Table 1. Summary of some of the key recommendations for chronic pain management made in the SIGN guideline

Grade A, at least one meta-analysis, systematic review or randomised controlled trial (RCT) rated as 1++, and directly applicable to the target population, or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results;

Grade B, a body of evidence, including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results, or extrapolated evidence from studies rated as 1++ or 1+;

Grade C, a body of evidence, including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or extrapolated evidence from studies rated as 2++;

Grade D, evidence level 3 or 4, or extrapolated evidence from studies rated as 2+;

GPP, good practice point: best practice based on the experience of the guideline development group, in the absence of good-quality evidence.

For more information on grading, see *Scottish Intercollegiate Guideline Network. SIGN 50: A Guideline Developer's Handbook, revised Edn. Edinburgh: SIGN, 2011.*

Area addressed by key question	Summary of key recommendation	Level of evidence
Assessment and planning of care	In order to best direct treatment options, a comprehensive biopsychosocial assessment, including identification of pain type (e.g. neuropathic) should be carried out in any patient with chronic pain	GPP
Supported self-management	Self-management can be used from an early stage in a pain condition, with patients being directed to self-help resources at any stage in the patient journey	GPP
Pharmacological therapies	There should be at least annual assessment of patients on pharmacotherapy for chronic pain	GPP
	Strong opioids should be considered for chronic low back pain or osteoarthritis and only continued if there is ongoing pain relief	B
	Specialist advice or referral should be considered if there are concerns about rapid opioid dose elevation or if 180 mg per day morphine equivalent dose is needed	D
Psychologically based interventions	Consideration should be given for referral to a pain management programme for patients with chronic pain	C
	There should be an awareness of the impact of healthcare workers behaviour, and the treatment environment, in reinforcing unhelpful responses	GPP
Physical therapies	Any form of exercise is recommended for patients with chronic pain	B
	In addition to exercise therapy, advice to stay active should be given to patients with chronic low back pain. This will improve disability in the long term. Advice alone is insufficient	A

Source: Colvin et al.¹

throughout the levels of the Scottish Service Model.

The lunchtime marketplace session was an opportunity for the service improvement groups to network and share resources and ideas.

Afternoon workshops in Pain in Primary Care, Measurement and Data, Service User Engagement, Pain in Children and Younger People and Learning and Development engaged the

delegates in planning how to implement the guidelines in their health board and on a national level. The service improvement groups then had time to agree on their top three aims to be achieved in 2014.

We have recorded the meeting and will be publishing a slideshare resource in the near future – this will be available at <http://chronicpainscotland.org>.

On 20 March 2014, we will hold a follow-up meeting to build on the establishment of a national network of service improvement groups, which will then take over coordinating the work that Healthcare Improvement Scotland has been leading over the last 8 years. For more details of this, see *Pain News* September 2013, pp. 142–144, http://www.britishpainsociety.org/bps_nl_vol11_issue3.pdf

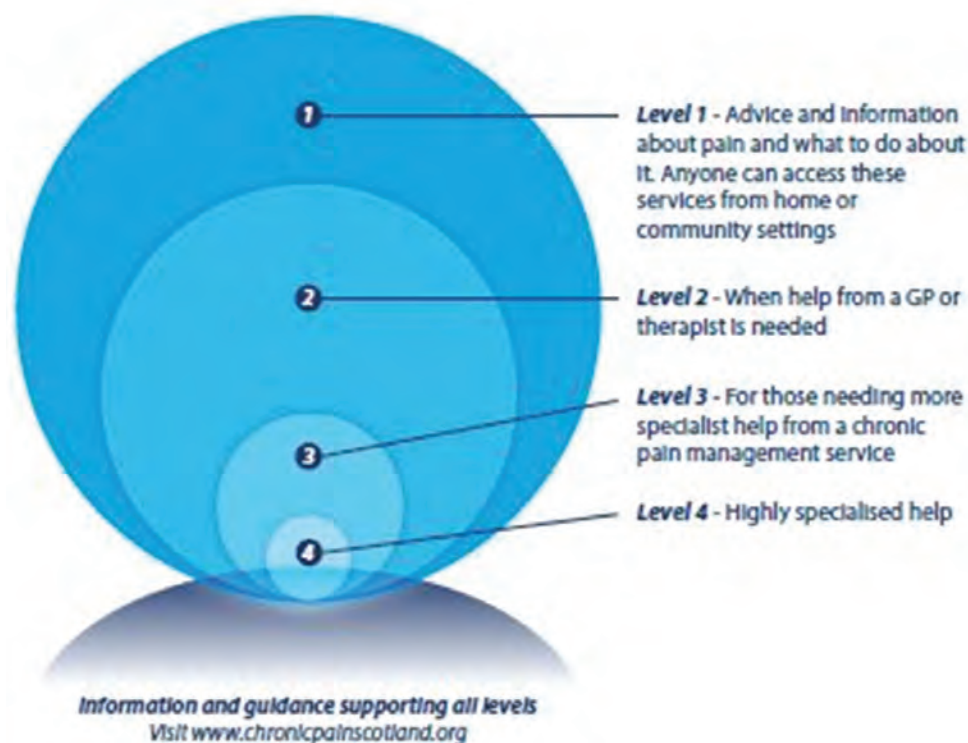
Table 2. Some of the identified research gaps and recommendations for further research.

Area addressed by key question	Research recommendation
Assessment and planning of care	Examine effect of assessing different components of pain on treatment outcomes Studies for early identification of patients most at risk of poor outcomes and to assess the effect of early referral Investigate efficacy of simple approaches to improving professional–patient interaction and impact on outcomes
Pharmacological therapies	Study patterns of opioid prescribing and factors to optimise good practice use of opioids Studies of long-term effects of opioids on pain and adverse effects Studies on combination pharmacotherapy Studies on factors contributing to inter-individual variation in treatment responses and possible clinical biomarkers of response
Psychologically based interventions Complementary therapies	RCTs on acceptance and commitment therapy Well-designed studies (e.g. RCTs) to assess alternative therapies such as herbal medicines, dietary interventions, music therapy, hypnosis and acupuncture

Source: Colvin et al.¹

RCT: randomised controlled trial.

Most people get back to normal after pain that might come on after an injury or operation or for no apparent reason. Sometimes the pain carries on for longer than 12 weeks despite medication or treatment – this is called chronic or persistent pain.

**Acknowledgements**

Full details of the membership of the guidelines group can be found at <http://www.sign.ac.uk/pdf/SIGN136.pdf>, p. 45, section 13.

Conflict of interest

Dr S Gilbert was a member of the guideline group and is on secondment to Healthcare Improvement Scotland as National Lead Clinician for Chronic Pain.

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The SIGN guidelines launch meeting is featured in Pain Concern's "Airing Pain" programme 52 – accessible at <https://audioboo.fm/boos/1858890-airing-pain-programme-52-better-care-for-people-in-pain-14-01-14>



Changing the culture of pain medicine: a desirable and achievable international goal?

Clare Roques *Chair of the Pain in Developing Countries SIG*

Based on a transcript from the Philosophy and Ethics SIG meeting, Launde Abbey, 2013

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I would like to start with a brief idea of how health care and culture interact, and then to question whether it is desirable to try to do anything to change this picture, and to consider what may be achievable. Then, I'll talk about some of the initiatives and ongoing work in this field. For the purposes of this article, I will be focusing on parts of the world that are, broadly speaking, less well resourced than so-called 'developed countries' such as the United Kingdom and the United States.

Culture is, I think, quite a nebulous albeit highly complex concept, but we can describe two different ways of thinking about culture in relation to health care.¹ First of all, culture *in* health care. In other words, how the environment and social culture that a patient is situated in, influence his or her illness. Second, we can talk of the culture *of* health care, which, as I understand it, is the focus of this meeting. That is, our culture and the culture of the health-care system within which we are treating patients. Whether we are working overseas or at home, I therefore think it is important to be reflexive, to be aware of our own culture and our own perspective that we bring to a particular situation. What may seem common sense to us may be completely alien to others.

So, is it desirable from a global perspective, to change aspects of culture related to pain medicine? I'm not going

to question the benefits of treating an individual person's pain, but I do want to share a fairly shocking statistic:

The World Health Organization (WHO) estimates that 5 billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for moderate to severe pain.²

There have also been a number of other high-profile publications, and I'm sure you are all familiar with International Association for the Study of Pain's (IASP) 2010 Declaration of Montreal,³ which states that 'Access to Pain Management is a Fundamental Human Right'. Similarly, the campaign group Human Rights Watch⁴ is among many organisations who have described access to palliative care as a human right.

The causes or so-called 'barriers' to this lack of access to treatment are complex and broad, and include overarching social and global problems, as well as local, organisational and individual issues.⁵ Some of these barriers are nicely summarised in these quotations from The Declaration of Montreal

There is inadequate access to treatment for acute pain [...] and failure to recognise that chronic pain is a serious chronic health problem requiring access to management ...

There are major deficits in knowledge of health care professionals ...

Most countries have no national policy at all or very inadequate policies ...

There are severe restrictions on the availability of opioids and other essential medications ...³

Much of the debate and published work has focused on this last issue, and specifically on access to morphine. This is a drug that is on the WHO's list of essential medicines,⁶ but in many countries, restrictions aimed at controlling diversion are so strict that very limited amounts of the drug are available for legitimate medical use. Another WHO publication (a part of the Organization's Access to Controlled Medication Programme) states,

The ICNB acknowledged in its annual report that in 2003, six developed countries accounted for 79% of global morphine consumption. Conversely, developing countries which represent 80% of the world population accounted for only about 6%⁷

Three key areas related to the lack of access to morphine are often described.⁸ First, a lack of adequate policy, with many countries having phenomenal amounts of legislation and bureaucracy, leaving health-

Changing the culture of pain medicine: a desirable and achievable international goal?

care workers in fear and unable to obtain opioids easily. In several countries, work is underway to try to simplify narcotics laws, but this is neither an easy or speedy process. The second problematic area is that of availability. For example, it may be very difficult or impossible to obtain cheap oral morphine, but fentanyl patches may be available, albeit at prohibitively expensive prices. Finally, there is lack of knowledge associated with so-called 'opiophobic attitudes'.

Some notable organisations such as Pallium India, led by Prof. Rajagopal, and the palliative care group Hospice Africa Uganda, founded by Dr Anne Merriman, have done a huge amount of work towards making cheap oral morphine available. Similarly, Dr Jim Cleary leads The Pain and Policies Study Group at the University of Wisconsin, a group whose work is dedicated to improving global access to opioids. This organisation has a fantastic website (<http://www.painpolicy.wisc.edu>) with freely available statistics and graphs of opioid usage across the world.

So is change achievable? The answer I think is 'Yes ... but only to a certain extent'. We do need to be realistic and remain aware that this is just one possible point of view. The two areas where it appears we could make progress are education and advocacy. But, within this, I think we need to share ideas about what works *and* about what doesn't work, rather than simply trying to impose a UK model overseas. There is, of course, also a huge amount we can learn in return.

Palliative care

As I have suggested already, much of the work in this field has emanated from Palliative Care groups. Although I'm not aiming to list all the organisations working in this field, I would like to emphasise that there are many, for example, the International Association for Hospice and Palliative Care, Help the Hospices, the Worldwide Palliative



Care Alliance and the Union for International Cancer Control. Furthermore, many freely available very useful resources have been produced such as mapping studies.^{9,10} The International Observatory of End of Life Care, based at the University of Lancaster, has prepared detailed reports on the state of palliative care in many countries which are freely available on line (<http://www.lancaster.ac.uk/shm/research/ioelc/international/#countryrep>). Many of you may also have seen an excellent series of short films called 'Life Before Death' (funded by several organisations and freely available at <http://www.lifebeforedeath.com/movie/short-films.shtml>) which eloquently describe many of these global issues extremely well.

I think it is also important to understand that some models of

palliative care may differ from those familiar to us here in the United Kingdom. For example, Dr Suresh Kumar leads a project called the *Neighbourhood Network of Palliative Care* in Kerala, India. There, patients are treated under the umbrella of palliative care, with a vast range of health problems including mental illness, dementia and paraplegia.

So, I think, within the field of pain management, we need to work closely with palliative care and build on the work that is already underway. There is a great opportunity for us to widen the patient groups who can benefit from improved access to opioids, such as those with acute post-operative pain. Furthermore, collaboration could also lead to improved access to treatments other than opioids, which are more appropriate for certain conditions, and currently not the focus of many overseas projects.



Changing the culture of pain medicine: a desirable and achievable international goal?

IASP activity

I would like to move on to more general work, rather than that specifically within palliative care. The work of IASP has been comprehensively summarised by Sir Michael Bond in a 2012 article in the *British Journal of Pain*.¹¹ But I will note that as well as general educational and advocacy work, the work of the Developing Countries Working Group set up and chaired by Sir Michael Bond until 2012 has included a survey looking at education and training in developing countries, a series of 'bottom-up' grants and the support of clinical fellowships (in collaboration with the World Federation of Societies of Anaesthesiologists (WFSA)).

Pain in Developing Countries SIG

It has been difficult to know what such a small group can do about such a phenomenally large problem, but I do think that there are some worthwhile initiatives. So, we try to keep these issues in the news, with regular articles in *Pain News*. We have established a database of British Pain Society (BPS) members who are interested in working abroad, or who have already worked overseas and have ongoing links; we then hope to match up these people with the groups that might benefit from the resources we can offer.

Our first specific project has involved a course called Essential Pain Management (EPM),¹² written by two anaesthetists, Wayne Morriss and Roger Goucke, with the Australian and New Zealand College of Anaesthetists (ANZCA). This is a basic workshop, for all health-care workers, with the aim of improving knowledge and addressing barriers to pain management. One of the key elements of the project is the encouragement of early handover to local clinicians. EPM has become increasingly popular across the world and has been supported by IASP and

the WFSA. I will be running a set of EPM workshops in Uganda in September 2013, generously funded by the BPS and the Association of Anaesthetists of Great Britain & Ireland (AAGBI) Foundation. Following on from this, we are collaborating with the Faculty of Pain Medicine of the Royal College of Anaesthetists and the EPM subcommittee of ANZCA to coordinate similar projects across Africa.

Conclusion

So, is change desirable? Personally, I think it is. But is it achievable, with five



billion people in need, in a phenomenally challenging economic and social environment? We frequently fail to adequately treat chronic pain in the United Kingdom, so we clearly cannot manage everyone's pain across the world. But, it is easy to be overwhelmed and paralysed into thinking that we shouldn't try to do anything at all.

I think there are some things we can do, but we need to be very realistic and quite specific about picking out the things we are good at while being aware of where we are not so successful. In turn, we can also learn from many of the successful initiatives in action overseas.

Perhaps we should also be aiming for a better understanding of cultural context – becoming 'culturally competent', rather than simply trying to change others. We

could all learn to be more aware of our own culture and the social context in which we are working.

We need to build on the inspirational work that is already underway. For instance, taking advantage of improved access to opiates for palliative care and using them more effectively in acute pain.

I suggest that the way forward lies in working collaboratively, in education and in advocacy.

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Glasgow Caledonian University professorial lecture by Nick Allcock

On 16 April 2014, Prof Nick Allcock, Chair of the Communications Committee, will be delivering the Inaugural Glasgow Caledonian University professorial lecture. This event will be held in Deeprose Theatre at 5.30 p.m. The title of his talk is *Nowt to Killin': The struggle with pain in ageing population*.

Professor Nicholas Allcock

Professor Nick Allcock graduated and qualified as a registered nurse from Surrey University with a BSc (Hons) in Nursing Studies in 1983 and, after periods of practice as a staff nurse in neurosurgery and as a charge nurse in Intensive care, trained as a registered nurse tutor taking up a post in Nottingham in 1988.

Nick moved to the University of Nottingham in 1990 to work on a new Bachelor of Nursing programme and studied for his PhD, exploring the experiences of student nurses caring for patients in pain. He was awarded his PhD in 1997 and undertook a range of roles at the University of Nottingham, including Director of Practice Development, The Director of the Practice Development Research Centre and Director of Postgraduate Studies. Nick's interest in evidence-based practice led to him establishing the Nottingham Centre for Evidence Based Nursing and Midwifery, the first UK Joanna Briggs Institute collaborating centre, and he has been involved in a range of systematic reviews and evidence translation projects.

Nick was awarded a leading Practice through Research Fellowship from the

Health Foundation and explored ways of improving pain assessment in older nursing care home residents and has been awarded National Institute of Health Research (NIHR) HfPB and health research (HR) grants. Nick is a co-opted Council Member of the British Pain Society having been elected for two terms and now serving as a co-opted member and Chair of the Communications Committee. Nick has continued to practice in the field of pain

Overview of professorial lecture

Demographic changes across many countries are resulting in ageing populations. While this reflects positively on improvements in health and social care, additional years of life are of reduced value if they are blighted by chronic illness and pain. Chronic pain is common, affecting 18% of the Scottish population, and can have a significant impact on the quality of life of those who experience it. Prevalence surveys of



GCU Professorial Lecture

throughout his academic career and is a trained acupuncturist and member of the British Medical Acupuncture Society. Nick was appointed in January 2013 as a Clinical Academic Professor of Nursing at Glasgow Caledonian University and Greater Glasgow and Clyde Health Board. Nick works with Glasgow Pain Service and is a trustee of Action on Pain and an advisor to Pain Concern.

chronic pain in older adults suggest that 50% of community dwelling and over 80% of older adults in residential care are experiencing pain.

While pain is not an inevitable consequence of the ageing process, the ageing process can affect the experience of pain. Co-morbidity of pain with other long-term conditions is common, with almost 70% of those with chronic pain

Glasgow Caledonian University professorial lecture by Nick Allcock

experiencing two or more other conditions. While pain is not an inherent feature of dementia, they often coexist. As both dementia and chronic pain are age related and as the population ages, the prevalence of both pain and dementia in older adults is likely to increase. It is estimated that 1 in 14 people aged over 65 years have a diagnosis of dementia, increasing to 1 in 6 people aged over 80 years. Dementia is likely to affect the response to, reporting, assessment and management of pain.

Detecting and managing pain in people with dementia presents significant challenges for carers, particularly in

those individuals who may be unable to self-report (88%–95% of people with dementia have difficulties with verbal communication). There is a wealth of evidence to suggest that pain is commonly under-detected and poorly managed in people with dementia, particularly within acute care, leading to an increase in functional decline, slow rehabilitation, disturbances in sleep routine, poor appetite, impaired movement and an increased risk of falling. People with dementia may fail to recollect, interpret and respond to recent pain and report only their immediate experiences despite being susceptible to the same potentially

painful conditions as those who are cognitively intact.

This talk will explore the nature and experience of chronic pain and pain in older age. Drawing on previous and ongoing research, the talk will explore the challenges of identifying pain in those with cognitive impairment and discuss possible future strategies to improve pain assessment.

Please RSVP to profnicholasjohnallcockglasgow.eventbrite.co.uk. Should you have any queries regarding the event, please contact Chris Cadogan on 0141 331 8402 or by email on chris.cadogan@gcu.ac.uk.

Pain UK e-petition

This year's Pain UK Pain Champion, Jean Gaffin, has an e-petition at <http://epetitions.direct.gov.uk/petitions/58377> to attempt to trigger a parliamentary debate to prioritise pain in the National Health Service (NHS).



Jean's 'Championship pledge' asks for pain to be discussed, measured, treated and recorded at *every appropriate patient contact*. Please sign the petition and encourage our friends to sign it also. Together we could make a difference and move pain up the health agenda.



Interventional Pain Medicine Special Interest Group Annual Report 2013

Dr Manohar Lal Sharma *Chair of the IPM SIG*

manoharpain@yahoo.co.uk

Interventional Pain Medicine Special Interest Group committee office

Chair: Dr Manohar Lal Sharma

Secretary: Dr Ganesan Baranidharan

Treasurer: Dr Neil Collighan

British Pain Society (BPS) Council

Liaison: Dr Rajesh Munglani

Interventional Pain Medicine (IPM)

Special Interest Group (SIG) Committee:

Drs A Bhaskar, AR Cooper, A Erdmann, S Gupta, A Hammond, J Richardson, A Lawson, R Munglani, S Thomson, P Toomey, S Ward and C Wells

Total membership: 190

IPM SIG workshop during BPS Annual Scientific Meeting, Bournemouth, 2013

IPM SIG organised a workshop on updates on radiofrequency denervation and lumbar transforaminal injection techniques. These techniques are recommended in spinal pain pathway, developed by BPS and available on Map of Medicine as a commissioning guide for primary and secondary care for radicular pain (http://bps.mapofmedicine.com/evidence/bps/low_back_and_radicular_pain1.html). This session was very well attended and received excellent feedback. Drs Sherdil Nath, Sanjeeva Gupta and Manohar Sharma presented at this session.

IPM SIG Annual Scientific Meeting on 18 October 2013

IPM SIG organised a successful Annual Scientific Meeting (ASM) on 18 October 2013 in London at the Royal College of Anaesthetists. The meeting had invited posters to encourage engagement with SIG members and provide a forum to present and discuss audits and clinical case series. IPM SIG received nine posters, and these are being published as proceedings of annual meeting of IPM SIG in the *British Journal of Pain* (BJP). Editor of *BJP* (Ms Felicia Cox) has been very supportive of publishing these abstracts which have been peer reviewed by IPM SIG office bearers. This meeting had sessions on post-surgical chronic pain management with surgery, benefits of dorsal root ganglion stimulation for intractable cases of abdominal cutaneous nerve entrapment syndrome (ACNES), low back pain diagnostic issues and management including newer technologies including high frequency spinal cord stimulation, outcomes and new developments in IPM and current concepts in managing chronic pancreatitis. The meeting had invited external faculty from Europe and from other disciplines (general surgery and spinal surgery) to encourage collaboration and learning. More than 90 delegates attended this meeting, and the general atmosphere was positive. The meeting received very good support from industry. This meeting was planned by Dr

G Baranidharan with input from IPM SIG Executive Committee.

IPM research project

Health Technology Assessment (HTA) application on feasibility study on facet joint injections versus usual care and sham has been given approval. This work has been led by Prof. Richard Langford and Dr Vivek Mehta. Formal contracts are being awaited from HTA to start this study in three centres, that is, Barts and London National Health Service (NHS) trust, Basildon NHS Trust and The Walton Centre Liverpool. HTA call on this project was invited by National Institute for Health Research (NIHR). IPM SIG is hopeful that this feasibility project will be successful and it may be possible to include other centres in definitive study if funded by NIHR.

Good practice in IPM publications

Good Practice Guidelines for Medial Branch Block and Radiofrequency Denervation: This document has been endorsed by the Faculty of Pain Medicine and the BPS. It is in final stages of publication. This work has been led by Drs Sanjeeva Gupta and Neil Collighan, and many SIG members have contributed.

Good Practice Guidelines for Percutaneous Spinal Intervention Procedures (excluding epidural): This work is in progress.

Interventional Pain Medicine Special Interest Group Annual Report 2013

IPM SIG workshop BPS ASM, Manchester, 2014

IPM SIG has planned joint session with Pain Management Programme (PMP) SIG for BPS ASM, Manchester, 2014 on 'MDT for chronic pain management: Rationale and relevance'. Dr Paul

Wilkinson, Dr Simon Thomson and Mr Mark Draper will be presenting, and Drs Manohar Sharma and Kerry Mathews will be co-chairing the session. There will be meeting of IPM SIG members on Wednesday, 30 April 2014, at 07:45–08:45 a.m.

IPM SIG Annual Meeting, Manchester, 17 October 2014

IPM SIG is planning next annual meeting on 17 October in Manchester. Dr Neil Collighan is taking lead to organise this meeting. Please submit any ideas on topics and speakers for the meeting to Dr Neil Collighan.

Honorary award for Jean Gaffin OBE



Jean Gaffin OBE, a distinguished figure within UK health care, was honoured by the University of Greenwich recently; she will be receiving the degree of Honorary Doctor of Science (HonDSc) in a

ceremony at the Greenwich Campus, in recognition of the key role she has played for many years in health care and research policies.

As a former Chair of the Patient Liaison Committee within the British Pain Society, she has consistently promoted the needs of patients with chronic pain or end-of-life issues, as well as being an advocate for the needs of the general population. She was involved with producing national guidelines on the assessment and management of pain, and worked tirelessly through her contacts within the care home sector to promote their adoption.

The former Chair of Brent Teaching Primary Care National Health Service (NHS) Trust, between 2002 and 2007, she is currently a Member of the Advisory Board for Pain UK; a Hospital Manager for Barnet, Enfield and Haringey NHS Foundation Trust, and for Central and North West London NHS Trust; and a Trustee for St Luke's Harrow. An Honorary Member of the British Pain Society, her past public appointments include that of Honorary Secretary of the Royal Society of Medicine, and Chair of the Advisory Committee on Telecommunications for Disabled and Elderly People.



National Institute for Health and Care Excellence (NICE)

The Society is a generic stakeholder for National Institute for Health and Care Excellence (NICE) guidelines. The Society is also a generic stakeholder for Interventional Procedures and Health Technology Assessments for NICE.

Since November 2013, the Society has received over 30 communications from NICE on topics with relevance to pain. Of those, the Society has formally respond to the following topics:

- Low Back Pain Draft Scope – Consultation (submitted November 2013).

- Quality and Outcomes Framework - indicators consultation (submitted February 2014)

Consultations

Throughout the year, the Society is invited to participate in various consultations relating to pain; in addition to the numerous requests from NICE, the Society has also submitted comments to the following consultations since December 2013;

- D04 Neurosciences Clinical Reference Group Stakeholder

Product Response Feedback – submitted 4th December 2013.

- A13 Specialised Rheumatology CRG stakeholder product response feedback – submitted 5th December 2013.
- D08 Specialised Pain Service Specification - Stakeholder product response feedback – submitted 12th December 2013.
- D08 Specialised Pain CRG - Intrathecal Pumps Commissioning Policy Stakeholder Testing – submitted 8th January 2014.

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Arthritis Research UK research on pain in ethnic communities



THE BRITISH PAIN SOCIETY

Pain News

2014, Vol 12(1) 24

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A new study in the London Borough of Tower Hamlets, funded by medical research charity Arthritis Research UK, may help improve general practitioners' (GP) understanding of chronic musculoskeletal pain among different ethnic groups and develop better strategies for self-management as a result. The two-year study is the first of its kind to directly compare the prevalence and characteristics of chronic pain in White and Bangladeshi people living in the same geographical area and attending the same GP surgeries. The prevalence and impact of chronic pain is known to differ between ethnic groups, with previous research identifying a need for better management of chronic pain across ethnic groups.

Researchers from the Queen Mary University of London looked at whether the features and effects of chronic pain are similar or different in the Bangladeshi and White populations living in Tower Hamlets. The results of a sample of 4,480 patients registered at 16 general practices in the area showed that chronic pain is both more common and more severe in people who grew up in Bangladesh than in either British Bangladeshis who grew up in the United Kingdom, or the White British. However, quality of life was adversely affected by chronic pain in all ethnic groups. People with chronic pain were six times more likely to have poor quality of life than those with no pain. Chronic pain was very common in all three groups, occurring in 50% of Whites

and British Bangladeshis and over 70% of people who grew up in Bangladesh.

Around 10 million people in the United Kingdom struggle with chronic pain almost every day, resulting in a major impact on their quality of life and more days off work. Chronic pain, defined as pain being present for three months or more, also represents a major challenge to GPs and places a large cost burden on the health service. However, research shows that chronic pain may be preventable and that GPs have an important role in its assessment,

living in a deprived area of East London. We found that chronic pain was very common and had a major adverse effect on quality of life in all the groups we tested, and have shown for the first time that there are important differences in the health impact of chronic pain between Bangladeshis who grew up in the UK and those who grew up in Bangladesh. Next, we plan to explore the reasons for these differences. This is important in designing services that are appropriate and effective for all patients suffering from chronic pain

Dr Tom Margham, GP lead at Arthritis Research UK and a practising GP in Tower Hamlets, said,

Living with chronic pain can be a devastating experience and steals quality of life from too many people in the UK. While some people are able to manage their pain effectively, others become isolated and suffer from a reduced quality of life. This new study gives a real insight into the large numbers of people living with long-term pain in the area where I work and the impact it has on different ethnic groups. Understanding the burden of disease in a local area should help those delivering care and commissioning services in their planning to improve outcomes for people affected by chronic pain.

Clin Rheumatol (2013) 32:1375–1382
DOI 10.1007/s10067-013-2286-3

ORIGINAL ARTICLE

Prevalence and impact of chronic widespread pain in the Bangladeshi and White populations of Tower Hamlets, East London

Yasmin Choudhury • Stephen A. Brenner • Anwara Ali • Sandra Eldridge • Chris J. Griffiths • Iqbal Hussain • Suzanne Parsons • Anisur Rahman • Martin Underwood

management and treatment.

Lead researcher Professor Martin Underwood, who originally started the project at Queen Mary University of London but has now moved to Warwick Medical School, said,

It has been suggested through previous research that pain can be more common in South Asians than Whites and that South Asians living in the UK have different ways of communicating their pain to health professionals and to their families. But the challenge for us was determining the impact of chronic pain in different ethnic communities



Essential Pain Management in Kampala

Clare Roques *Chair, Pain in Developing Countries SIG*

Much of this article is based on a formal report, written by Clare Roques and Emmanuel Ayebale

One of the main projects that I have become involved in through the Pain in Developing Countries Special Interest Group (SIG) is an education programme called Essential Pain Management (EPM), which many of you will have read about here in *Pain News*. In 2012, I travelled to Borneo, Malaysia, to gain some first-hand experience of EPM, and after much thought and discussion with colleagues experienced in working overseas, I decided to try to run a set of workshops in Uganda.

One of the many potential problems with overseas work is a lack of integration, so we were keen to link in to established projects both internationally and with other local groups working in pain management in Uganda. Not only does the SIG have members who have worked in palliative care in Uganda, but through Isabeau Walker at the Association of Anaesthetists of Great Britain and Ireland (AAGBI), I was introduced to several Ugandan anaesthetists and most importantly to the fantastic Dr Emmanuel Ayebale (Assistant Lecturer, Department of Anaesthesiology, Makerere University) based at Mulago Hospital in the Ugandan capital, Kampala. With funding generously donated from both the British Pain Society (BPS) and the AAGBI Foundation, and with support from Emmanuel and his senior colleagues in Mulago, we proceeded to plan a three day set of workshops to be run in September 2013.

Uganda is a beautiful, fertile country, located in East Africa, and although landlocked, a large part of Lake Victoria is situated within the country. It has a population of just over 36 million and is classified as 'low income' by the World Bank. Mulago Hospital is situated in the capital city Kampala and is the national referral and teaching hospital for the country with a bed base of 1,500. It provides specialist services, including surgery, internal medicine, paediatrics, obstetrics and gynaecology,



anaesthesiology and critical care, radiology and palliative care. In addition, it serves as the major hospital for the Kampala district which has a population of about 1.72 million. Pain management in Mulago is carried out primarily by the departments of palliative care medicine (especially for chronic cancer pain) and anaesthesiology (especially for acute nociceptive and chronic non-cancer pain).

So, after several months of non-stop emailing and planning, I finally arrived in Kampala, to find that Emmanuel had done an incredible job, arranging facilities, publicising the workshops and coordinating the participants for each day. We spent a couple of days checking out the final details, planning the catering, printing the course materials, finding white boards and pens, checking power supplies and bathroom facilities and visiting both Mulago Hospital and Hospice Africa Uganda.

Key to the ongoing success of this work and indeed one of the reasons we wanted to run EPM in Uganda was the extensive work already underway in the country within palliative care. Many of you will have seen Barbara Duncan's article in the last edition of *Pain News* describing some of the inspirational figures working in Uganda, and I was also lucky enough to meet Anne Merriman (the founder of Hospice Africa Uganda) during my short visit.

We were therefore particularly fortunate to have two very experienced palliative care clinicians as instructors for the course, Dr Elizabeth Namukwaya (Physician, Department of Palliative Care, Makerere University and Mulago Hospital) and Dr Ludoviko Zirimenya (Physician, Hospice Africa, Uganda). Similarly, we were also hugely grateful that Dr Sarah Hodges (Consultant Anaesthetist, CoRSU Rehabilitation Hospital, Kampala)

Essential Pain Management in Kampala



was able to come along as an instructor for the workshops. She is, I think, another truly inspirational doctor who has worked as an anaesthetist in Uganda for many years and was an invaluable member of the team. I was also particularly pleased that Barbara Duncan (a friend and colleague from the BPS SIG) was already working with Hospice Africa Uganda in Kampala. Not only was she an instructor on the course, but she also provided me with money and clothes, after I was caught in a torrential downpour during a walk to what turned out to be an out of order ATM on my first afternoon, when my luggage had sadly not completed its journey from the United Kingdom!

Essential pain management is an educational programme for all healthcare workers, developed by two anaesthetists, Roger Goucke and Wayne Morriss, with the Australian and New Zealand College of Anaesthetists (ANZCA). The course has become increasingly popular across the world with widespread support from organisations including the International Association for the Study of Pain (IASP).

The underlying premise is that across the world, pain is frequently not recognised and often poorly treated. So, the stated aims of the course are to improve knowledge, to provide a simple framework for treating pain and to address pain management barriers. EPM is, however, not only a tried and tested programme, but also a very complete package (with slides, handbooks, feedback forms, certificates, checklists and a report template) designed to make early handover to local healthcare workers as straight forward as possible.

The programme is run as a set of interactive workshops, containing a mixture of short lectures and small group work. We ran a set of workshops over three days as follows:

- Day 1: One day Workshop – 34 participants (doctors from anaesthesia, surgery and medicine)
- Day 2: Instructor Workshop – 8 participants (selected from day 1)
- Day 3: One day Workshop – 21 participants (mostly anaesthetic and nursing officers) delivered by the 8 newly trained instructors from the workshop on day 2, overseen by the overall course instructors.

We were honoured that the workshops were officially opened by Dr Doreen Birabwale, Deputy Executive Director of Mulago Hospital, and Dr Cephaz Mijumbi, Clinical Head of Surgical Services. Each of the one-day workshops then commenced with a brief overview of the current work underway locally, given by three of the instructors: Dr Ayebale, Dr Namukwaya and Dr Zirimenya. The workshops themselves

were great fun for both the participants and instructors, and especially Ludo's highly popular 'energiser exercises'. The participants engaged very enthusiastically during the programme and contributed extensively to discussions. The venues and catering were generally very good, although, despite Emmanuel's meticulous planning, there was a small problem on the final day due to an unavoidable last-minute change in location, with an inconsistent power supply making delivery of power-point lectures rather tricky.

The EPM materials, which we used for the course although standard, are designed with the ability to make small changes if needed to suit the local situation. Although EPM has been run in many locations across the world, relatively few workshops have been conducted in Africa. After several discussions on day one, related to treating pain in sickle cell disease, we realised that it would be helpful to create a new case which we used successfully for the rest of the programme. Another particular difficulty many of us noted was the huge variation in abilities of many of the participants, which we did try to address when compiling future recommendations. However, the participants completed a test at the beginning and end of the workshop, and there was still an improvement to mean scores. As well as this assessment,



Essential Pain Management in Kampala

participants and instructors completed feedback forms at the end of each course which overall were extremely positive. From this formal feedback and more informal discussions we put together a report (based on an EPM template), which included a set of recommendations for future work.

These recommendations, including running more workshops in the future, both as refresher courses and for wider groups of clinicians, but also to more specifically targeted groups with more uniform abilities. A lack of protocols was noted to be a 'barrier' during the course and in order to build on the considerable local work underway within palliative care, one recommendation focused on developing nationwide protocols, in conjunction with palliative care, for the

treatment of non-cancer pain. Finally, we included a recommendation to try to assess the impact of EPM with markers such as pain scores, patient satisfaction and the use of analgesics.

I am truly indebted to all those who worked on EPM out in Uganda for their fantastic enthusiasm and hospitality, and in particular to Dr Emmanuel Ayebele who made the whole project 'happen'. I am also extremely grateful for the support of Dr Doreen Birabwa-male, Deputy Executive Director of Mulago Hospital and Dr Cephas Mijumbi, Clinical Head of Surgical Services, and finally of course to the BPS and the AAGBI who generously met the costs of the workshops.

Overall, I thoroughly enjoyed working on this project, but of course with such endeavours come many ethical

questions and dilemmas, with which I continue to wrestle. I do, however, hope that this has been just the first step to future collaboration with the team in Uganda. As you may well have read here in *Pain News*, following on from this project, I am now working with Kate Grady, Doug Justins, the Faculty of Pain Medicine of the Royal College of Anaesthetists (RCoA), and the ANZCA EPM sub-committee to coordinate further EPM workshops across Africa. For more information about this project, please contact us via Dawn Evans at the RCoA (fpm@rcoa.ac.uk). More general information regarding EPM and some basic course materials can be found at the EPM website: <http://www.fpm.anzca.edu.au/fellows/essential-pain-management>



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Looking back

Arasu Rayen *Birmingham*



THE BRITISH PAIN SOCIETY

Pain News

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SAGE



I could not believe that it has been three years since I broke the shackles of 'literary virginity' and voiced my opinions and ideas in an open forum. When the outgoing Editor asked me to write a regular column in *Pain News*, my reaction was similar to the feeling I had when I decided to join medicine, marry my wife or have a child. I had the feeling of uncertainty and the fear of responsibility. There were lots of questions – can I carry out responsible and readable writing? Can I manage the timeline? Can I keep my promise? In three years, somehow I managed eleven columns! Every good thing has to come to an end. My column is no exception (really!). I am sad to say that this is my last *Rayen's Column* (I know how sad you are to miss my column!).

Writing my last column is like giving a farewell. It is similar to saying goodbye. To make it appropriate for the occasion, rather than writing about a new subject, I decided to revisit some interesting subjects that I have written – rather like a farewell speech, looking back on your footsteps. Hope you don't mind!

Health on Net (HON) (*Pain News*, Summer 2011)

I decided to write this because of the experience in the clinic with patients who brought reams of Internet information regarding new and 'wonderful' remedies for their chronic pain problems. I knew that most of the supposed 'miracle cure' remedies were preposterous. Any website can claim that they have the new cure for all the diseases in the world. There is no control on the information published on the medical website. So I searched to find out about the control on information published on websites and bumped in to HON.

HON is a non-profit, non-governmental organisation created to

governance framework for the voluntary health/medical website owners and managers. The idea is that the website owners and managers apply for the HON code of conduct certificate and adhere to it. Having a HON certificate for a website means that the information being published there is accurate, unbiased and trustworthy. There is a rigorous practice of yearly visits to the website by the HON approvers.

The HON website gives valuable advice and tools to the general public and professionals regarding safe navigation on the web if they are looking for health information. It also presents a few reliable search engines for those in pursuit of health information.

HON still has a fully functioning website – <http://www.hon.ch/>. Please note that the previous website address (<http://www.healthonnet.org/>) has changed since I wrote the column in 2011. The layout and functionality of the new website is still the same. At the time of the visit, more than 7,300 websites and 10 million pages from 102 countries uses the HON code. Every day, the HON website gets 27,000 visitors worldwide. It has been translated and is in use in 35 different language versions. This is the same information that I found during my earlier visit to the website in 2011. It looks like the information has not been updated (even though the website states that it was updated 13 June 2013). Even though some information looks out of date and not updated, HON is still a good source to direct your patients to in order to obtain reliable health information.



'promote and guide the deployment of useful and reliable online health information, and its appropriate and efficient use'. The intention of this service is to provide a voluntary

I wish we had ... (Pain News, June 2013)

Professional perspectives

Rayen's column:
I wish we had...

Dr Arasu Rayen, Birmingham



Any sufficiently advanced technology is indistinguishable from magic.
—Arthur C. Clarke
(in: Profiles of the Future: An Inquiry into the Limits of the Possible)

Information such as address of general practitioner (GP). Every registered patient carries this card on their person. When the patient attends the clinic or GP practice, a secured card reader brings up the patient information from the electronic record.

Seamless electronic patient record
Implementation of the National Digital Health Superhighway paved the way to the seamless electronic patient record system. As the name suggests, it is a national digital network where all the registered patient's health records are stored and accessed across the country.

a form of wireless communication between devices like smartphones or tablets. Contactless communication allows a user to wear the smartphone over an NFC-compatible device to send information without needing to touch the devices together or go through multiple steps setting up a connection. The same happens when the patient goes to the pharmacist. The NFC reader on the pharmacy reads the electronic prescription, cross-checks for validity and authenticity, and dispenses the medicine.

Video games for treating painful conditions
Video games have been shown to be of



- Medical service information, including drug allergy history and long-term prescriptions of ambulatory care and certain medical treatments. This information is planned to be gradually added depending on how health-care providers adapt to the system.
- Public health administration information (such as the cardholder's personal immunisation chart and instructions for organ donation).

Their system has been so successful that even United States wants a similar system (<http://www.northcarolinahealthnews.org/2013/08/28/different-cultures-different-systems-comparing-health-care-in-the-u-s-and-taiwan/>). France and Canada are a few of the other countries that have the smart card system. More information on health smart cards around the world and local smart card pilot project can be found at <http://www.bmj.com/content/314/7080/573>.

SMSness (Pain News, June 2012)

Since I have written this article, there might have been a slight decline in use of SMS. There has been a proliferation of instant messaging services. WhatsApp is currently leading the pack. It is subscription based, cross-platform instant messaging service. Hangout (Google), BBM (BlackBerry Messenger), iMessage (Apple) and Skype (Microsoft) are few of popular instant messaging services. Some of the messaging services allow users to have video and voice chat. This can be exploited to carry out case conferences and teleconferences in chronic pain.

The 'other side' (Pain News, September 2012)

In this article, I detailed my close shave with discogenic cervical

Last year, I wrote about ideas about my utopian health service. I desired national health cards, seamless electronic patient record, total electronic prescribing, virtual reality in treating painful conditions and more. A year on, I don't see much improvement towards my utopia. Electronic prescribing may be the only item in the wish list, which may have been used in some trusts. Recently, I came to know that Taiwan uses seamless electronic patient record. They call it health smart card. It is hailed as one of the best systems in the world. It contains following information (taken from the website http://www.smartcardalliance.org/resources/pdf/Taiwan_Health_Card_Profile.pdf):

- Personal information, including the card serial number, date of issue and cardholder's name, gender, date of birth, ID number and picture.
- National Health Insurance (NHI)-related information, including cardholder status, remarks for catastrophic diseases, number of visits and admissions, use of NHI health-prevention programmes, cardholder's premium records, accumulated medical expenditure records and amount of cost-sharing.

Rayen's Column

Looking back

Rayen's Column

SMSness

Dr Arasu Rayen, Birmingham



My mobile phone contract is due for renewal. I have been discussing with my service provider the details of my next

I realised that the culprit could be dopamine, which causes the brain to feel constantly as if it is one of the chemicals involved in reward-driven learning. Among all drugs, there are the worst offenders. According to research, there is an average of 10 to 15 texts a day. Text messaging - aka Short Messaging Service or SMS - is 20 years old. The first SMS was sent on 3 December 1992 over the Vodafone network in the UK. The message was 'Many Christmas', sent by engineer Neil Papworth of the British technology company Cerberus. This was sent across wire and radio, not instantly.

I recently had a referral from a general practitioner (GP) with some observations like 'X', 'Y', and 'Z'. Who knows what will happen in 2032? Abstraction may be the norm in medical correspondence. SMS for text language may be accepted as a norm in day-to-day or least 24 applications to help in disease prevention. Pharmaceutics (PG India Ltd) developed a system of printing unique, random codes with a private virtual phone number on each packaging unit of drugs. Consumers, on buying medicines, send the unique code to a virtual phone number of Pharmaceutics via SMS and receive instant confirmation of the drug's expiration date and authenticity. This is a cost-effective way of fighting counterfeit drugs. Fortinet (ZMC) is an open-source, free software. Once installed, it helps the user to send and receive ZMC to a group of people and collect and analyse data regarding the activity of the ZMC usage. This has been used across the globe, but mainly in the developing world, in various projects to enhance the health of society.

radiculopathy. I am almost free of most of the pain except occasional 'twinges'. I still follow few of the lessons I learned with that. I discovered that my Vitamin D was very low at that time. Literature search found that low Vitamin D is common in the South East Asian population living in this country. But over these two years, I noticed that it is also common in the Caucasian population especially those who have fibromyalgia or whole body pain. It probably needs investigating!

Oh, one last thing!

I borrowed this phrase from Steve Job's book. So I have to thank him for his contribution (in addition to so many). In spite of my uncertainty and fear about the responsibility in the beginning about the adventure I was undertaking to write for *Pain News*, I should admit that I thoroughly enjoyed it. The writing also pushed me to

Rayen's Column

The 'other side'



another severe bout of pain and spine. The pain became intolerable to the extent that I had a near-fatal attack. I had to ask for an ambulance to go from the scanner up to the waiting room. After

As I had had pain I decided that rather than waiting a precious hospital bed, I could go home and take it easy. I had persuaded the admitting team to discharge me so I went down to the lobby

to pre-gablin 150 mg led because of the side effects. I had a neurological consultation, as expected. The advice was to continue what I was doing and be reviewed in a month's time. Car journeys in the last three weeks were very painful. I could not even sit in the car and go for more than a few hundred yards as the pain became more intense. I could not even go to the hospital to do my physiotherapy because of the pain. Luckily, I had a physiotherapy friend who came to my home and helped me. These weeks following my discharge was another saga. I could not sleep properly as lying down and turning over in bed was painful. I had to sleep in a sitting position for so many nights. I hardly had one to two hours sleep at night and I couldn't sleep during the daytime. I had to resort to sleeping if I felt that I needed some sleep. During the night I had to use books to fill the time and managed to finish Steve Job's biography in a week. If I had more sleep at night I could naturally have pain the next day. Daytime TV became my

Looking back

look into the subjects beyond my everyday practice, patient's perspective, the future and my own perception of pain. I learned

a lot during this process. I hope that I made your reading interesting and thought provoking. Good things have to come to

an end. So I have to say goodbye for now. I look forward to seeing you in my editorial in every issue from now on.

Philosophy and Ethics Special Interest Group of the British Pain Society

Annual Meeting 30 June – 3 July 2014

Rydal Hall, Cumbria (www.rydallhall.org)

Compassion in Modern Healthcare: a Community of Care?

To cure sometimes, to relieve often, to comfort always: but have we lost sight of compassion in healthcare? Recent reports have highlighted failures in our healthcare systems: what factors have led to this? Is there a lack of a caring community in the NHS?

The 2014 meeting of the Philosophy and Ethics Special Interest Group will seek to address these issues. Our usual eclectic mix of speakers will present their own viewpoints, providing a springboard for stimulating debate, while the idyllic Lakeland countryside will provide balm for the soul.

Reserve the date in your diary and look out for full details on

www.britishpainsociety.org/members_sigs_philosophy.htm

Save the date

**Annual Scientific Meeting
29th April – 1st May 2014
Manchester**



Don't forget to book your place **now to attend
the British Pain Society's 47th ASM in Manchester
29th April - 1st May 2014**

Why you should attend:

- Network with colleagues
- Raise questions, partake in debates and discuss outcomes
- Meet with poster exhibitors and discuss their research
- Meet with technical exhibitors and hear about their products and services
- Discuss your own research

Join us at this prestigious event and register today online at
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We look forward to seeing you in Manchester.



THE BRITISH PAIN SOCIETY



Picturing pain: using creative methods to communicate the experience of chronic pain

Susanne Main

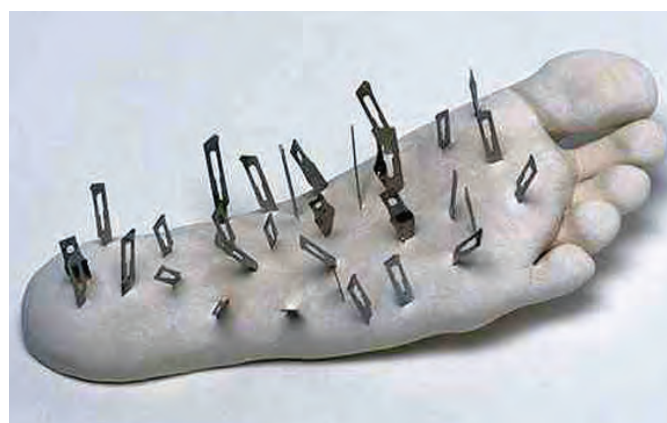
suemain80@gmail.com

Pain News sincerely thanks Mark Collen, CEO and Director, Pain Exhibit, Inc. for giving us the permission to use the illustrations from www.painexhibit.org

It can often be difficult for those people living with chronic pain to communicate the experience because of the condition's subjective and invisible nature. I propose that an alternative form of communication is both possible and appropriate for some individuals with chronic pain. Using creative methods to communicate can aid the articulation of the pain experience visually, providing objectification of it. Such techniques enable insight into the individuals' lived world for both professionals and informal support networks while empowering the individual, potentially enabling greater ability to manage their chronic pain.

Why 'creative methods'?

The term 'creative methods' is being applied as defined by Gauntlett,¹ to refer to methods in which people express themselves in non-verbal ways, through the making of something. While 'communication' is used to encompass more than verbal exchange, namely, the portrayal of emotions and thoughts through language, visual depictions, body movements and so on (Hunter²). While art therapy may be understood as an effective intervention in terms of both therapeutic value and as a pain



Courtesy: Mark Collen, www.painexhibit.org

management tool (enabling distraction from pain and other associated benefits, such as improved mental well-being (Angheluta and Lee;³ Stuckey and Nobel⁴)), this is not the aspect with which the use of creative methods are being considered here.

This article posits that creative methods can be used to communicate the experience of living with chronic pain when expression through language fails an individual. Pain, writes Good,⁵ shapes its world to itself and is dependent upon the sufferer being able to articulate the experience. Yet, the very thing to be

articulated is destroying the means to do so, as pain 'shatters' language (Scarry⁶). By nature of the condition being chronic, there are repeated opportunities for a chronic pain sufferer to relate his or her illness narrative. It should not be assumed, however, that having the opportunity to

communicate equates to doing so effectively. The philosopher Daudet⁷ noted that 'words only come when everything is over [...] they refer only to memory'; it is for this reason that Daudet believes them to be powerless or misleading. Consequently, an alternative means to communicate the condition is of value.

One of the concerns for people with chronic pain is that their expression of it often forms the only evidence that their pain exists (Davey and Seale⁸). Difficulties of measuring empirically an individual's pain add to the challenges intrinsic to

Picturing pain: using creative methods to communicate the experience of chronic pain

living with, and communicating, the experience. This can lead to being dismissed as demonstrating 'abnormal illness behaviour' (Kenny⁹). Using creative methods to visualise and objectify the pain may assist the person to communicate more effectively.

Language, narrative and chronic pain

To have pain, writes Scarry, is to have certainty, but to hear of pain in another is to have doubt (Scarry⁶). Such doubt can 'threaten a pain sufferer's very identity' (Hurwitz¹⁰). Padfield¹¹ notes that being unable to talk about his pain, even to those closest to him, led one patient's 'self' to 'disintegrate'. Pain is unshareable because of its resistance to language (Scarry⁶). The breakdown of language ensures that objectification of pain is impossible. Scarry⁶ argues that it is through objectification that pain can be eliminated.

Scarry⁶ notes that choices of adjectives to describe pain can aid diagnosis, for example, 'burning' rather than 'throbbing' is likely to have different physiological origins. Thus, the role of language and semantics has a significant bearing. Facilitating the visibility and/or objectification of the felt-attributes of pain outside of the person's body will aid communication of their suffering and experience to someone else (Scarry⁶). In turn, this may enable a greater sense of validation and credibility, aiding the management of experiences such as others' scepticism.

People experience illness within a narrative or story which shapes and gives meaning to what they are feeling (Donald¹²). There is reliance upon the ability to use language to construct a narrative that enables the experience of chronic pain to be understood objectively by another person. Consequently, if the formation of a narrative via language is not possible, an alternative means through which to relate the experience of



Courtesy: Mark Collen, www.painexhibit.org

the condition is required. Utilising a 'visual language for pain' is one possible means to facilitate meaningful communication (Novartis Pharma AG¹³).

A visual language for pain

Padfield¹¹ writes of the challenge to share aspects of the 'internal invisible qualities inherent to individual pain' and the attempt to create a 'visual language for pain'. The effectiveness of objectifying pain to aid communication is demonstrated through the ability of images to create a 'shared reference point' that patient and doctor can use collaboratively to 'disentangle aspects of the pain' (Padfield¹¹). Padfield posits that by patients taking control over

what is viewed and its context, a more equal and mutually beneficial starting point for effective communication may be achieved.

Motivations to create depictions of pain have included the frustration of struggling to communicate personal experience, a wish for doctors to have greater understanding, and a desire to let others with pain know that they are not alone (Padfield¹¹; PAIN Exhibit, Inc.¹⁴). Some artworks demonstrate and facilitate autonomy, for example, through creative methods, Yolland¹⁵ has added her own voice to her medical records as a copy of her artwork (*Today's Forecast*) is included among them. This demonstrates that a number of aims may be achieved through creative methods of communication.

Analysis of works of art featured on the PAIN Exhibit website (PAIN Exhibit, Inc.¹⁴) led to identification of themes (Main¹⁶), including emotional responses to the experience of pain, pursuit for effective treatment, or the invisible nature of the condition (Main¹⁶). Communication of pain is a common theme in the art exhibited on the PAIN Exhibit site (PAIN Exhibit, Inc.¹⁴) and may be demonstrated through the depiction of the pain sensation (see Collen's¹⁷ *CP II*) or the experience of living with the condition (see Collen's¹⁸ *CP III – Trapped In Hell*). Thus, the artworks function as a form of advocacy, attempting to facilitate insight into the experience of the condition for the creator of the work.

Use of creative methods to communicate chronic pain

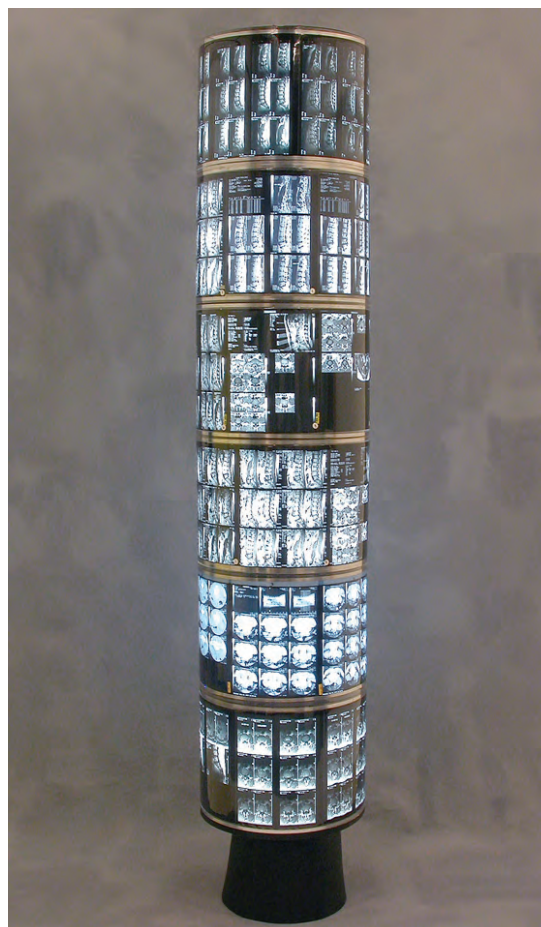
Morris¹⁹ writes that creative uses for unavoidable pain can be found, with pain providing material for 'personal and artistic triumph'. While Morris refers to the spectrum of physical, emotional and mental pain, Hurwitz¹⁰ observes that there are few depictions in art of pain by chronic pain sufferers. He argues that visualisations of pain can play a role in

Picturing pain: using creative methods to communicate the experience of chronic pain

medicine beyond illustrating the symptoms, to include experience and treatment (as seen in Collen's²⁰ work *Hey Doc, Have You Figured It Out Yet?*), as already practised in areas such as educational psychology. While pain may be intangible and subjective, it is not unshareable, in Hurwitz's¹⁰ opinion, arguing that images by those with chronic pain act as 'vivid testimonies' to the importance of the condition. Depictions of the lived experience of chronic pain enable health-care professionals to grasp visually and emotionally the nature of the experience, improving patient care (Hurwitz¹⁰). Consequently, the individual, subjective and 'unknowable' condition of chronic pain may be communicated in a manner that enables the individual to express their experience despite difficulties with language.

The benefits of using creative methods to communicate chronic pain

O'Dowd²¹ comments that public expressions of pain are an attempt at communication, for example, sighing, rubbing and taking medication. As Möller²² observes, without visual representation, pain would be invisible. Having a visual method by which to communicate chronic pain offers an important tool through which an individual may find a means to explain his or her experience. Collen²³ showed photos of art that he had created about his pain to his doctor, stating that, for him, it was the most effective means of communicating his pain experience. Although it may be unrelated, Collen notes that he is treated with respect and compassion by this doctor; the extent to which effective communication through the use of artworks has contributed to this is unclear. However, the validation of his chronic pain experience which Collen encountered as a consequence of the doctor's response to his artwork, may have contributed to effective discourse,



Courtesy: Mark Collen, www.painexhibit.org

even if the artwork itself did not. It is not only with health professionals that Collen has experienced effective communication through his art.

Social networks of friends and family often find it difficult to comprehend the experience of living with chronic pain; creative methods may be effective at addressing this. Collen²³ found that no one was truly able to understand until they saw the art he had created about pain. This demonstrates the potential of creative methods to address issues about the 'unknowable' nature of chronic pain (Good²⁴) and its 'unshareability' (Scarry⁶). The sharing of experience is important for chronic pain sufferers; Daudet⁷ wrote of 'astonishment and joy

at finding others who suffer as you do'. This is demonstrated further by research participants who described the importance of 'no longer being alone or misunderstood with their pain' (Henare et al.²⁵).

Collen²³ states that the 'process of creating art helped to alleviate the crisis [of the pain experience] and was cathartic', through the transference of pain and suffering from being internalised to externalised and objectified, a necessary part of managing the condition (Scarry⁶). Padfield¹¹ writes of the objectification of the subjective experience of pain leading to the creation of a shared reference point from which patient and doctor can work to untangle the pain depicted.

McLaren²⁶ remarks that art helps ease the pain; though vertebrae were burning while producing the piece *Holy Scoliosis!*, the pain eased for some time after finishing. Others remark on the therapeutic nature of producing a work, though this might not always be through the management of the pain itself.

Reynolds²⁷ states that artwork which is psychologically engrossing enhances present quality of life and improves belief in the future. Peterson's²⁸ *Suffering for Art* illustrates, through the depiction of a hand on fire over a pencil drawing, the pain involved in creating artworks, yet the will to do so despite this. Arguably, the use of creative methods of communication facilitates the development of self-efficacy through the empowerment and achievement of creating artworks.

Art and narrative

As Good⁵ remarked, narratives of chronic pain may be told repeatedly, this leads to a re-working of them, just as art can be

Picturing pain: using creative methods to communicate the experience of chronic pain

re-worked. However, in the moment of recording by a researcher or clinician, narratives are spontaneous and 'do not always result in an ordered story' (Thomas-MacLean²⁹). This raises the question of whether art is a more effective form through which to communicate illness as the need to achieve a discernible plot is not the same.

As these works were not created for research purposes, it is unknown over what period of time each was worked on or the extent to which it was re-worked. In addition, the accompanying text (PAIN Exhibit, Inc.¹⁴) is not spontaneously provided; it has been prepared for, and submitted to, a public website. What's chosen to articulate in textual form in that context may not be what is expressed in private or spontaneously. This raises the possibility of artists presenting a certain self (Goffman³⁰), rather than a 'true' self. This may lead to a more accurate representation of the overall experience of living with pain rather than a momentary snapshot. However, it might also be that a certain image is manipulated, for example, to solicit sympathy or to appear more in control than one feels.

Communicating chronic pain

Stickley et al.³¹ have shown that art can reflect emotions, provide a sense of achievement, and promote socialisation and optimism. Reynolds³² notes that many of the participants in her research found that artwork played an important role in enabling the finding and expression of a personal voice. It is through having a 'voice' that autonomy and self-efficacy can be achieved, potentially enabling more effective communication and self-management of chronic pain.

Staricoff³³ notes that when psychiatric patients have used art to show those images in their minds, it provides the

medical staff with the possibility to understand better the patient's illness; it also affords a way in which to follow the development of the patient. Works created at different stages in the person's experience of living with chronic pain may emphasise different elements. This is in accordance with Reynolds²⁷ note that participants recognised changes in their works, during the process of being ill. For example, changed choices of image and colour were associated by the artists with improvements in functioning or coming to terms with illness (Reynolds²⁷).

One method by which to consider the creative communication of chronic pain would be to analyse the artworks according to the display of factors featured in the McGill Pain Questionnaire (Melzack and Wall³⁴). It would be of interest to obtain questionnaire results regarding severity of pain, levels of disability and self-efficacy, to examine alongside the works, seeking any relationships between them. Alternatively, these could be implemented before and after the provision of creative art sessions to examine the therapeutic benefit of using creative methods to communicate the experience of chronic pain. This would be in keeping with Reynolds²⁷ argument for research into the objective benefits of creative arts involvement on physical health and well-being. This article has not considered the requirements for an interest in, or prior experience of, creativity in order for creative methods to be an effective means of communication for those with chronic pain.

Concluding thoughts

The limitations of using language to explain the experience of chronic pain has been explored above. In accordance with the argument of Broadbent et al.,³⁵ it is possible that the use of creative methods to

communicate the experience of chronic pain may lead to the expression of feelings and thoughts that are outside the range of some questionnaires, for example, those used in pain management programmes. Consequently, the use of a 'visual language for pain' (Padfield et al.³⁶) should be explored, as should the provision of sessions that enable patients to explore the use of creative methods as a form of communication. Such creative art therapies can be what patients with severe pain need to find a way of 'expressing themselves without words' (Bullington et al.³⁷).

If used in clinics the patient and professional can use creative methods as a tool through which to construct a dialogue, as shown by Padfield's¹¹ work. Communicating via creative methods can facilitate a discourse to accompany the artwork. In addition, Padfield¹¹ notes that focussing on visual objects, rather than verbal histories, changes the dialogue produced. This is supported by Reynolds³² statement that creating artworks provides a method through which feelings about illness can be expressed. Stuckey and Nobel⁴ cite Sholt and Tavron (2006, cited in 2010), noting that moulding clay can be a powerful method 'to facilitate verbal communication and cathartic release'. While a limitation to the use of creative methods as communication may be the ambiguity of interpretation, the role that artworks can play in facilitating discourse between patient and both their support network and professionals has been demonstrated, together with opportunities for further research. As Pither³⁸ observes, the addition of a visual dimension to narrative can aid communication, by those with unspeakable pain, of that which cannot be said with words.

Due to space restrictions, references are not included but can be obtained from the author by email.

Save the date

**Annual Scientific Meeting
29th April – 1st May 2014
Manchester**

Don't forget to book your place NOW

The British Pain Society would like to invite all healthcare professionals to attend its 2014 Annual Scientific Meeting, which will be held at Manchester Central from Tuesday 29 April – Thursday 1 May 2014.

The new three-day format packs a stimulating and informative programme whilst requiring one day less of your study leave.

Why you should attend

- Learn about new developments and research in the pain field
- Network with colleagues from home and overseas
- Raise questions, partake in debates and discuss outcomes
- Meet with poster exhibitors and discuss their research
- Meet with technical exhibitors and hear about their products and services
- Discuss your own research

Join us, too, at the new 'Bend It Like the BPS' welcome party for a night of food, drink, entertainment and dancing at the National Football Museum in Manchester.

The multidisciplinary nature of the Society is reflected throughout the scientific programme, with lecture and workshop topics chosen specifically to be of interest to all participants, whatever their specialty.



Those of you who regularly attend the Annual Scientific Meeting have become accustomed to a high quality of speakers; 2014 is no exception. We are delighted to have secured a distinguished faculty of speakers from Europe and the UK.

In addition to the scientific programme, participants may view the poster exhibition, visit the technical exhibition, attend satellite symposiums or join in the social programme, all of which run alongside the Meeting to create an informative and enjoyable environment for all participants.



Join us at this prestigious event and register today online at http://www.britishpainsociety.org/meet_asm_register.htm

We look forward to seeing you in Manchester.



THE BRITISH PAIN SOCIETY

The Yorkshire Health Study: informing and facilitating chronic pain research

Dr Mark A Green and Dr Clare Relton



THE BRITISH PAIN SOCIETY

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SAGE

With detailed information on 6,224 individuals who report suffering from long-standing pain, the Yorkshire Health Study (YHS) provides an exciting opportunity for pain-related research. The study can provide researchers with (i) anonymised datasets for secondary analysis and/or (ii) a fast and efficient facility for identifying and recruiting potential research participants.

Introduction

The study was set up in 2009 as a large longitudinal population-based cohort survey collecting up-to-date health information on the residents of South Yorkshire, England.¹ The study, originally known as the South Yorkshire Cohort, was renamed the Yorkshire Health Study (YHS) in 2014 and is now covering the whole of the Yorkshire and Humber region.

Data collection and recruitment

During 2010–2012, information was collected on demographic, current and long-standing health, well-being, health-care usage and health-related behaviour. Location (postcode) is also present in the dataset, allowing further geographical variables such as deprivation to be attached to individuals. Furthermore, the health questionnaire used for data collection included an option for individuals to allow researchers to access their medical records. This will allow National Health Service (NHS) data to be accessed, providing further data on diagnoses, medication and health-care usage. Data for first wave were gathered through a two-stage approach.¹ Patients who have undergone general practitioner (GP) surgeries were contacted, and 42 agreed to participate in the cohort.

Health questionnaires (with a link to an online application form also) were then sent out to all eligible patients (individuals aged 16–85 years) in each surgery.

Regional research platform

The cohort also provides a strong regional health research platform. The cohort can be used to identify and recruit participants quickly and economically to a wide range of studies. The cohort is uniquely set up to facilitate the 'cohort multiple randomised controlled trial' approach to experimental research.² This approach utilises the large cohort study as a research platform to facilitate recruitment to multiple, pragmatic randomised controlled trials (RCTs; with treatment as usual as the control). This approach provides a number of benefits to studies utilising the YHS research platform: detailed information on potential research participants and their efficient (quick and inexpensive) identification² and ongoing information as to the natural history of the condition and treatment as usual. The particular benefits for RCTs include long-term outcomes as standard, increased comparability between each trial conducted within the cohort and increased efficiency particularly for expensive or high-risk interventions.

Results

Data were collected for 27,806 individuals (a response rate of 15.9%), making this a large population cohort size. Of these, 81.7% agreed to be contacted again, and 79.7% provided access to their medical records. From 2014, the size and geographic scope is being expanded.

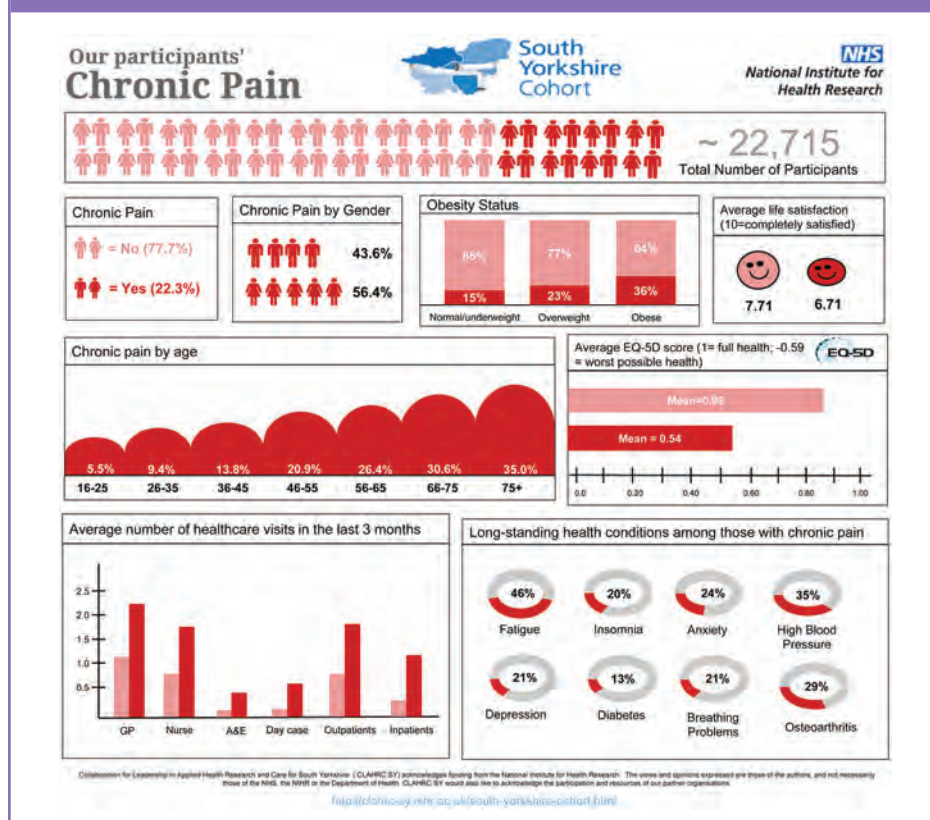
The baseline characteristics of the individuals in the cohort who agreed to be contacted again are presented in Figure 1. The large size of the cohort means that a wide breadth of individuals are captured, useful for recruiting a representative sample in studies. There is a slight bias in the data, with the elderly, females and more affluent areas slightly over-represented in the cohort.

As Figure 1 shows, the cohort captures a large number (6,224) of individuals who are suffering from long-standing pain, highlighting how useful the cohort is for pain-related research. Table 1 presents some demographic characteristics of these individuals. Long-standing pain was more commonly observed in the elderly and females. A social gradient also persists, with it being more common in deprived areas.

Co-morbidities

The co-morbidities for individuals self-reporting long-standing pain are

Figure 1. An infographic showing details of the characteristics of individuals who agreed to be contacted again in the South Yorkshire Cohort, 2010–2012



presented in Table 2. Individuals who reported long-standing pain were more likely to also report other long-standing conditions, especially when compared to the rest of the cohort. Tiredness/fatigue was the most commonly associated condition, although there were also high percentages of high blood pressure, osteoarthritis, breathing problems and depression. The average number of additional long-standing conditions an individual reporting pain had was 3.7. Exploring the interactions between these co-morbidities, social and demographic factors and other health-related dimensions presents a new and policy-relevant area of research.

With the first wave of cohort data only recently collected, use of this first large dataset is at an early stage. Studies so far have explored how weight management strategies differ by deprivation level and the association between diabetes and disability in younger adults. The YHS research platform has helped researchers to recruit participants to a wide variety of studies since 2011. These have included both qualitative studies and trials. Topics covered include improving the

Table 1. Demographic characteristics of individuals reported long-standing pain

Variable	Percentage
Age	
16–25	1.4
26–35	4.0
36–45	7.7
46–55	14.4
56–65	25.5
66–75	28.8
76+	18.3
Sex	
Male	43.6
Female	56.4
Indices of Deprivation 2010 Quintile ³	
Least deprived	9.3
Low deprivation	20.1
Average	15.0
High deprivation	20.8
Most deprived	34.8

Table 2. Co-morbidity of individuals reporting pain in the study

Long-standing condition	Percentage with (%)
Fatigue	46.3
Insomnia	19.0
Anxiety	24.0
Depression	20.6
Diabetes	13.3
Breathing problems	21.5
High blood pressure	35.6
Heart disease	14.0
Osteoarthritis	29.0
Stroke	4.9
Cancer	5.5
Other	38.4

The Yorkshire Health Study: informing and facilitating chronic pain research

self-management of long-term depression (IQuEST), investigating how people make decisions concerning weight management (DaWM) and telephone friendship groups to improve well-being in the elderly (Putting Life in Years (PLINY)). The first RCT trial utilising the YHS and the cohort multiple RCT design² is now being implemented. This trial is testing the effectiveness of treatment by homeopaths for people with self-reported depression (DEPSY).

A list of current and past projects can be viewed at <http://www.yorkshirehealthstudy.org/#!/your-research-studies/c17r5>.


If you are interested in either YHS anonymised datasets for secondary analysis or the YHS facility for identifying and recruiting potential research participants, please do contact Dr Clare Relton (email c.relton@sheffield.ac.uk) or Dr Annette Haywood (email a.haywood@sheffield.ac.uk).

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LIPS

Low-dose Intravenous Immunoglobulin Treatment for Complex Regional Pain Syndrome



BATH

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LONDON

NORFOLK & NORWICH

LEICESTER



Inclusion/ Exclusion Criteria:

- Patients with a diagnosis of complex regional pain syndrome I or II according to Budapest criteria
- Moderate or severe pain
- Aged 18 years and above
- Disease duration of between 1-5 years
- No other significant chronic pains, or unstable medical conditions.
- Willing and able to travel to a recruiting site

(if you are uncertain of any of the study requirements please contact us to discuss)

This trial is led by Dr Andreas Goebel, Consultant in Pain Medicine at the Walton Centre NHS Trust and is managed by the King's Clinical Trials Unit (UKCRC) London. It is funded by MRC/NIHR (EME).

Recruiting investigators are:

ANDREAS GOEBEL
The Walton Centre NHS Trust, Liverpool

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All participants for the study need a referral letter from their GP or pain Specialist. This should include all relevant clinic letters. If you have a patient who wishes to take part and you would like a referral template, or for any other queries about the study please contact Miss Holly Milligan on h.milligan@liverpool.ac.uk, or on 0151 529 5835.

Hoist the Blue Peter! An update on Traveling Pain School

Dr. P. Vijayanand *Convener, Traveling Pain School, India*



The Indian parliamentary elections are upon us in a few short months, where an 800 million strong electorate would be casting their ballots to elect the 16th parliament. Traditionally fought along multiple axes (pun intended) such as class, religion, gender, caste and region, this once-in-five-year exercise is a smörgåsbord of emotions, people and culture. All the more compelling are the shrill debates in the media, forecasting a future which is simultaneously reminiscent of a Stalinist Gulag, a Mussolinian nation and – because of the falling rupee – a Weimar Republic. None of these would happen, of course. Not when our timid rule makers are content with flirting with and pirouetting around Ms Big Idea constantly, rather than asking her hand. Not when there is a constant disruption of parliamentary proceedings due to varying agendas,

diversity of opinions and political turmoil. Not when cutting across party lines and coming together on a common platform, for a worthy cause, is anathema. So much so that, to put a convenient gloss, the parliamentarians could not bring themselves together to make amendments to the draconian Narcotic Drugs and Psychotropic Substances (NDPS) act, which would have simplified access to morphine for the suffering millions.

The need for undergraduate pain education

While these endless debates on arriving at a policy decision could pass off for attempts at idealism, the implementation of such policies could do with a bit of realism. Often the executive machinery would sport the look of a man on a flight home from a holiday, when the reality slowly dawns on him that he has left his house keys in the hotel safe. To fulfil the medical needs of the rural population, the government of India is in the process of introducing compulsory rural service, following graduation, for medical undergraduates. India produces more than 40,000 medical graduates every year, but pain management is not part of the undergraduate medical curriculum. On the one hand, inadequately taught and ill-equipped junior doctors, under duress, might be left to tackle complex pain problems in resource-poor settings. On the other hand, despite the good intentions of the government, patients might be at risk of sub-optimal care. To untie this Gordian knot, which involves

multiple stakeholders, would be to empower the undergraduates with the requisite skills and knowledge to manage pain within a simple framework.

Essential Pain Management

To improve pain knowledge among Indian medical students, Traveling Pain School has launched a nationwide educational programme utilising the teaching capabilities of locally available specialists. More than 250 undergraduate students participated in the pilot projects which were held at Ahmedabad (Gujarat) and Theni (Tamil Nadu). Delivered as interactive lectures and group discussions over five hours, it addressed the practical components of managing pain competently, including overcoming barriers for effective pain care. The curriculum, teaching content and delivery method were adopted from Essential Pain Management (EPM) of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists. With the feedback from the students being overwhelmingly positive (with the occasional admonishment for not serving hot samosas), the formal inauguration of EPM for medical students has been planned for early 2014 at Hyderabad, India. The EPM faculty, travelling to teach from across the world, would be involved in the 'Train the Trainers' programme, with which the multi-disciplinary delegation of medical and allied health specialists from across India are expected to benefit. This ecosystem of cross-pollination, we hope, would benefit



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close to 3,000 medical students this year, with plans to scale it up to teach 10,000 students every year.

Pain in the virtual world

This year, with 250 million Internet users, India is poised to overtake United States as the second largest Internet base in the world after China. A third of the online population are from rural India, three-fourths of the online population are under-35s and seven out of eight access it from their mobile phones. Distributive justice, for a volunteer organisation such as ours, engenders the cost-effective use of the now not new-media. It has given us plentiful ideas about how to choose our emphasis and where to invest our energies – on education and advocacy. Drawing inspiration from the 2009 'Survey of undergraduate pain curricula for healthcare professionals in the United Kingdom', of the British Pain Society and the recently published 'Advancing the provision of pain education and learning (APPEAL)', study by the European Pain Federation (EFIC®), an online survey of Indian medical students called IMPACT – Indian Medicos Pain Awareness Curriculum and Training – has been initiated. The results of which would be made available to the various stakeholders later this year. Another area of focus is to aid the exam preparation of postgraduates. The videos and webinars on exam-oriented chronic pain topics planned for the year, we hope, would

supplement the teaching (if any at all) on the subject. The usual culprits – Facebook, Twitter and the obligatory website – have all been made part of the social media strategy towards this.

Advocacy

Writing about the un-pigeon-holeable frenzy that is Indian elections, without being prolix, is an onerous task. As bewildering as it could be wearying, under the Model Code of

Conduct, no new projects with support from local political leaders could be launched close to the elections. The Election Commission of India, a powerful constitutional body, ensures this to provide a level playing field for all the contestants. The Traveling Pain School's project to adopt a village in one of the most backward and poverty stricken districts in the country has, therefore, been put on hold till the party is over. For, any local politician in league with us would be barred from contesting the elections, and without the support of all concerned, projects such as this are non-starters. This does not, however, stop us from providing self-management tips and recent research on pain, in plain English, over the Internet.

Inextricably tied to our advocacy efforts is our contention that it should be towards capacity building, increasing the knowledge base and creating a medical force skilled in managing pain effectively. An online multiple-choice examination leading to an undergraduate prize in pain medicine is part of it. Similarly, part of the proceeds of the sale of the *Textbook in Pain Management* (third edition), edited by our core committee member and released recently, has been directed towards our efforts. The learned societies, in particular, the Indian Society of Anaesthesiologists

and the Indian Society for Study of Pain, had been steadfast in their support for our programme. We have, in addition, been in touch with other learned societies to evolve an interdisciplinary strategy which could contribute to a national pool of dedicated teachers in pain medicine. Furthermore, strategies to utilise the services of the diaspora of pain management professionals across the globe are being put in place.

The journey so far

How far one should explore pain education and advocacy is hard to describe when it is the ocean and we are the plankton. A similar jeremiad from me was published in the spring edition of this newsletter last year, where the challenges specific for India were highlighted. The journey hitherto has been both exponentially difficult and



exceptionally rewarding. The team work made sure that the ideas floated were not lead balloons. An important idea, then, was to reach out and teach 1,000 practising physicians in a year. We managed that and beyond, reaching out to a 1,300 physicians. In doing so, the faculty collectively travelled a distance of more than a 120,000 km. More than a hundred thousand pages of printed material on evidence-based pain management were distributed, and more than a thousand e-books on basic concepts in managing pain were

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delivered. This makes the endeavour by far the largest in scale, and reach, ever attempted in the country. The total expenditure stood at 5,000 pounds, half of it coming from restricted educational grants and the rest from our savings. But

to dwell upon this is to put too fine a point on too fine a point.

The future

Inspired thereof, the leitmotif has been carried with conviction in other parts of the country as well. Karnataka, a state with a population of 60 million, is currently being criss-crossed by a team of dedicated teachers, not least by some who are fellows of the Faculty of Pain

Medicine of the Royal College of Anaesthetists. To postulate a golden age for pain education – in our exuberance, though there is nothing irrational in it – would be to cast a jaundiced eye on all

that came before. The brilliant Russian chemist Dmitri Mendeleev had a considerable penchant for Sanskrit – the liturgical and philosophical language of many a religion in India. One should excuse us for feeling like Dmitri in 1869, sitting in his study and organising the elements into a periodic table. Like Dmitri's, there are as yet many more missing elements to our efforts. But, like him, we are sure enough that our table is right. We have no qualms about leaving the blank spaces. We hope that the future, full with the spirit of volunteerism, would prove us right by filling in the blank spaces. We hope that the Indian elections – that refreshing celebration of democracy – would still be part of that future.



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Learning and teaching about pain: the evidence and the values

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All the biomedical sciences, most social sciences and most clinical sciences can be included in teaching about pain. This can be integrated both horizontally, linking the material that students are learning at a particular time, and vertically, as you can spiral back to more complex pain topics during the clinical years developing student understanding.

Pain is also an ideal topic for students to learn what shared decision-making looks like. I like to talk about learning *with* patients; it is important for students to realise that they learn as much from patients as they do from physicians. I hope that nowadays people teach around patients and not 'cases'.

The patient isn't defined by the condition or by pain, and the rule 'no teaching about me without me' should be observed. The days of the secretive ward rounds where clinicians disrespectfully cast aspersions on the history of some patients describing chronic pain should be long gone.

Person-centred health care

The recently launched European Society for Patient Centred Healthcare defines this as

that which takes full account of patients' values, preferences, narratives, cultural context, fears, worries, anxieties, hopes and aspirations.

I would emphasise *hopes and aspirations*. Conventional communication

skills teaching about the patient's *ideas, concerns* and *expectations* can result in a focus on the negative aspects of patient 'concerns', whereas emphasis on the positive drivers can remind patients of the things that can get you out of trouble.

I believe passionately in the importance of narrative. Some years back, I was involved in the design of the new graduate entry fast track medicine course at Oxford, which included a day a week of clinical learning from day one before students know anything about medicine, which involves just listening to patients. I have used this again and again even at the stage of postgraduate medicine. There is evidence that we actually harm students' inherent capacity for communication even though we try to teach communication skills. I emphasise that people must learn to *listen* before they learn to *format* the history into present complaint and past history and so on. I rarely down-rate a student because they have not formatted in a disciplined way, except when they have not heard the appropriate story or have not facilitated the telling of that story. They can do it quite well naturally, and all that needs to be taught is to check back that we have captured what they are trying to tell us.

Medicine is about a person interacting with a person: one is the expert in their own condition, and the other may be trying to become more expert in the management of similar conditions.

Values-based practice

The values of each individual service user or client and his or her communities must be the key determinant for all actions by professionals (National Institute for Mental Health for England). In teaching values-based practice, we like to invoke the 'two-feet principle': the best clinical decisions are based both on the best available scientific evidence and on the values relevant to the individual patient situation. These are two very different paradigms. In a biomedically dominated world, scientific evidence is generally gathered on populations, and the randomised controlled trial (RCT) ranks very highly. Thinking about individual values means looking at an 'n of 1'.

When I ask you to come up with words which convey 'values', some of your words would be *examples* of values like integrity, hope, truth and sincerity; some would be *descriptive* words like beliefs, meanings, passions and principles; and some which emphasise a *quality* of values – their importance, their dimensions – such as direction, heartfelt, individual. There is a common link: values are above all action-guiding. If we want to understand how a person might act or how we might want to act, we need to look at values.

Evidence-based medicine (EBM) was defined by Sackett as the integration of the best research evidence, clinical experience and *patient values*; the latter defined as the unique preferences, concerns and expectations that each



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patient brings to the clinical encounter and which must be integrated into clinical decisions if they are to serve the patient.

For example, in the debate about caesarean section, the Royal College of Obstetricians and Gynaecologists (RCOG) recognised that patients' requests should be taken into consideration as well as concerns about obstetric safety and so on. Here is policymaking influenced by values and the recognition that EBM is not the trump card that we can beat patients about the head with in the way that we used to. We are now expecting clinicians to balance evidence with values, to say to patients 'this is the evidence – what do you feel?'

A curriculum for the training of general practitioners (GPs) requires that

All General Practitioners should be able to:

Recognise the ethical dimension of every healthcare encounter.

Identify the values that patients, families and members of the healthcare team bring to a specific healthcare decision.

Understand the nature of values and how they impact on healthcare.

Demonstrate moral reasoning skills in the process of choosing an appropriate course of action or resolving conflicting values.

Use knowledge, skills, and attitudes for effective communication in eliciting and understanding the values of patients, negotiating an acceptable course of action and justifying that course of action.

Demonstrate knowledge of the professional ethical guidelines and legal framework within which healthcare decisions should be made.

Recognise their personal values and their influence on decision-making.

So when we talk about respecting patient values, do we mean medicine

which is 'patient centred?' – or 'patient focussed?' – or 'patient led?' – or 'patient empowering, or enabling?' Or in which 'anything goes'? It is only that last I would disagree with. It would be doing our patients a disservice to change from paternalistically telling patients what they need to saying 'yes dear – you decide what you need'. We cannot deny our expertise when we believe it is of help to that patient.

Patient enablement and empowerment

Patient Enablement describes the effect of the clinical encounter on a patient's ability to cope with and understand his/her illness, encouraging the patient to realise his/her autonomy.

J.C. de Sousa



In the National Health Service (NHS), most of us have to do patient satisfaction surveys. Satisfaction is conceived as a consultation outcome in and of itself, and these surveys say very little about how we have actually helped people. This is in contrast to *enablement*, which is conceptualised as an indicator of the self-efficacy benefits of consulting a doctor, is expected to be associated with behaviours like treatment adherence and self-care and is much more useful. Patient empowerment helps people gain control over their own lives, their

communities and in their society, by acting on issues that *they* define as important.

Values-based practice starts from a basis of mutual respect for a diversity of values and excludes things like racism which is disrespectful of others. All the '-ists' – sexist, racist, ageist – need special skills to work with to achieve mutual respect.

We try to integrate two forms of values reasoning: first, *principles reasoning*, as with Beauchamp and Childress' four principles of beneficence, nonmaleficence, justice and autonomy. These principles will not of themselves answer ethical dilemmas, but they do help define the parameters and give a really helpful format of reasoning. Ethics based on process are much more useful for decision-making than those based on rights. The other form of reasoning includes *casuistry*, or *case-based reasoning*. If you're stuck with a patient

who has come to you with a difficult dilemma and you are wondering how to handle them, you may want to first apply the four principles and then relate it to other cases that you or your colleagues may have seen. It can be very effective to use more than one approach. It is easy for those who have been trained in critical appraisal to find knowledge involving scientific evidence; finding knowledge about values is

more difficult but the resources are available.

Balanced decision-making within a shared framework of values

The use of a shared framework, which I think will work in pain, is exemplified by assisted suicide. Say a patient comes requesting this, and if as a physician it goes straight against my values, there is a conflict. I would tackle that in the light of values-based practice by listening to a

patient's values and their narrative, and then demonstrating that all important understanding, showing that I have heard, that I am respectful in my hearing and that within the limits of understanding what another human being thinks, I have done my best to appreciate and respect the values they have revealed. I would then expose my own values and why I hold them, and clarify the differences between us. At that point, we may agree to disagree and constructively work around our differences:

OK, let's look at what we do have in common: both of us want you not to suffer, both of us want you to have a death in which you lose neither your dignity nor the respect you want, and between us we can achieve a huge amount on that

It is looking for that common ground. Our different values have been recognised and *worked with* instead of allowing them to become a barrier between us – using dissensus constructively.

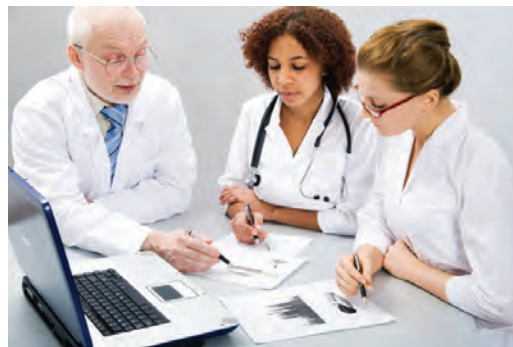
Undergraduate teaching

How do we communicate values awareness? A medical student assured me that patients with prostate cancer don't care about sexual function on the grounds that the one patient he had seen with the condition was quite clear he did not care about it, and he had extrapolated it to everybody. We all do this and we all have a psychological bias to believe that surely everyone thinks like we do ('surely' is a red light warning word!) And we forget how impressionistic those early medical experiences are on students. We can teach how to balance the two-feet principles. You can relate this to your teaching about pain management.

To return to consensus and dissensus, when it comes to the evidence base, we

want to teach consensus. I would hope that if I am managing a patient with pain and you know a better way, we will try to achieve consensus. But with values, we have to learn the completely different skill of dissensus, working across differences, and that isn't emphasised a lot in conventional teaching. We don't notice values when we are all going in the same direction, but when consultations go wrong, it is more often because clinicians were not able to deal with the values than because they did not know the evidence. It is useful to allow learners to get it wrong and then demonstrating a better way.

Students have a tendency to jump in with the biomedical stuff and completely forget everything they have received from



patients. They have to learn that sharing information involves a two-way conversation. I see many postgraduate learners as well as early stage students who have failed to grasp this. Questionnaires can get in the way of communication.

In the context of pain, a values question might be something like 'What does your pain mean to you?' We have established the nature, site, intensity and so on of the pain, and found out how it is restricting activities and so on, but it still remains to ask an open-ended question like this to establish whether there is any disassociation of values. We need to understand at a philosophical level what pain is about for them. For instance, do

they feel that they are being punished for something? We will not know unless we ask. There may be cultural or religious issues. We need to be able to ask someone from a different culture about their sexual practices without causing mortal offence. Cultural competence is important but can lead to assumptions, and assumptions are the enemy of values. The more we assume, the less we find out.

We referred earlier to taking forward communication skills teaching in values-based practice. Three keywords derive from the three main models of communication skills teaching used in the United Kingdom. They are *ideas*, *concerns* and *expectations*, which result in the acronym ICE, beloved of medical students. For better

communication around values, we add patient *strengths*, *aspirations* and *resources*, thereby developing the acronym ICES^{tar}. A danger of acronym reminders is that they can encourage 'tick-box' behaviours in novices who have yet to become fluent in communicating with patients.

You, as pain experts, would be able to teach these skills because it is something you do incredibly well when you have a patient

whose pain is getting in the way of their way of being. You do look with them at their strengths: *how did you overcome past obstacles – what did you bring to bear when you had similar trials and tribulations in your life – what are your aspirations – what are your resources – what else can you draw upon?* These are the underemphasised aspects of communication generally. But you must not forget to identify values – the patient's, the learner's, your own and the societal and institutional values in the background – when you are teaching about pain; you should show how to bring values and evidence together when you approach your

clinical decision-making. Please never forget that role-modelling has a significant impact on student professional attitudes.

Ed's simple model of clinical decision-making

I developed this model to improvise the way we actually gather information. Often, what we gather about a patient in the conventional ways of history, examination and investigation leads to immediate action, and there is only one appropriate treatment. Leaving that aside, I am concerned with how we interact in the clinical consultation with what we know about the patient.

Conventional medical teaching suggests that there can be no treatment without diagnosis; we work with our patient to narrow down the range of likely

diagnoses. But at the same time, and particularly in primary care, in many clinical situations, management decisions are reached before a firm diagnosis is reached. There is nothing wrong with that. You can start with all the possible actions, but you might, for instance, rule out surgery fairly early and arrive at much simpler possibilities of management. Management decisions and diagnostic decisions go together, and you cannot make a diagnosis without evidence, be it a science base for a structural diagnosis, or a 'social' diagnosis, not forgetting that evidence involves your clinical experience as well.

But you also need values. People say to me, *'hang on – I can see that values can guide management but what have they to do with diagnosis?'* I think they have an awful lot. Let us think about the patient with depression. How do we

characterise her illness, pain or suffering? Has she got 'sadness', 'depression' or 'stress'? What are we going to call it? All diagnosis is value-laden. So what we are trying to achieve is a professional judgement that involves moving forward with a plan based around our total knowledge of the patient.

In my model, we build a sphere of knowledge about a patient. Coming from a universe of possible diagnoses, and possible options for management, we use our skills in evidence basing and values basing to 'square down' to probable diagnoses and appropriate management plans that best 'fit' the patient. Professional judgement and empathic working with our patients will help us achieve balanced decision-making within a shared framework of values.

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Compassion in healthcare: Report of a meeting held at Royal Society of Medicine, November 2012

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The author prepared this report which was presented in the Philosophy and Ethics SIG Meeting at Launde Abbey; Peter Wemyss-Gorman has kindly prepared the transcript for the benefit of our readers. As this is a subjective impression of the authors, they do not claim accuracy as to their actual words.

This meeting was run jointly by the Royal Society of Medicine (RSM) Open Section and the Institute of Medical Ethics, in association with The Human Values in Healthcare Forum. The objectives were to address the barriers and facilitators to compassionate practice, to examine the ways in which education can affect compassion and to share ideas, resources and experiences of effective strategies for developing, promoting, delivering and sustaining compassion in healthcare.

In his presentation *The science of compassion in the healthcare context*, Paul Gilbert, Professor of Clinical Psychology and Head of Mental Health Research Unit, University of Derby, stressed the importance of agreeing to a definition of compassion without which we may waste time talking at cross purposes. He suggested this definition by the Dalai Lama:

Sensitivity to the suffering of self and others with a deep commitment to try and relieve and prevent it

Note *self* and others. In Western culture, and particularly in the caring

professions, it is very easy to overlook the importance of self, and think that compassion is all about other people. Compassion starts with ourselves; that is not selfish or egotistic, it is essential. It is like love: unless you can love yourself, any love you can give out is always going to be conditional. Compassion always has to be unconditional. We do not want anything back from our patients. Compassion has an actual measurable outcome. It affects the brain in regions involved in behaviour and motivation. Threat and competition also affect these regions and therefore reduce compassion; it is difficult to be compassionate if you feel threatened.

Compassionate goals (e.g. *'Be supportive of others'*) often work against self-image goals (e.g. *'Avoid the possibility of being wrong'*). Ideally, compassion should be accompanied by reduced self-image goals. Compassion is not just caring. It involves caring *and* helping. It involves both head knowledge and direct experience. Humans function best (for instance, as regards the immune and cardiovascular systems) in a compassionate, non-threatening environment, and the human brain is very

sensitive to kindness and compassion. Compassion is promoted through relationships. The most important things in life involve our relationships with other human beings.

Prof. Gilbert described three systems by which emotion is regulated. The first involves our response to threat and self-protection. Let us imagine, for example, wanting our children to do well in their exams. The first is the threat system: *'get an A or I'll kill your guinea-pig'*! The second is the reward system: *'get an A and I'll buy you a guinea-pig'*. The third involves enhancement of contentment and promotion of feelings of safety: *'how are the guinea-pigs doing? how's the swotting going?'* We probably all find ourselves slipping into the first two because they are easy and have directly measurable results. The third one gives the best results but is difficult to measure. When threat level is high, we respond in a threatened way: threat-focus takes over and leads to threat-focused solutions. If threat is low, we can form collaborative relationships and creativity flourishes.

We would all like to be in an adult-to-adult relationship with our patients, but

Compassion in healthcare: Report of a meeting held at Royal Society of Medicine, November 2012

all too often find ourselves in a parent–child situation, where the patient is acting as a child and wanting you to be the parent. When the National Health Service (NHS) was set up, most of the doctors were used to milking their rich patients so that the poor people could be treated for very little. They were highly committed to providing healthcare for all. In the beginning, the NHS was a collaborative and cooperative venture informed by a compassionate and facilitative mentality, but it has moved towards a threat/reward mentality – the easy option – driven by competition, fear of error and litigation, and targets. Threat reduces compassion as their psychologies are incompatible. There is a pressing need to identify inhibitors and facilitators for the development of compassion. It is no good just telling people they have to be more compassionate.

In her presentation *Compassionate care from resilient professionals: removing the barriers*, Dr Alys Cole-King, Consultant Liaison Psychiatrist, Betsi Cadwaladr University Health Board, drew on her experience of people who had tried to commit suicide. She wanted to examine the feasibility of compassion in the real world: to take it from something that would be nice to something *actual*. There is a need to remove barriers between doctor and patient: not only organisational barriers or those imposed by ‘good working practice’, but also personal and professional barriers like lack of time, the fear of missing something or making matters worse and tolerance of others’ distress.

She acknowledged that it is more difficult, if not impossible, to be compassionate if you are having a bad time yourself, for instance, if you are being threatened by your superiors or in competition with your peers. If you don’t develop a compassionate relationship with a suicidal patient, they are not going to open up and tell you their ‘most shameful’ secrets. They are likely to go out of the door and try again.

Compassion can make the difference between suicide and carrying on. Identifying and addressing issues and *listening* can make a huge difference. Samaritans provide a great example of compassionate listening.

The next talk, *Compassion and the education of doctors*, by Professor Jenny Firth-Cozens, Clinical Psychologist, Imperial College, struck a chord with Sarah Dixon who has recently had a major experience of being a patient and was only too well aware of the difference between compassionate and non-compassionate healthcare. ‘*You want to get better for the nice doctor! – you want to be a good patient*’. Like everyone else, doctors have an innate fear of things like death, disease, distress and disfigurement happening to them. Physical and psychic pain can cause pain to those



witnessing it. Coping strategies such as avoidance of death and failure to engage with dying patients and the inappropriate use of humour are incompatible with compassion.

Doctors often work with high levels of stress and are especially vulnerable to depression, burnout and anxiety. Stress levels are even higher in managers than doctors. Organisational factors such as targets increase stress and decrease compassion if they increase distancing from patients. The biomedical model of training doctors – looking at the disease instead of the patient – is not conducive

to learning compassion. There is evidence that empathy decreases over training. Students enter medical school wanting to help people but find they want to do this less and less over time. To counter this tendency, it has been suggested that there should be proper assessment of and reward for compassionate care, and compassionate care should be included as part of personal and professional development. But this is very difficult to measure. Role models for students are tremendously important. They should model self-compassion and look after juniors compassionately.

Learning to get close to patients may be facilitated by role-playing sessions and by sharing the experience of doctors who are themselves patients. ‘Family liaison’ sessions involving talking to the families of patients are also very valuable.

Encouraging juniors to express their feelings and difficulties in a non-judgemental setting is very important. All too often, if a medical student sees something that doesn’t seem right – for instance, the way a doctor spoke to a patient – they may have no one to talk to about it.

Organisation of hospital care is frequently not conducive to compassionate care. Compassion takes time. There has been strong advocacy for the adjustment of accident and emergency (A&E) targets with this in mind. Managers must be compassionate too, and need to address staffing issues leading to high levels of stress. High bed occupancy (currently approaching 100% in some hospitals) makes compassionate care particularly difficult. Compassionate care is important not just because it is good in itself but because it also has significant practical good consequences. It increases patient satisfaction and improves outcome. It reduces the risk of litigation, even if mistakes are made. Re-attendance rates are lower if the patient is treated with

compassion. It is better for staff and reduces rates of staff turnover.

In her talk *Compassion and the education of nurses* Dr Ann Gallagher, reader in Nursing Ethics, University of Surrey, advocated the adoption of 'slow ethics' and the need to calm our frenetic lives and let virtues such as integrity, patience and respectfulness prevail. The 'slow movement' is the antidote to our obsession with fast food, fast travel, fast parenting and fast life. Life should be approached with care and attention and we should attempt to live in a meaningful, thoughtful, sustainable and pleasurable way. It requires courage and integrity as well as patience. This contrasts with the prevailing 'fast ethics' involving a 'quick fix' mentality, focussing on single values and over-simplification of complicated issues. It is typified by the tendency of doctors to hurry into dealing with patients' current symptoms and disease and unwillingness to listen to their back-story, and a disinclination to learn from past failures of treatment. There is a tendency to over-rely on ethicists – apparently in the United States, large hospitals employ an ethicist who can be bleeped if an ethical problem arises instead of working things out for ourselves.

Virtue Ethics (the theme of the BPS Philosophy and Ethics Special Interest Group (SIG) conference a couple of years ago) is of particular relevance in this context as it asks, in a particular situation, the question '*how should I be*' rather than '*what should I do?*' – a much better guarantor of right judgement than reliance on algorithms and speedy expert responses. Dr Gallagher suggested that the implementation of 'slow ethics' in healthcare involved four key measures: first, listening and dialogue – taking time with patients, families and practitioners; second, learning from research, scholarship and engaging with other disciplines; third, leading by example in articulating, aspiring and valuing care both as professionals and citizens; and

finally, living slowly and mindfully – appreciating and celebrating people, places and practices. One might be forgiven for wondering how practical an approach this is in the context of the NHS, but as a guiding philosophy, it has much to recommend it.

In an inspiring presentation on *Strategies for enabling compassion*, Professor Raanan Gillon, Emeritus Professor of Medical Ethics, Imperial College London, suggested that a cynical, anti-humanity attitude is contagious. If high-level managers or doctors don't believe in a compassionate, hands-on approach and express these views, it will foster a culture with reduced compassion. The scientific and human approaches are not incompatible. It is perfectly possible – indeed essential – for a doctor to be technically highly proficient as well as a compassionate human being. Self-reflection is very important.



Dr Jocelyn Cornwell, Director of the *King's Fund Point of Care Programme*, described its aims as '*to help healthcare staff deliver the quality of care they would want for themselves and their own families*'. She quoted many testimonials of horrifyingly bad care. Staff seemed astonishingly unaware of patients' distress, and to ignore their feelings, until they were told about these after the study. She conceded that it was extremely difficult to leave your personal

prejudices at home and avoid being judgemental.

Schwarz Center Rounds are monthly hour-long meetings that give healthcare staff time to open and honestly share and explore their feelings in a non-judgemental setting. They enable staff to feel less alone, and even if only small proportion of staff attended, there will be a large subconscious effect on other staff.

At the end of the programme, participants split up into several workshops from which the same central themes involving building relationships emerged. These were, first, connecting with the person as an individual, not a diagnosis or label. When you stick a label on a person, you don't see them anymore. It is very difficult not to label because that is what we are programmed to do. But we have to avoid this if we are to allow people to stay themselves and to have normal

human-to-human interactions with them. The second theme was the importance of time, and of 'being in the moment.' Healthcare staffs often lack time to just be with their patients. A better example is hospital chaplaincy: chaplains are paid to have time for staff and families as well as patients. Although teamwork and trust within a team are vital and can be facilitated by mutual respect between team members, high turnover makes it difficult to develop trust over a long time.

Conclusion

Although compassion in healthcare is vitally important and improves outcomes for patients and staff, there are formidable organisational, personal and professional barriers to putting it into everyday practice. Overcoming these involve personal reflection and relationship building as well as training, of which role-modelling is a vital ingredient.

End stuff



THE BRITISH PAIN SOCIETY

Pain News

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 SAGE

Good-Bye Pain I Don't Want To See You Again: A Banishing Ode To The Opiate

Dear Opiate,
If I take you
I am an Idiot
For you are no chariot
Out of Hell,
You can not simply quell
What I long to dispel:
The physical beastly Agony
That I can not endure indefinitely.

Albeit I take you as I am riven insane by pain.
In vain I had sworn to abstain,
Because I know what you do –
It's untrue that you simply subdue;
You bastard – you follow through,
With a nefarious stew
Of side-effect Kung-Fu
Because, you evil little narcotic,
You are quite, quite despotic;
After the longest while
You eventually allow me to
Writhe and wretch,
I heave and shake and am sick
And you certainly are no magic trick
To kill this pain that
Sends me Insane
AGAIN and AGAIN and AGAIN.

As I quiver and shiver and heave
Reaching decibels for which there are no parallels
I cleave to the hope,
That, if not in my horoscope,
There's something that soon will emerge;
Something to finally purge and let me elope
Away and away from this land of pain
That I have tried
In vain to Explain
Because my small brain
Just reaches for the profane
As I fumble to describe the impossible:
Physical pain that swindles you of life
And makes you a caterwauling animal
Clinging on well below sub-optimal
I say: 'No more Opiate!'
Because after such a long while
It surely is appropriate,
That I am rendered capable of bidding you Adieu!
Because I want my life:
No more pain as sharp as a knife;
And I'd quite like to be someone's wife:
I'm not ready for the afterlife
I want to stay here
Here, you hear,
For many, many a fine long year.

By Lucy Mayhew



Commentary to the poem

In spring 2008, all semblance of life as I knew it was forced to a standstill. I was in my twenties and had been working as a freelance journalist writing for the London and national newspapers and women's glossies. I placed myself under a lot of stress as my issues close to my heart – ironically health and nutrition as well as humanitarian and environmental subjects – are not always easy to get either commissioned or published, still containing the most valuable information – the pay also stinks. However, this stress that surely played a pivotal role in my collapse was as nothing compared to the stress caused by the physical pain to come.

My illnesses have been given various unhelpful labels over the years as I have consulted with over 70 specialists in the fields of orthodox, integrated and alternative medicine from every continent bar Africa and the Poles. None have really been able to explain the full extent of the, often barmy, symptoms my body has thrown at me – indeed were I not to have direct experience of them, I would not have believed some of the symptoms I have experienced. Without relaying the symptom minutiae of this unwelcome and seemingly endless endurance test, it should be plain to any person that a switching from a life of great activity, drive and passion to being largely bed bound for over five years is no picnic. Being largely unable to speak due to an immune condition which renders my throat sore after speaking a pathetically feeble amount is isolating for anyone, particularly someone who thrives on human company, but none of the litany of strange, limiting and profoundly uncomfortable symptoms have come close to being as bad as the rounds of

unendurable gut pain I have endured often weekly or even two to three times a week. These attacks of indescribably intolerable pain that begin without warning or trigger have been hardest to bear because there has been no effective, tolerated pharmaceutical or pain management intervention. This poem was written after a 75 hour attack, which ended after I could take the pain no longer and gave in to taking tramadol which I am highly sensitive to and often takes hours and hours to work before bringing on a new round of 24 hour of appalling sickness and side effects. In the past, I have described the choice of giving in and taking tramadol or going on enduring the pain to a kind of Sophie's Choice – one is stuck between the proverbial rock and hard place.

Unlike emotional pain which most people have varying degrees of experience or awareness of, I believe physical pain is less easy for others to empathise with. Consequently, it is more isolating. Most people 'love', and can therefore imagine one of life's greatest fears: the horror of losing a loved one even if they have not personally been struck by grief. I lost my mother to a premature, and particularly unpleasant, death – she was the greatest love of my life, but five years of tortuous physical pain belongs to an entirely separate solar system of distress, even to grief. Because so few can understand the invisible hell of living with mercilessly long episodes of agony (and I am mindful that what I have endured is as nothing to many), compassion is less forthcoming when it is most needed.

Since feeling understood is such an essential human need and if your illness prevents socialising, even in virtual form

(as mine has), there is value in coming across something that may express some of the feelings you experience. Everyone's journeys with pain are different, and if you suffer from pain where opiates produce their own hellish side effects, this may resonate. All I know is that if one is fortunate enough, like me, to have the opportunity of recovery and one is tenaciously continuing to seek out healing and recovery, then it may be counter-productive to find Internet pain forums, where an ocean of terrible despair and suffering can bring one down too low. That said, finding one thing that echoes sentiments and experiences one has gone through brings with it a brief but valuable shared feeling of in-the-same-boat kinship. This is why I shared my poem with the British Pain Society through this newsletter. Intrinsically, it is not the most uplifting read, but if some of it brings a flicker of recognition in any reader, then it has served a small purpose. To this, I would add that I am currently pursuing my most radically alternative programme (and I have already pursued a host of highly unusual interventions) to facilitate and bring about the recovery that I am determined and confident *is* in motion. What helps and aids some will not work for others, but at my lowest ebb, I am constantly reminded of a small picture outside the office of a private doctor I saw in the first year of my illness – '*Never, Never, Never Give Up*'. For me, this dictum has often been virtually impossible to live by, but the sentiment has continued driving me on to find a more lasting peace, and if that is possible for those who suffer, it is well to grab on because release from pain is always worth it.



Review of net-based video clips

How Your Doctor Can Help You Manage Your Arthritis Pain Self Management For Arthritis Pain

Dr Austin Leach Consultant in Pain Medicine British Pain Society Council Member

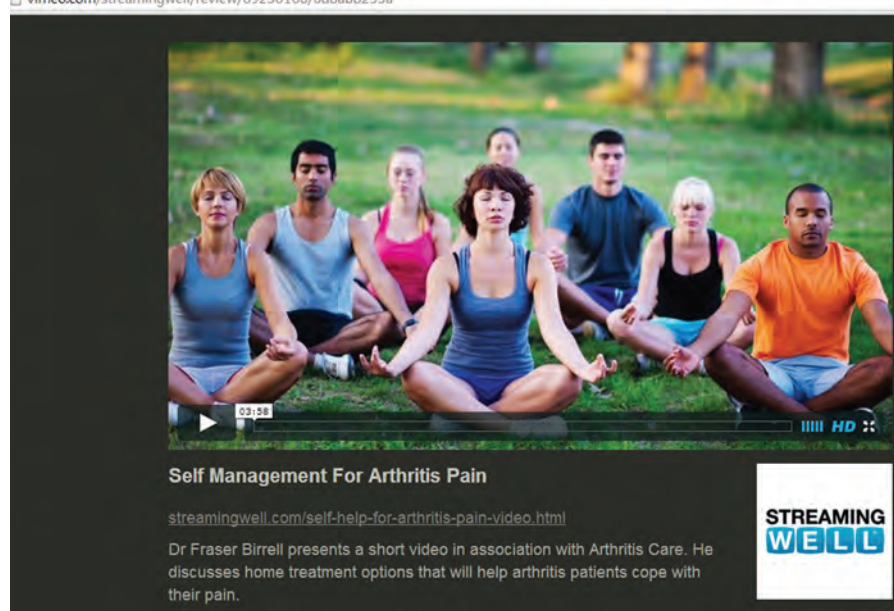
These short (each less than 5 minutes) videos summarise some of the manoeuvres that may be available to arthritis patients to help reduce the impact of their arthritis symptoms on their quality of life. The presenter is Dr Fraser Birrell, a consultant rheumatologist from the North East of England. His presentation style is unemotional, but the information and advice offered is not contentious.

I think that patients will find the 'Self management for arthritis pain' the more useful of the two clips, as it contains some practical advice that patients can try out for themselves: the use of massage; hot or cold pads; the benefits of physical training for both muscle strength and cardiovascular fitness. Maybe a mention of the use of a 'goal-setting and pacing' approach to fitness training might have been a worthwhile inclusion.

'How your doctor can help...' is worth a view if you are a patient with arthritis who has not yet sought advice from their doctor about their condition, but I can't imagine this being a particularly large audience. The advice offered is uncontroversial and sensible.

As an introduction to 'what is out there' in terms of web-based patient information these two clips are fine. I suspect that the discerning patient who truly wishes to engage and participate in the management of their arthritis would leave wanting more than is on offer in these short films.

vimeo.com/streamingwell/review/69230166/0d8abb255a



Liz Killick Patient Member of the Patient Liaison Committee

These two short videos have been produced as part of the Streamingwell series, which provides very brief – 2 to 3 minutes – and simply presented introductions to medical topics. The aim is to introduce patients to very basic ideas and principles. They are the right length for YouTube viewing, or perhaps playing in a GP surgery. Every video in the series is unfortunately bookended by what I found to be irritating musak.

The videos are presented by Dr Fraser Birrell, a consultant rheumatologist from Northumbria, who presents the information cheerfully and clearly. Both the language and delivery are slow and deliberate, and the content is subtitled.

The first video covers the medical help that is available – counselling (is it possible to correct the annoying spelling mistake?), tablets, TENS, topical ointments and surgery.

The second covers self – help – appropriate strengthening and aerobic exercise, and hot and cold treatment, rest and sleep. I was surprised by a technical reference to 'gating pain at a spinal level', the meaning of which isn't explained.

On first viewing these two videos seemed too simplistic, and even a little patronising. But they are designed to encourage people who are not coping with the pain of arthritis to begin to understand that they can take back some control, so that their life is not

ruled by their condition. Life can be stressful for so many of us, and managing pain requires intention and work. I write as someone who is experienced at managing my pain, and

who is failing pretty successfully to pace myself in the run up to Christmas. Simple reminders of the basic principles of pain management certainly have their place. And if they encourage patients to

start to make simple changes, or to visit the Arthritis Care website, where information is comprehensive and simply presented, they will serve a very good purpose.

End stuff

Research Design Service London meeting feedback

Open Day held on 1st October 2013

Gillian Chumbley *Consultant Nurse - Pain Service, Imperial College Healthcare NHS Trust*

The Research Design Service (RDS) in London was launched five years ago. This meeting, held in London's Living Room in City Hall, celebrated their achievements in the past five years and publicised their new funding for the next five years. In the past five years, RDS has successfully supported 188 studies, which represents research awards in excess of 100 million pounds.

The RDS is a free service, whose remit is to help researchers develop successful grant submissions by improving the quality of their applications. They help all levels of researcher from novice to expert. They are happy to discuss your initial thoughts about possible areas of research and help you to develop your research questions. Equally if you know your research question, they can help you to design your study, put together a



research team and identify suitable funding sources. They have particular expertise in facilitating patient and public involvement in research, to ensure that your study addresses issues of importance to patients.

The London RDS has centres based in Kings College, Imperial College, Queen Mary and University College. For further



information, you can access their service on-line at: <http://www.rdslondon.co.uk>



Letter to the Editor

Dear Editor,

First, let me congratulate you on the *Pain News*. It delights me to see how this has progressed from the time when, as assistant secretary of the then Intractable Pain Society (IPS), I was the Founding Editor in 1982/1983 of the Society's first ever newsletter, the *IPS Forum*. Keep up the hard work!

I notice in the present *Pain News* that you have included one of the submissions for the Pain Relief

Foundation Student Essay Prize. This competition was started by me over ten years ago now. It occurred to me that you might be interested to publish the winning essay, provided that the current organisers are happy with that, and possibly the runners up ones. Best wishes and kindest regards,

Dr Timothy P Nash
Emeritus Consultant, Walton Centre for
Neurology and Neurosurgery

Response from the Editor

The Editor sincerely thanks Dr Nash for his letter; he feels really humbled by the kind words from such a big stalwart of our specialty. Pain News will always endeavour to encourage the works of medical students and trainees; the incoming Editorial team will also support this. Sincere thanks!

New Members

Ratified at the December Council Meeting

Name	Position	Institution
Dr Frances Bernau	Consultant Anaesthetist	John Radcliffe Hospital, Oxford
Dr Sarah Aturia	Consultant Anaesthetist	Milton Keynes Hospital
Mrs Karen Wilson	Pain Nurse Specialist	Great Western Hospital
Dr Akilan Velayudhan	ST7 in Anaesthetics	University Hospital Coventry
Dr Michael Gilhooly	ST5 Anaesthesia	National Hospital for Neurology & Neurosurgery
Dr J Aggarwal	SPR Anaesthetics	University Hospital of North Staffordshire
Dr Carol Clark	Senior Lecturer Physiotherapy	Bournemouth University
Dr Maria Georgiou	Locum Consultant Anaesthetist	Chelsea & Westminster Hospital
Ms Asha Gudibandi	Senior Physiotherapist	King's Mill Hospital
Dr Maria Stasiowska	ST5 Anaesthesia	Charing Cross Hospital
Mrs Danijela Serbic	PhD Student / Teaching Associate	Royal Holloway, University of London
Mr Stephen Hunter	Advanced Practitioner Physiotherapist	Calderdale Royal Hospital
Dr Scot Richardson	GP Principal	St Andrews Group Practice, Hull
Miss Catherine Kinsella	Specialist Nurse Practitioner - Pain Management	Oxford University Hospitals
Dr Moein Tavakkolizadeh	Advanced Pain Trainee	King's College Hospital

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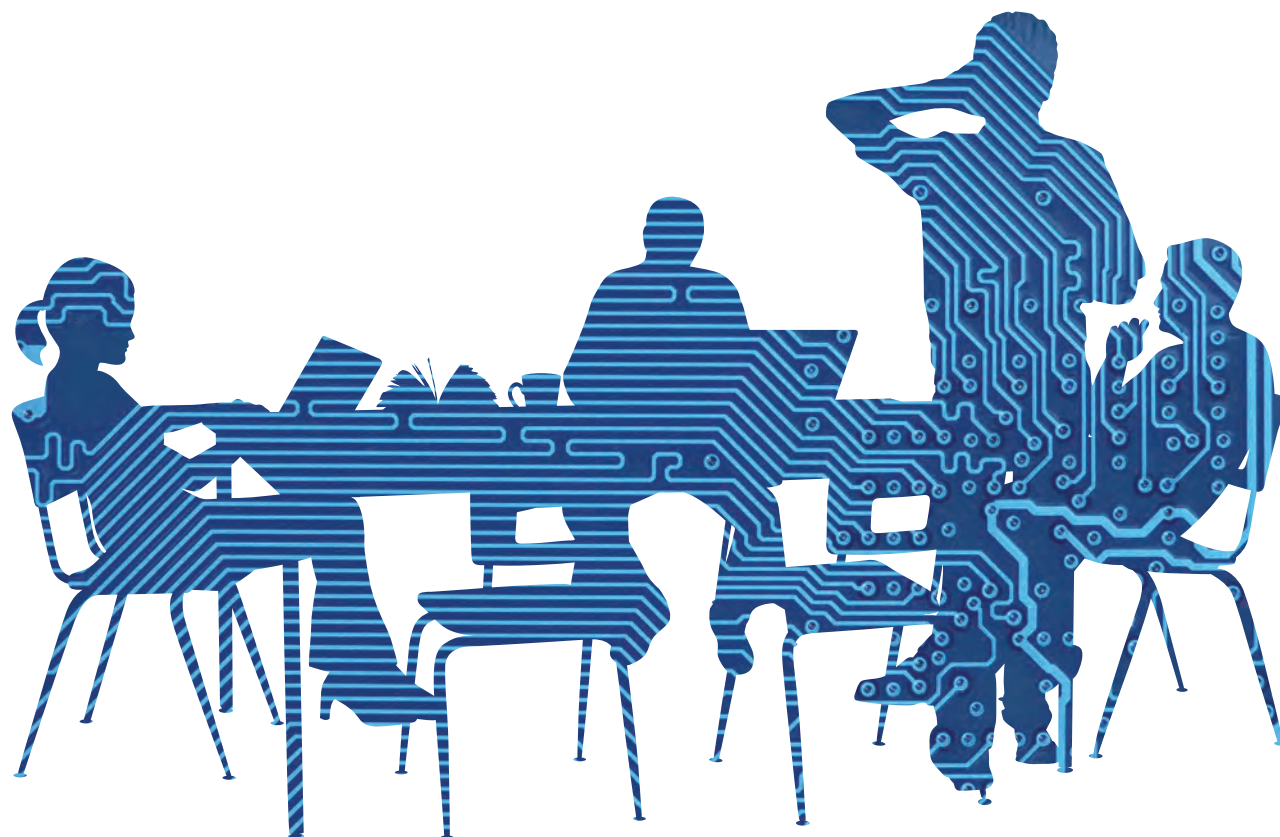
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