

SEPTEMBER 2014 VOLUME 12 ISSUE 3

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



Social Media – benign influence or spin?
Changing attitude towards analgesics
Where is your pain?
Teams in Pain Management
Spotlight - Antony Chuter



THE BRITISH PAIN SOCIETY

ISSN 2050-4497



http://www.britishpainsociety.org/members_newsletter.htm



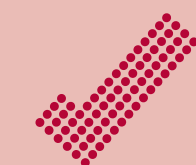
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Association of Palliative Medicine

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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.



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

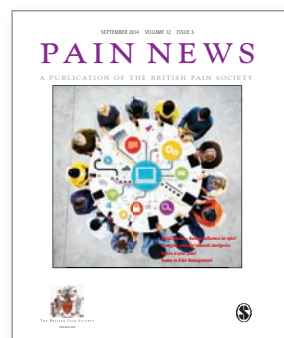
**Next submission deadline :
10th October 2014**

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Calendar of Events

2014

Interventional Pain Medicine SIG Annual Meeting

Friday 17th October

Manchester

www.britishpainsociety.org/meet_bps_sigs_meeting.htm

Patient Liaison Committee – Annual Seminar

Thursday 23rd October

Churchill House, London

www.britishpainsociety.org/patient_liaison_cmttee.htm

Musculoskeletal Pain (32nd Study Day)

Tuesday 28th October

Churchill House, London

www.britishpainsociety.org/meet_bps_study_days.htm

Faculty of Pain Medicine Annual Meeting: Pain Management in Special Circumstances

Friday 14th November

Churchill House, London

www.rcoa.ac.uk/faculty-of-pain-medicine/events/events-calendar

Pain Education (33rd Study Day)

Monday 24th November

Churchill House, London

www.britishpainsociety.org/meet_bps_study_days.htm

2015

Cancer Pain (34th Study Day)

Friday 13th February

Churchill House, London

www.britishpainsociety.org/meet_bps_study_days.htm

Annual Scientific Meeting

Tuesday 21st April – Thursday 23rd April

Glasgow

www.britishpainsociety.org/meet_ASM.htm

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THE BRITISH PAIN SOCIETY

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SAGE



I have just come out a severe bout of flu. It was so severe that I have lost my sense of smell for nearly a week. As you know, when you don't have sense of smell, you can't

taste any food. For nearly a week all food tasted the same. I just ate to survive. It was so frustrating to be in that position. At least I knew that my loss of sense of smell was temporary. During that period of anosmia, I thought about one of my friends who lost his olfaction (sense of smell) following pituitary surgery. His loss was permanent. He always commented that he just ate to survive.

Most of our chronic pain patients are in the same position. They lose so much in their life because of their pain – independence, job, relationships, hobbies, self-esteem, enjoyment of life, sleep etc. The loss may sometimes be permanent. They not only have to deal with the burden of pain but also have to deal with this added baggage of losses and the consequences. We, as a specialty, understand this very well and manage the chronic pain as a 'biopsychosocial' problem rather than 'just a pain problem'.

Chronic pain management which started as a single modality specialty has come a long way. We are a true multidisciplinary specialty. Pain clinics with professionals from relevant disciplines such as medical, nursing, physiotherapy, psychiatry and occupational health, are considered ideal rather than single discipline based clinics. This understanding and advancement

were due to pioneers in pain management like John Bonica, Ronald Melzack and Patrick Wall. In this issue of *Pain News* John Loeser shares his experience with John Bonica during those early days of pain management. He starts the article with statements 'The pain world started with one person. That man was John Bonica'. The article is a description of a first hand experience with legends such as John Bonica.

Bronwyn Lennox Thompson, in this issue of *Pain News*, discusses in detail 'the pain management team'. In her article Ms Thompson describes how the concept of multidisciplinary pain management teams came along. She questions who should be in the team and details the challenges facing the teamwork and strategies to improve.

In addition to the above, there are more articles for you to read and enjoy. Please do read them and send your comments to us.

Finally, from this issue onwards, *Pain News* will have the following QR code and web address on the cover page for ease of accessing the electronic version from the British Pain Society website.

QR code for *Pain News*



What is QR code?

QR code or Quick Response code is a type of popular barcode used widely including train tickets. These codes can be scanned by various mobile operating systems; Google Goggle is an app, which can be used both in android and iOS to scan the code. The app will link it straight to the URL (weblink). Windows phone can do the same through its Bing search app. Blackberry has its own native QR code reader.

What do you do with QR code?

Just open one of the above given QR code reader apps and scan the code. The app will take you straight to the webpage of *Pain News*.

We have also developed the following QR code for *British Journal of Pain*:

QR code for *British Journal of Pain*



Cover Photo
Social media/Multidisciplinary team working

Dr William Campbell



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Pain News

2014, Vol 12(3) 138–139

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Firstly I must belatedly congratulate two individuals.

Pete Moore was selected as Pain Champion for the year 2013–2014. Despite close competition, the nominators from the British Pain Society, Pain UK

and the Chronic Pain Policy Coalition (CPPC) were unanimous in awarding this award to Pete for his sterling work over many years, championing patients causes and providing a wealth of material to enable patients to help themselves. In addition, one of our Council members, Paul Cameron, must also be congratulated on becoming the Chronic Pain Co-ordinator for The Scottish Government. Well done.

British Pain Society Membership & Special Resolutions ratified at last AGM

Most of you will realise by now that the membership numbers fluctuate at various times of the year, and currently there are 1334 members.

Following our Strategy Day in December 2013, we decided to set up a new membership working group to review the retention and recruitment of new members. The group are currently exploring recruitment within primary care, physiotherapy and nursing. I am grateful to the representatives of these disciplines who sit on Council for carrying this topic forward.

As advised at the April AGM, at the July Council meeting it was proposed that the membership fees increase in all bands by 3% for the year 2015.

Approval for special resolutions on categories of membership, including electronic voting, was made at our last Annual General Meeting held on the 30th April 2014 in Manchester.

e-Learning Pain

This project, which started a few years back, became an active website early this year and now the majority of the teaching modules are live on the site. The project has been set up and co-ordinated via the Faculty of Pain Medicine, Royal College of Anaesthetists and the British Pain Society. Yet again I would wish to thank all the module leaders and authors for their very considerable contributions to this project which can be visited at <http://www.e-lfh.org.uk/programmes/pain-management/>. To access the teaching material it is necessary to register first as well as having a recognised NHS email address.

Low Back Pain – Pathfinder project

This project which was initiated last September, has reached its conclusion in relation to consensus of clinical opinion from a very wide number of stakeholders, including the British Pain Society. The working group, chaired by Professor Charles Greenough, National Clinical Director for Spinal Disorders, had representation from primary care, psychology, physiotherapy, spinal surgery and many others. It was a credit to Charles that a consensus was reached by all within

10 months. The next stage is for the commissioners to agree the way ahead. Although this work is similar to a mix of parts of the NICE CG88 and the British Pain Society Pathways on this topic, it is considerably less restrictive on advice.

As one of the physiotherapists on the group quite rightly said, there are so many ways of managing low back pain and evidence for each isn't great. It is hoped that the Pathfinder for low back pain will replace CG88 until the replacement NICE guidance becomes available in 2016.

Pain Consortium

This is an entity established last year between the British Pain Society, Faculty of Pain Medicine, Chronic Pain Policy Coalition and CRG Specialist Pain Services. Up to two representatives from each body sit on the Consortium and we tend to meet just before each of the British Pain Society Council meetings. The last meeting was held on 2nd July and we covered topics such as the Pain Summit recommendations and commissioning. Following the Pain Summit the following work was tasked as follows:

Problematic / complex pain (Faculty of Pain Medicine)

Awareness campaign (Chronic Pain Policy Coalition)

Commissioning guidance (Royal College of General Practice)

Epidemiology of chronic pain (British Pain Society)

Professor Gary Macfarlane, Epidemiology Group, University of Aberdeen, is heading up the work stream for our Society – entitled Make Pain Count. He has planned 3 themes to the work:

- Data sources, including what is already known and the need for core data (Lead: Gareth Jones)
- Terminology associated with routine recording in clinical practice (Lead: Cathy Price)
- Health Measures (Lead: Candy McCabe)

This is a substantial amount of work that Gary has established and the results should considerably compliment the National Pain Audit that has been very ably led by Cathy Price over the past few years.

Orofacial pain

We are well into the IASP and EFIC year against orofacial pain. Naturally the British Pain Society supports this initiative and work carried out in this area, such as that by Justin Durham who shares some of the project information below. Developing Effective and Efficient care pathways in persistent Pain: DEEP Study.

As we are all aware, persistent pain is a distressing problem for patients (Breivik et al 2006) and can be difficult and sometimes distressing to manage for clinicians (Kristiansson et al 2011). Persistent pain affecting the face, mouth or head (persistent orofacial pain [POFP]) is common, affecting an approximated 13% of the population (MacFarlane et al 2001). POFP also exerts many of the same impacts that we see in other persistent pain conditions affecting other parts of the body (Durham et al 2010, 2011b; Wolf et al 2006; Nilsson et al 2011). Diagnosis and treatment for POFP conditions is slowly improving through the institution of new, targeted, diagnostic tools (Schiffman et al 2014) and advances in genomics (Meloto et al 2011), but current care pathways may not maximise therapeutic potential and

may, paradoxically, worsen POFP (Durham et al 2011b).

POFP patients are known to use more healthcare resource compared to other dental patients (Aggarwal et al 2008; Glaros et al 1995; White et al 2001), but what is unknown is why and where this utilisation occurs. Previous research (Durham et al 2011b) suggested that a large proportion of this resource utilisation may occur as a result of inadequate care pathways for patients with POFP: cyclical referrals accompanied by multiple and unnecessary consultations which often only serve to increase confusion and sometimes worsen the patient's complaint. Clearly this is a costly process for both the patient and the health service and therefore in addition to delivering more accurate diagnoses and treatment, we need to understand how and where we can streamline services in order to get patients to the most appropriate care efficiently and effectively at the earliest possible opportunity, thereby maximising the therapeutic potential of any available management strategies.

A simplistic unidimensional assessment of the costs of POFP care pathways is insufficient to capture the biopsychosocial dynamic relationship of POFP and the care received (Suvinen et al 2005). A "whole systems perspective" (Phillips et al 2008) is required in order to assess current care pathways and produce patient centred services "designed around patient's needs" (Donaldson 2008). Without identifying where the negative economic, biomedical, and psychosocial impacts exist on the current care pathway from both the consumer and the providers' perspectives, it is impossible to model new pathways that provide appropriate care in a patient-centred, efficient, efficacious and expedient manner. The NIHR funded DEEP study aims to longitudinally and prospectively examine

care pathways in POFP in order to identify areas where the current pathways could be modified, and model the estimated impact of change to determine what changes would improve outcomes for patients and use resources more efficiently. Its recruitment stage is drawing to a close and interim preliminary analyses suggest that entry to the study visit costs are by far and away the largest driver of total healthcare utilisation costs and that quality of life measured by EQ-5D-5L is comparable to other chronic conditions affecting other areas of the body (Durham et al 2014a & b).

See - Durham et al. BMC Oral Health 2014, 14:6

<http://www.biomedcentral.com/1472-6831/14/6>.

For further information about this work, run by Justin Durham see <http://research.ncl.ac.uk/deepstudy/>.

The Society supports this work and looks forward to further information on this topic.

Finally, Heather Wallace has fought for pain patients for many years via Pain Concern and airing pain. Please take some time to check the Pain Concern website at www.painconcern.org.uk

Many of you may be aware that an e-petition, headed by Jean Gaffin is currently active until mid December 2014. If 10,000 individuals sign up to this it will trigger a government response, and if 100,000 sign up there will be a debate in Parliament. In order to get a sufficient response it will be necessary to get patients to sign up as well as healthcare professionals. Patients have the power, so do encourage your patients, whether in primary care, physiotherapy departments, etc. to sign up please.

The link for this is - <http://epetitions.direct.gov.uk/petitions/58377>.

Now accepting primary research papers



Official journal of the British Pain Society

The Journal aims to broaden its scope and become a forum for publishing primary research together with brief reports related to pain and pain interventions. Submissions from all over the world have been published and are welcome.

Good reasons to publish in **British Journal of Pain...**

- Published by SAGE since 2012, the journal is now fully online and continues to be published in print. Browse full text online at bjp.sagepub.com
- Official journal of the British Pain Society, the journal is peer reviewed, with an international multidisciplinary editorial board
- Submit online and track your article on SAGEtrack
- High visibility of your paper: the journal is currently free to access and is always free to link to from cited and citing references on HighWire Press, the world's leading e-content provider

www.britishpainsociety.org

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Adjuvant therapies for acute and chronic pain
Basic science
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Local anaesthetics
Mobile technologies
Neuraxial analgesia for acute pain
Neuropathic pain
NSAIDs and COX-2 inhibitors
Opioids
Pain management in palliative and end of life care
Pain management in patients with HIV

Pain management in the adolescent/young adult
Peripheral regional analgesia
Pharmacogenomics
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Psychology
Psychology of pain
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Sleep and pain
Therapies including lifestyle orientated treatments
Transition between acute and persistent pain

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Pain Education Study Day

Sue Jenkins *Lecturer, Cardiff School of Infection and Immunity*

The Pain Education SIG were delighted to be invited to organise a Study Day as part of the Society's learning in Pain Series (LIPS). Janet McGowan, Sue Jenkins and Emma Briggs have developed an exciting programme that will ensure a highly interactive day, exploring the principles and practice of clinical, patient and university education.

The Study Day is appropriate for clinicians, educators and anyone who has an interest in the delivery of education to patients and healthcare professionals. It provides an opportunity to consider interactive and novel methods of delivering education, to share good practice and to discuss some of the challenges we face in helping others learn about pain.

The Study Day will be held at the British Pain Society in London, on 24th November 2014.

The day's objectives are:

- to present, consider and discuss principles and practice of clinical education
- to explore good practice in educating patients and healthcare professionals on pain management
- to network with like-minded colleagues and discuss ways of building a pain education community

The morning sessions will introduce the principles and different approaches used in education. We are pleased that Dr Michele Russell-Westhead (Academic Lead Educational Development, King's College

London) will be the keynote speaker. Michele specialises in clinical education and interdisciplinary teaching and learning and is one of only 40 people in the country to be awarded the status of Principal Fellow of the Higher Education Academy.

Dr Vinette Cross will be presenting the findings of a research study on self-management in chronic low back pain. Dr Cross, Senior Research Fellow at University of Brighton and University of Wolverhampton, has been involved in the collaborative study with East Sussex Healthcare NHS Trust, the Open University and the University of Brighton. The study has identified a variety of viewpoints held by both practitioners and patients on what self-management means to an individual with chronic low back pain, leading to insights into why this approach is sometimes challenging.

The afternoon is made up of a series of engaging masterclasses where delegates and SIG members have the opportunity to consider and discuss how pain education delivery can be improved.

We hope that you can join us for this stimulating Study Day. Contributions to the sessions and workshops run by the SIG are also welcome. If you are involved in any of the areas covered (listed on the itinerary), please contact Janet or Sue. The outline of the programme is:

Morning

- Principles and Practice of Clinical Education

Committee Members

Emma Briggs (Chair)
Nick Allcock
Michelle Briggs
Sarah Henderson
Ethel Hili
Geraldine Granath
(PLC Representative)
Sue Jenkins
Despina Karargyri
Janet McGowan
Pat Roche
Alison Twycross
Sharon Wood

- Patient Education: Patient Choices in Self-management
- Building a Pain Education Community (SIG Members)

Afternoon Masterclasses

- Challenges and Rewards of Patient Education
- Building an Evidence Base for Pain Education (SIG Members)
- Designing and using e-learning for Pain Education (SIG Members)

If you want to attend the day, please contact Ken Obbard (meetings@britishpainsociety.org) / Tel: 020 72697840 for an application form.

Article of interest

The following article presents an interesting discussion on the factors influencing practice and the need for pain education and is co-authored by SIG member and former committee member, Dr Willy Notcutt.

Notcutt, W. and Gibbs, G. 2010. *Inadequate pain management: myth, stigma and professional fear*. *Postgrad Med J* 86:453e-458e.



Pain Education Study Day

This study day has been organised by the Pain Education SIG for the Society.

This will be an exciting and interactive study day exploring the principles and practice of clinical, patient and university education. A great opportunity to meet with like-minded colleagues who want to improve pain management through education. The day creates opportunities for interactive learning, sharing ideas, best practice and addressing the challenges.

CPD points applied for.



THE BRITISH PAIN SOCIETY



Forthcoming Annual Scientific Meeting of Interventional Pain Medicine Special Interest Group

Neil Collighan *Consultant in Anaesthesia and Pain Management, IPM SIG Treasurer*

As an office-bearer of the British Pain Society Intervention Pain Medicine Special Interest Group it fell to me to organise the upcoming SIG Annual Scientific Meeting. I have always felt the SIG is a forward looking group, open to new developments in interventional pain medicine throughout the world, but not following the latest fashion unless a good evidence based approach has been used in the process. Being hard-nosed about new innovation has also brought on retrospection about interventions already delivered. A groundswell has occurred over recent years to produce good evidence for what we already provide, and some long delivered procedures have fallen by the wayside when the high quality evidence was found wanting.

In an effort to produce an interesting and educational programme I thought it to be a good idea to look back at previous years' programmes and the impact on clinical practice.

In 2012, for the Annual Meeting organised by Dr Manohar Sharma, the topics included:

- 'Dorsal root ganglion stimulation: Indications, evidence and experience' delivered by Dr Liong Liem (Netherlands).
- 'High frequency dorsal column stimulation: Indications, evidence and experience.' by Dr Iris Smet (Belgium).
- 'Neurosurgery, Pain and Neuroablation; When to refer to Neurosurgeon?' by Mr Paul Eldridge (Liverpool).

- Cordotomy for cancer pain: Evidence and progress on Registry study. Prof Matthew Makin (Wrexham).
- 'Lumbar Chemical Sympathectomy: it time to abandon?' Dr Dudley Bush (Leeds)
- Good practice guidelines (Lumbar Radiofrequency): Dr Neil Collighan (Kent)/ Dr Sanjeeva Gupta (Bradford)
- Update on research feasibility group; Progress so far: Dr Vivek Mehta (London)
- Translational Research: Evidence driven clues for optimizing NeuroStimulation solutions for pain: Dr Greg Molnar, Medtronic (USA)
- Role of Interventional Pain Medicine in Palliative care: Palliative care perspective. Prof Sam Ahmedzai (Sheffield)
- Absolute alcohol and Neurolysis for cancer pain: Indications, technique and Outcome: Dr Arun Bhaskar (Manchester)

What did we learn and what happened next?

For many years neuromodulation was delivered by standard placement of epidural leads with conventional stimulation parameters. Over the recent years novel methods of delivering neuromodulation, either by high frequency or alternative placement peripherally or on the dorsal root ganglion have been studied. These newer methods have now been introduced into the armamentarium of

neuromodulation centres across this country and in the world. This has expanded the number of patients who would be suitable for neuromodulation and moved the exciting field of interventional pain medicine forward in leaps and bounds.

The meeting invited posters for the first time to encourage more engagement with SIG members to support their audits and to be shared with wider audience. These posters were published as proceedings of the Annual Scientific Meeting of IPM SIG in the *British Journal of Pain*, supported by British Pain Society.

Following deliberation and guidelines publication, the use of chemical lumbar sympathectomy has receded as it was unsupported by evidence.

In 2012, the SIG submitted proposals to the BPS for two good practice guidelines to be prepared by the IPM SIG:

'Good Practice Guidelines for Medial Branch Block and Radiofrequency Denervation for Lumbar Facet Joint Pain'

'Good Practice Guidelines for Percutaneous Spinal intervention Procedures (excluding epidural).

Currently the first guideline has now been published and the second guideline is now in full draft form awaiting final editing by myself, the working party and with Faculty of Pain Medicine and British Pain Society's support.

In 2011, the IPM SIG set up a research feasibility group under the leadership of Dr Simon Thomson and Dr Tony

Forthcoming Annual Scientific Meeting of Interventional Pain Medicine Special Interest Group

Hammond to help enhance the evidence base behind our many procedures. The group has rapidly established its research credentials and a recent feasibility study on facet joint injections has been given approval and the study is about to start. This is great news for research possibilities in interventional pain. This work has been led by Prof. Richard Langford and Dr Vivek Mehta.

It was noted that collaboration between palliative care and pain medicine had not been as strong as previously and efforts have been made (including inviting them to present at our meetings!) to re-establish those links. Interventions in malignant pain can be significantly life prolonging as it has been stated that we cannot allow procedures to not be available to this cohort of patients.

In 2013, for the Annual Meeting organised by Dr Ganesan Baranidharan, the topics included:

- 'ACNES (anterior cutaneous nerve entrapment syndrome) and its treatment' Dr R Roumen (Netherlands).
- 'Pain management after inguinal hernias and caesarean section related scar pain' Dr M Scheltinga (Netherlands).
- 'Alternatives to manage ACNES and Neuropathic post-surgical pain' Dr A Gulve, (Middlesbrough)
- 'Diagnostic work up for Low Back Pain: Dr S Ward, (Haywards Heath)
- 'Surgery and Low back pain, when to operate?' Neurosurgeon, (Leeds)
- 'Neuromodulation for Low Back Pain' Dr A Alkaisy, (London)
- 'Audit of Vertebroplasty in cancer pain' Dr A Magdy, (Burnley)

- 'Radiofrequency Registry, introduction and progress' Dr T Haag, (Wrexham)
- 'Investigating central sensitisation following DRG block- a prospective study' Dr V Mehta, (London)
- 'A progress on EX Stim Development' Dr T Goroszeniuk, (London)
- 'Chronic Pancreatitis, When to refer to a specialist Unit? Specialist MDT management including surgery' Mr A Smith, (Leeds)
- 'Interventional Pain management for chronic pancreatitis' Dr S Tordoff, (Leicester)

This meeting was enlivened by the articulate delivery on the treatment of ACNES. As a concept it is still open to debate in surgical circles but one couldn't help but be enthralled by the two presentations. With the recent updates on neuromodulation there has now been established a treatment pathway for this situation from simple injection, through surgery all the way to dorsal root ganglion stimulation.

It could be thought that Low Back Pain and Pancreatitis was a bit old hat but the SIG again was able to cover old and new issues to enable appropriate evidence based treatments for these diverse problems. Newer procedures, including radiofrequency denervation of the splanchnic nerve on the body of T12, were presented in an easy stepwise fashion allowing members to have all the information required to know if they wished to pursue gaining further experience in the procedure to be able to deliver to their local population. It is surprising how your own concerns can evaporate when a well delivered 'how to' guide is presented well.

Again, the SIG was looking to the future and how to collect data to support continuing practice. Here this included a presentation on a radiofrequency registry to help in the accumulation of reproducible information. The registry is now very close to fruition and many of the SIG members have shown interest in being part of it. The ultimate aim is for all episodes of radiofrequency use to be recorded.

Again, the newer novel neuromodulation techniques were examined to ensure the evidence base remains strong.

So, what have we got in store for this year?

This time we are concentrating on some applied anatomy and physiology, CRPS and Pelvic pain. As always there is a look to the future and especially as we deliver DRG stimulation now after talking about it two years ago. Maybe Genicular branch radiofrequency for knee pain will be next.

Below you will see the full programme and we hope you can come and join us to get involved in what promises to be a lively debate. We have a very strong panel of speakers (excluding my own short bit), again giving a counterpoint from European experience. Input has been taken from IPM SIG Executive committee members and BPS Council member liaison for IPM SIG for all these events, and attendance has grown steadily over the last 3 years.

Dr Manohar Sharma, the SIG Chairman, Dr Ganesan Baranidharan the SIG Secretary, myself and the IPM SIG Executive Committee look forward to welcoming you all to Manchester on 17th October 2014.



IPM SIG Annual Scientific Meeting, 17th October, 2014
Radisson Blu Hotel, Manchester Airport

An alliance of professionals
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the benefit of patients

08.30 - 09.25 Registrations

09.25 - 09.30 Welcome and Introduction: Dr Manohar Sharma

1st session Applied Anatomy and Pathophysiology

Chair: Dr Kate Grady, Manchester

09:30 - 10:10 Sciatica and Low Back Pain, "back to the roots": Prof Gerbrand Groen, Netherland

10:10 - 10:45 Neuromodulation for Pelvic Pain: Dr Jean-Pierre Van Buyten, Belgium

10:45 - 11:00 Discussion/Questions

11.00 - 11.30 Coffee / Tea

2nd session Recent advances in CRPS

Chair: Dr Rajesh Munglani, Cambridge

11:30 - 12:00 What is around the corner in CRPS management: Dr Andreas Goebel, Liverpool

12:00 - 12:30 Neuromodulation for CRPS (evidence & effectiveness): Dr Simon Thompson, Basildon

12:30 - 12:50 Discussion/Questions

12:50 - 13:00 Update on Lumbar Medial Branch Block and RF /Good practice guidelines: Dr Neil Collighan, Canterbury

13.00 - 14.00 Lunch

3rd Session Science and evolution in pain management

Chair: Dr Sanjeeva Gupta, Bradford

14:00 - 14:30 Pelvic Pain – a surgeon's perspective : Mr Neil Harris, Leeds

14:30 - 15:00 Pelvic Pain: Pain Clinic's role: Dr A Ravenscroft, Nottingham

15:00 - 15:15 Discussion/Questions

15.15 - 15.45 Coffee / Tea

4th Session New Developments in Interventional Pain Medicine

Chair: Dr Neil Collighan, Canterbury

15:45 - 16:00 Neuromodulation, what is on the horizon? Dr G Baranidharan, Leeds

16:00 - 16:15 New Disc procedures and outcomes: Dr Tony Hammond, Maidstone

16:15 - 16:30 Genicular Branch blocks and Radiofrequency, technique and outcomes: Dr Jacek Sobocinski, London

16:30 - 16:45 Cordotomy registry update on outcomes?: Dr Marlise Poolman, Bangor

16:45 - 16:55 Discussion/Questions

16.55 - 17.15 Business meeting IPM SIG members (Chair: Dr Manohar Sharma)

17.15 Close of meeting



THE BRITISH PAIN SOCIETY

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Impressions of a meeting: the Philosophy and Ethics SIG 2014

Compassion in Modern Healthcare

Katherine Irene Pettus

The author attended the recent Philosophy and Ethics SIG meeting for the first time. This presents the author's opinion about the meeting.

"When reason and mercy have fled out of the world there is nothing like a manual"

Virginia Woolf, among other writers, stated that in the face of pain, language "runs dry." It can only be described through metaphor. Yet at this year's BPS ethics and philosophy SIG, pain itself was the metaphor describing clinicians' sense of failure to alleviate significant patient suffering.

The SIG programme consisted of a heady mix of topics in philosophy, practice, and ethics chosen by a group of committed professionals for their potential to generate multiple, overlapping conversations. The setting was Rydal Hall in the justly famous English Lake District, and the majority of those present were pain physicians, although there were a few palliative care professionals, physiotherapists and psychologists. All of us are people who all think deeply about our vocations in the wilderness of pain, a universal phenomenon that is poorly diagnosed, treated, and alleviated, despite the best and most dedicated efforts of compassionate clinicians, top of the line hospitals, research, and pharmaceutical products in some parts of the world.

Papers and discussions distinguished

the managerial from the "professional" ethos, oriented toward the good of the patient as the foundation of the common good. The reverse does not necessarily follow: health systems constructed to meet ends focused on financial, rather than wellness-related outcomes, produce multiple health "bads." Much constructive discussion in the group focused on how to infuse the systemic imperatives of the NHS with a culture of compassion to counterbalance the dominant priorities of cost-effectiveness and targets.

The pain of the physicians/clinicians themselves, who have been forced to relinquish their calling, their vocation, to the logic of the market and the political flavour of the month, was palpable. The main constraint on their ability to properly work as clinicians is time, for the simple reason that lack of time reduces clinicians' ability to respond appropriately to their patients' pain. Participants in the discussion were reporting and expressing what is also known in the field as "moral distress." Rather than taking on a victim role, though, the spirit of the meeting was to inquire into the nature of this system-induced pain, and to engage in conversations about strategies that might alleviate it.

Discussions were generally non-adversarial, although there was some friction over about the inherent virtues of "professionalism." There was broad

agreement on the fact that clinicians need to have enough time to listen, to connect at a deep level with their patients' stories, to diagnose and experiment with different courses of treatment or care plans. Insufficient time for real attention generates suboptimal outcomes, leaving the complexities of chronic pain unaddressed.

Papers and lively discussion from the floor cited cases of successes achieved where clinicians took the time to listen and connect, to "be with" a person in their suffering in order to alleviate it.

Several presenters cited Simone Weil, who commented that:

"The capacity to pay attention to an afflicted person is something very rare, very difficult; it is nearly a miracle. It is a miracle. Nearly all those who believe they have this capacity do not. Warmth, movements of the heart, and pity are not sufficient."¹

The point being that resonance and healing begin in the capacity to pay attention — not necessarily "cure," but healing, which finds a new equilibrium for the damaged system. As a recent experiment run by a participant demonstrated, listening itself generates wellbeing for the person being listened to. All participants and groups in the study confirmed the transformative power of being heard. Another free paper

discussed the low-tech intervention of therapeutic knitting, which has beneficial effects on both chronic pain and memory.²

Many papers and attendant discussions centered on neuroplasticity, as both proven biological fact and metaphor. The science now shows that, just as brain cells can be damaged through traumatic physical, social, emotional, and spiritual injury, so can sufficient support, clinical skill, and attention generate and maintain new, resilient pathways in the brain. Stories can be changed: the damage narrative can be shifted to one of courage and endurance, which will eventually become part of the fabric of the person's being.

One suggestion that came out of the meeting was to rename "pain clinics" "wellbeing centres," which would shift the focus from the object of chronic pain itself to a more whole-person centred,

integrated approach similar to that characteristic of best practice palliative care. Such attention to language, which can be pathologising or healing, depending on the skill with which it is handled, is just another indication of how the paradigm might be shifted and better all round metrics achieved.

Themes of the SIG were attention to language, and commitment to intentionality and presence in the face of pain and suffering, including the pain and suffering of colleagues and communities. This was entirely fitting in the landscape loved by William Wordsworth, Beatrix Potter, Samuel Coleridge and other luminaries of the romantic movement, whose attention to language has left future generations with a rich body of literature that remains a source of inspiration and joy for many. As colleagues emphasised, attention to words, poetry, images and narrative

highlights the importance of including the medical humanities in the training curricula of pain physicians.

Serious discussions peopled by Kant, Spinoza, Simone Weil, and Etty Hillesum, were offset by long rambles through the peerless countryside during the afternoon, break, and relaxing evenings at the local Badger pub or the Rydal Hall bar. The SIG was four days of great professional company, fabulous food at the communal tables, and a sense that focused discussion grounded in attention, skill, and care can bend the evolutionary curve of healthcare systems toward justice and compassion.

Notes

1. Simone Weil, *Waiting for God*
2. Corkhill, Betsan, et al. "Knitting and Well-being." *Textile: The Journal of Cloth and Culture* 12.1 (2014): 34-57.



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¹ Al-Kaisy et al. *Pain Medicine* 2013
² Van Buyten et al. *Neuromodulation* 2013

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BPS feedback on the 2014 ASM in Manchester

Prof. Kate Seers *Chair, BPS Scientific Programme Committee; Professor of Health Research, Director Royal College of Nursing Research Institute*

I would like to introduce myself to those members I have yet to meet. I am Kate Seers, Professor of Health Research and Director of the Royal College of Nursing Research Institute at Warwick Medical School. I've worked in research related to pain since I obtained my PhD looking at pain, anxiety and recovery after surgery in 1987. My research has addressed chronic non-malignant and post-surgical pain. I've undertaken both quantitative and qualitative systematic reviews, RCTs, mixed methods studies and a range of qualitative research. I have been feedback editor for Cochrane Pain, Palliative & Supportive Care Group (PaPaS) since 2009. I was a co-opted member of Pain Society Council from 1991-1994, and an elected council member 1994-1997. I have been on the Scientific Committee for both EFIC and IASP and have been on the Pain Society Scientific Programme Committee since 2012 and am delighted to be chairing this Committee for the next three years.

ASM feedback

We had plenty of feedback from delegates (92 pages), which was incredibly helpful. Every single comment was read and we really appreciate the time taken to provide the feedback. Thank you.

We have listened to the feedback and will be making some changes. At times it was clear some people really liked a session or aspect of the meeting and others were less keen, so we were not able to respond to every comment.

In summary, the main points of the feedback were:

- It was noted that in some workshops, content did not reflect the title – we will be issuing specific guidance for workshop speakers to ensure they stick to the title
- Poster exhibition – it was noted that the space and angles of the poster area was too cramped, email addresses were needed on posters and judging of the posters was unclear. All these issues will be addressed in Glasgow.
- Ask plenary speakers to include science that is translatable to day to day care, and ensure there is a take home message. This will be addressed in guidance to plenary speakers.
- Comments on the standard and variety of lunches and the quality of coffee have been noted and options will be explored for 2015 in Glasgow
- Most people felt the number of workshops was about right
- Most people felt the length of the meeting was about right

- Over half felt the ASM changed something in their practice
- Early starts to the programme were generally not welcome, and we have addressed this.
- Although 70% would be happy with a paper free meeting, 30% would prefer paper copies of the programme. We continue to explore options in providing a 'paper-light' meeting for delegates, with stepped changes being introduced over the next couple of years.
- There were a range of comments about the social event, and we have lined up an excellent social event in Glasgow which should have wide appeal, will enable discussion with colleagues, and have some more substantial food and a ceilidh. The party will be held at Òran Mór, Gaelic for 'great melody of life' or 'big song', and a thriving arts & entertainment venue in the heart of Glasgow's West End <http://www.oran-mor.co.uk/>.

Thank you once again for submitting your feedback. This is your meeting and we welcome your views on how we can make the Annual Scientific Meeting *the* go to event!

If you have ideas about or comments on the Annual Scientific Meeting, please do get in touch kate.seers@warwick.ac.uk.



Tips for writing a good abstract for the Annual Scientific Meeting

Prof. Kate Seers *Chair, BPS Scientific Programme Committee; Professor of Health Research, Director Royal College of Nursing Research Institute*

We would like to accept as many high quality posters as we can for the Annual Scientific Meeting. Many delegates really value the discussions that take place and new contacts they make when viewing the posters. Make sure your poster is one of the ones on display. All types of high quality research relevant to pain are welcome.

Tips

- Follow the poster abstract submission guidelines http://www.britishpainsociety.org/meet_asm_poster.htm.
- Provide a concise background that shows why what you are doing is important.
- Make sure you clearly state the aims of your research.
- Give a concise description of your main methods, including sample, what you did and your analysis

- Provide a summary of your main results or findings – it is essential that there is data in this section so it is clear what you will be presenting.
- Conclusions are important and should follow from the data presented. What have you found and what is the importance of your findings?
- Audits should be well conducted using a recognised audit method, and provide new information or knowledge.
- It can be helpful to get someone else to read your abstract to make sure it is clear.

When you come to design your poster:

- Many people will scan your poster and read the aims and conclusion before deciding whether to read more, so the conclusion needs to make sense without having to read the whole poster.

- Delegates have said it is helpful if you add your email address to the poster.
- Resist the temptation to fill every space – think about the main message you want to get across. A well designed poster should act as a catalyst for discussion with interested delegates, and may engage delegates who didn't think they were interested!

The Scientific Programme Committee looks forward to reading your abstract, and we hope to see you with your poster in Glasgow in 2015!

You will be able to submit your poster abstract online from September 23rd, closing date 10th December 2014. We will let you know whether your poster has been accepted by mid-January 2015.

Clulow Research Grant 2015

The British Pain Society invites proposals for the 2015 Clulow Research Grant competition. We invite submissions from BPS members from a wide range of disciplines; from basic science to clinical services.

A grant of up to £50,000 will be awarded. The funds may be awarded for a variety of purposes in support of a research project (e.g. small project grant, salary support, capital equipment purchase, running costs or additional funding to an existing grant). However, should the Grant be awarded to cover a proportion of the total costs of a research project, it will not be released until funds covering the full costs of the project are in place. Applications will be peer reviewed and a decision made by the British Pain Society Science and Research Committee by October 2015.

A copy of the Society's research grant conditions can be downloaded from the British Pain Society website at www.britishpainsociety.org/members_grants.htm.

Applications must be made online at www.britishpainsociety.org/mbc/mbc_form.htm.

Closing date is Monday 11 May 2015.



Patient information leaflets

The Faculty of Pain Medicine of Royal College of Anaesthetists, British Pain Society, Royal College of Nursing, Royal Pharmaceutical Society and Pain UK have developed patient information leaflets for medications used in pain management. They are currently available online to download free from <http://www.fpm.ac.uk/faculty-of-pain-medicine/patient-information>.

Version 1, June 2014

Information for Adult Patients Prescribed

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for

the Treatment of Pain



Version 1, June 2014

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for

the Treatment of Pain



Version 1, June 2014

Information for Adult Patients Prescribed

Gabapentin

for

the Treatment of Pain



Version 1, June 2014

Information for Adult Patients Prescribed

Nortriptyline

for

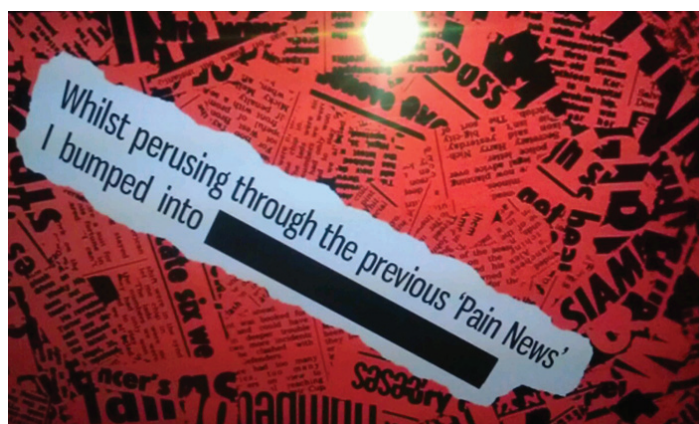
the Treatment of Pain





Pain News in 'Have I Got News For You'

Pain News had featured in the missing word section of recent 'Have I got News For You', a satirical comedy show at BBC. It was broadcast on 30th May 2014.





Reflections on changing attitudes towards analgesia

Margaret M. Dunham *Associate Editor, Pain News, Lecturer in Nursing & Pain Management
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I remember asking a Somali student what he was chewing, thinking it might be chewing gum and was told “....it’s like tea, we use it all the time as a mild stimulant....”. Is Khat ever used as an analgesic or just a substitute for alcohol in societies where alcohol is illegal? I’ve certainly since heard of Khat parties. However, Khat when chewed releases cathonine, which can have an effect akin to a mild amphetamine¹. It has been identified as having a contributory effect in psychiatric disorders² and may have unfortunate cardiac effects³. And now Khat is a banned substance, which in itself is not without controversy⁴.

Learning about this recent restriction naturally made me think about remedies or drugs, which are on the borderline with legality. Notably, many things used to be legal and were used commonly before someone decided to ban them. Also, the legality and availability of many substances varies from country to country. So I think we have to consider what is the evidence of greater harm than benefit? The sad thing is that it is not always the evidence, which informs these decisions but the politics of control and/or the popular lobby of society.

I am old enough to recall people not worrying about drinking and driving, even though a ban was introduced in the early 1960s, and there was even a kind of machismo about evading getting caught. I recall a television programme in the 1970s that had a special feature on the effects of a very small amount of beer on

one of their presenter’s abilities to parallel park a vehicle. The number of attempts and cones knocked over were contrasted with the presenter’s ability before imbibing the small beer. Perhaps the increasing number of cars on the road had meant that introducing the alcohol limit was a way of reducing car accidents and road deaths alongside the introduction of a speed limit to the new motorways¹.

Opiates and their derivatives were once legally unregulated and freely available in Britain. The fictional character Sherlock Holmes used various addictive substances including cocaine and opium. However, Sir Arthur Conan Doyle, rather than promoting the use of these substances, was only reflecting the 19th century society in which he practised as a surgeon. Indeed, substances including cocaine and laudanum (tincture of opium) were widely and commonly available with access via the ‘poisons register’ at many local pharmacies in the UK. This practice was initially regulated by the Poisons Act 1908 but was still widely accessible until after the end of the First World War with the introduction Dangerous Drugs Act 1922. It was an accepted and normal part of the UK’s pre-NHS health care provision: even the wonderful Florence Nightingale may have used opiates for chronic pain.

We cannot guarantee the future availability of well-used current health care preparations. Research may establish more effective remedies but



never underestimate the popular lobby as some practices become culturally unacceptable. Indeed, caffeine is an example of this. Over the counter preparations may contain a variety of additions including caffeine, which as yet remain legal but this may change. Caffeine in cold remedies and other medication may be the next target, after all the US FDA is considering regulating its use and we tend to follow where the US leads.

If the legal may become illegal then some currently illegal substances may prove to have beneficial effects.

Moreover, what of cannabis and cannabinoids? In the not so distant past cannabis and its derivatives were hailed as having great potential to solve many problems with chronic pain. However, their use has not become as widespread as was predicted⁵. The major issue is that, despite innovations and good quality small trials, new drug development is slow and costs a lot of money⁶. Investment in developing new analgesics will always be of less importance than many other pharmaceutical remedies. However, in the developed world we are still very

fortunate to have a choice of strong analgesic in contrast with many developing countries where their use is legally restricted or prohibited by poverty.

Note

1. The motorway system in the UK initially had no speed limit and the 70mph limit was introduced as an experiment in 1965.

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UK/PNC/13/0036 Date of Preparation: January 2014



What the practice of acupuncture has taught me as a doctor

Dr V R Alladi *Tameside General Hospital, Ashton under Lyne, Member of the Council, the Royal College of Anaesthetists*



One of the lucky things that happened to me as a medical professional is my accidental introduction to, and involvement in acupuncture. The experience has given me tremendous personal satisfaction and made me aware of the unknown factors that exist in diagnosis, efficacy of drugs and treatment and patients' perspective of disease, which I would otherwise not have appreciated.

As medical students we are trained to look at everything in medicine as cause and effect and possibly our patients as bodies with a bunch of chemicals and organs interacting with each other. Acupuncture gave me a different perspective; it made me look at patients individually as separate entities and not as anatomical or physiological groups. I have also learnt that the response to treatment varies from individual to individual and the treatment needs also vary enormously. This means that

classifying patients into groups and generalising their treatment based on signs and symptoms and investigations can be inaccurate. Acupuncture taught me that the body has several of its own defences and several of them are dormant. They have to be stimulated by some means or the other. Generalisation of anything in medicine is wrong and putting patients into groups whilst advising similar treatment to two different individuals may not be appropriate.

Creation of a sense of well-being should be a part of every treatment as every lesion has a psychological component to it in terms of effect and affect. The sense of well-being acupuncture engenders goes a long way to alleviate the misery of the disease. As doctors we need to spend more time in reassuring patients, calming them and treating them as people with emotional effects.

The importance of touch and palpation for tenseness and tenderness is not given any significance in conventional medicine. They are very important in assessing pain and determining the patients' emotional state. Communicating with the patient, assessing tone, eliciting reflexes and sensory impairment are valuable in locating lesions and making anatomical diagnoses.

As doctors we see patients once probably extensively then do not see them often enough to discuss and determine management and follow them up. The advantage I have is that I see my patients on at least four occasions and develop that all important relationship. It

gives me a chance to give appropriate advice and also gives the patient a chance to ask questions and confirm what they were told.

I realised the importance of right posture, minimal exercise (e.g. swimming), the need for relaxation and the role of nutrition in maintaining health. These are not emphasised and taught well in the regular medical curriculum.

We need to develop a tolerance to all modes of treatment especially the ones that have stood the test of time. We should not refuse treatment purely on lack of evidence. We should however give the benefit of the doubt to that treatment and study it concurrently.

An effect of my studies is that I started listening to patients more closely. I believe that it is essential to recognise that it is more important to do what a patient expects than do what the doctor wants to do. This may be a contentious viewpoint and goes against many practitioners attitude of 'I know best' but I have found it to be effective.

We should start publishing articles written by patients indicating the whole course of their disease with their comments on the treatment given to them. This will be a great source of education and CPD for more experienced doctors. Doctors need to know and appreciate patients' perspective of treatment.

The importance of symptomatic relief should not be underestimated. Patients of course look for cures but in certain conditions patients are seeking temporary easing especially for chronic pain. This tends to break the vicious

What the practice of acupuncture has taught me as a doctor

cycle of pain and resulting frustration. Acupuncture can give considerable temporary relief.

I believe that we may be doing disservice to patients by prescribing potent drugs like gabalins, non-steroidal anti-inflammatories and powerful opiates to musculoskeletal pains that need physical therapies. It is such a waste of time and if the drug treatment does not give meaningful relief, there is the possibility of side effects.

I am not too sure what people mean by placebos. Do they mean inert treatments or non-specific treatments? In relation to acupuncture as there are no chemicals involved we are trying to account for its action in terms of what needling does to physiology and stimulation of dermatomes and autonomic nervous system. This shows that mere stimulation of already existing bodily mechanisms have a role to play in healing.

Practising acupuncture is such a pleasurable experience to the patient and therapist as there is mystery and unpredictability to its effect (because most of the effects are immediate). It

makes a great adjunct to other treatments by potentiating their effects. The creation of well-being following treatment goes a long way in creating confidence in patients.

One of the best vocations in life is to alleviate pain. If it is acute and severe it is so rewarding to the patient and thrilling to the therapist and if the pain is chronic, then relieving it for any length of time is even more rewarding. This is what acupuncture can do.

The lessons I have learnt from practising acupuncture are the unknown factors in disease and the reality of miraculous or unexpected effects of treatment. The importance of symptomatic relief even if it is temporary and its impact on general well-being, the need for patient follow-ups in establishing the all important relationship with the patient whilst treating the whole patient, and the consequences of the lesion on the person, relatives and their life in general.

I remember asking one of my friends who got into oncology why he chose the speciality forty years ago when the prognosis for cancers was very poor. He

said that not all patients die early and some get better or get back to normal. He also said that even if one patient gets better it is more satisfying. I realised what he said later on when I started treating patients with chronic pain. It is indeed very satisfying even if I make one patient's life comfortable especially with a treatment like acupuncture. It also made me realise how little we know about how the body works, or better said, how much there is to know.

It amazes me every time I see a strong reaction when a patient bursts into laughter or cries (or even goes to sleep) after inserting a needle. This confirms that the body has its own defences and it is the imbalance of forces that causes disease. The role of the therapist is to detect this deficiency and correct the imbalance. If a treatment stands the test of time and if the patient thinks it works we should make it available even if there is no convincing scientific evidence to that effect and research concurrently. It is not wise to deny the treatment especially if there are no side effects and the patient is benefitting from it.

Chronic pain management - a learning experience



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Dr Umesh Ramesh *ST3 Anaesthetics Trainee in North Wales*



For any article/literature to be engrossing (or at least readable) a background is usually essential. To this end, I present to you my two-liner CV! Allow me to take you through the contrasting (yet similar) worlds of chronic pain management that I have travelled through.

I completed my anaesthetic training in India between 2006 and 2009. I started working in the NHS in 2010 as a Specialty Doctor in Obstetrics/Intensive Care and entered specialty training in UK in 2013 as an ST3. There... That's done.

Where I come from in India, chronic pain was invariably seen as amenable to intervention and manageable with medications and injections. This is where the anaesthetist would come into the picture. For example, if there was a patient with severe low back pain, he would be managed with routine pain killers, stepped up to oral morphine (with or without adjuvants like gabapentin). Physiotherapy would play an integral part throughout. The patient was very much a passive participant, expecting that we would treat him and make the pain go away. Eventually, the patient would reach a breaking point. He/she would join the

bandwagon and get an epidural steroid injection. Many patients would still have pain, and would probably switch doctors at that point, expecting a miracle cure. All this happened with no input from the patient and no lifestyle/social modifications on their part. It was not entirely the patient's fault. We, as members of the Pain Team, were equally to blame for leading him up the ladder as a passive recipient. At this juncture, I should emphasise that I do not speak about Pain Management generally in India. Whatever I describe pertains to the region where I trained at that particular time. This was my idea of pain management until recently. My perception changed significantly after my first Pain Module in North Wales in 2013.

After seeing the type of patients that walk through the doors of the Chronic Pain Clinic, I have become more and more convinced about managing it more holistically. I have realised that management is about finding the right balance between the various approaches and disciplines. This does not mean to say that I have suddenly become averse to interventions and injections. They have their own place. But, in isolation, they are not the only way to manage chronic pain.

Here are some striking and key things I learnt in my module in Chronic Pain Management:

1. The Patient is at the centre of it all

It is important the patient understands that the pain is often not going to go away completely. It is about reducing the pain. But, more importantly, it is about

managing and living as best and functionally as possible, even with the pain.

2. Pain is a separate entity

The concept of pain always being a symptom of something bad happening in the body is an old idea. It no longer holds true, especially, in the chronic pain setting. Pain is a system on its own, an entity on its own; to be respected for what it is! It is not always possible to find an underlying cause for the pain.

3. Multi-disciplinary approach

I learnt a lot about team-working and the crucial role of various disciplines. I expected Physiotherapists and Specialist Nurses, along with Anaesthetists would play a key role. What surprised me was the impact and the role of the Clinical Psychologist. I was struck by the way psychological aspects of the human brain was intertwined with our perception of chronic pain. I was fascinated by the way the Clinical Psychologists worked their way through the maze of thoughts of the patient, and more often than not, managed to get through successfully.

To take the same example of the patient with chronic low back pain, the management aspects are pretty similar from the medical side of things. But, it differs markedly in that there is a lot of encouragement for the patient to take an active role in their pain management. There is greater emphasis on biopsychosocial conditioning and modifications. And I think, rightly so. I have seen passive patients here as well.

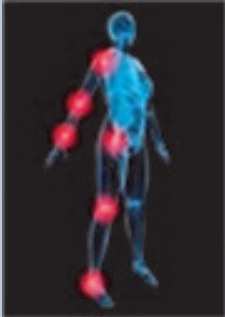
But, the great majority understand the concepts of chronic pain management, take an active role in their pain management and respond very well to the multidisciplinary approach.

To conclude, after the Pain Module, I have awoken myself to the various aspects of pain management. I don't think of pain management purely as an Anaesthetist/Pain Doctor, but try to look

at it in a more holistic manner. I learnt various team-working skills from all the members of the multi-disciplinary team. It was an enriching learning experience, and it will stay with me for the rest of my life.

LIPS

Low-dose Intravenous Immunoglobulin Treatment for Complex Regional Pain Syndrome



BATH

CAMBRIDGE


GLASGOW

LIVERPOOL (LEAD)

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

CANDIDA MCCABE
Royal National Hospital for Rheumatic Diseases, Bath


NICHOLAS SHENKER
Addenbrookes Hospital Cambridge


MICK SERPELL,
Gartnavel General Hospital, Glasgow


NICK PADFIELD
Guy's and St Thomas' Hospital, London


MARK SANDERS
Norfolk and Norwich University Hospital, Norwich

KARIM SHOUKREY
University Hospital of Leicester NHS Trust.


National Institute for Health Research


The Walton Centre NHS Foundation Trust


UNIVERSITY OF LIVERPOOL


UKCRC Registered Clinical Trials Units

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.



Social media in medicine: benign influence or spin?

Dr Trish Groves *Deputy Editor, BMJ & Editor-in-Chief BMJ Open*

It's difficult to predict the future and technologies often come out of the blue. We could never have expected to have more computing power in our pockets than the Apollo moon rockets. In the 1960's we had mainframe computing and now they are talking about everyday wearable computing and glasses that will project what you want from the Internet straight into your eye.

This has driven how we communicate with each other. In the 1990's people danced at pop concerts – now they video, click, share and tweet each other. It's not surprising that India is second in world Internet usage; back in the 1990's I was writing articles in the BMJ about the need to get telephone lines to people in their homes and in hospitals so that doctors and healthcare workers could get easy access to information from books and journals by wired internet, but mobile phones have completely leapfrogged that.

Social media have been variously defined as:

Applications that build on ideological & technological foundations of Web 2.0 & allow creation & exchange of user-generated content (Alqvist *et al*, 2008)

Interactions in which people create, share, & exchange information & ideas in virtual communities & networks (Kaplan AM, Haenlein M, 2010)

Information tools that both exploit & celebrate our social nature (Coiera 2013)



The first definition is about the technology, the second is about people, but the third is about the tools that allow them to interact and to exploit and celebrate our social nature. These things are just tools; the medium is not the message - what's important is what we do with them.

The General Medical Council has a social media policy which covers blogs and micro blogs such as Twitter and Internet forums e.g. doctors.net and the BMJ's Doc2Doc, which doctors use to talk to each other; content communities such as YouTube and Flickr and social networking sites such as Facebook and

LinkedIn. People can use LinkedIn to share their work profiles etc; it is used enormously in India and, apparently, increasingly here.

A survey by the consultancy survey ranked the usage of various media internationally. Facebook, YouTube and Twitter came way out top and there were some at the bottom which are being increasingly used by the young, such as Tumblr which is huge amongst teenagers mostly for sharing images and blogs and Instagram which is an app which allows you to share photos to which you can add effects. These things generally go in and out of fashion.



Twitter

The great and powerful thing about Twitter is that you can share links to articles and websites etc. I use it all day and everyday and get all my information from Twitter now – I've given up on reading journals. The way it works is you join and have your own profile. The trouble with emails (my email inbox which always contains about 600 emails and I simply cannot answer them all) is that you feel obliged to answer every one, whereas you can eyeball Twitter and see immediately if you are interested or not. It is a stream which you can step in and out of and if something whizzes past and looks interesting you can click on it. It's the equivalent of a ticker at the bottom of the TV screen which gives you the news headlines. You can look to see who has picked up or re-used the tweets you have sent. It's not time-wasting – it's actually parsimonious. People take Twitter seriously and the LSE has by far the best guide '*Using Twitter in university research, teaching and impact activities, a guide for academics and researchers*', published in 2011, <http://blogs.lse.ac.uk/>. It is concise but very informative and contains lots of different ways of using Twitter. If you only contact the Internet twice a day on your home computer then Twitter may not be for you, and it is probably much more useful if you have a phone or a tablet that you can use 'on the go'.

Twitter can be narrative because within those 140 characters you can attach a link which can be as long as you want. There is a tool called Storify with which, for instance you've sent a lot of Tweets at a conference, you can pull all of them into Storify and drag in your tweets and it turns them into a blog, and a nice story of the conference has written itself in seconds.

Blogs and Facebook

There are lots of blogs; the BMJ has a very active blog site, Doc2Doc. We get bloggers from all over the world. People will share information through different media. The cardiologists in the US have a huge network with closed areas where they can consult one another about patients, as well as forums for discussing academic issues. I think there is an industry site where industry can get feedback from sponsorship. Discussions in Doc2Doc cover a wide range of subjects, recently including *Why do medical students behave badly; Why do doctors prescribe expensive drugs; Should castration of sex offenders be banned; Ignorant doctors and blood pressure and Should unconscious patients be tested for HIV?*

I only use Facebook for family but lots of companies, journals, hospitals patient groups – you name it – do use it and it is a great way to tell people what you are doing.

Interaction

Enrico Coeira, a Professor of Medical Technology, argues that we can use social media to improve patient care, particularly with what have been called social shape diseases. He describes the concept of *social contagion*: that illnesses and health states can be transmitted socially. For instance, it is known that people tend to marry others with similar rates of heart disease or diabetes. But it also includes things like poverty, education, diet and smoking.

There is increasing evidence that chronic, lifestyle type diseases do spread within social networks. This seems to accord with the concept of *Homophily*. Recent controlled experiments suggest that not only do people tend to have friends who are similar to them but, individuals alter their behaviours to match those of their peers.

Coeira suggests that you can intervene in networks, using the tools I was talking about. You can intervene between individuals; 'champions' central to a network can increase diffusion of evidence based practices. If you want to intervene in groups, such as multi-professional teams, for instance to improve hospital safety or perhaps quality of nursing care, you can look at social interactions as well as professional interactions to change behaviour. 'Network induction': spreading information by word of mouth, snowballing and viral interventions, can be facilitated if you understand how the group functions socially, as with HIV prevention messages among peers. 'Network alteration', for instance in the management of alcohol or drug use, involves removing someone from a group who is a particularly bad influence, or changing the nature of connections. This may seem rather obvious but we have academic studies which show how to do this in a planned way. One on-line support group has reached someone living with severe FMS in a remote farmstead in South Africa.

Crowd-sourcing was used by astronomers without the time to analyse all the data from the Hubble telescope to enrol lots of amateurs in finding new nebulae using their home computers and to define the structure of a protein, by putting images on the internet and telling people what patterns to look for, and has been similarly used with great success in cancer research. An Italian patient did this with his own brain tumour: he had a rare one and there was something about his clinical test data that his doctors were

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puzzled about. So he put it on the Internet as a blog and asked if anyone could help solve the puzzle, and was successful in this.

Privacy

There are rules governing identity and the prohibition of defamatory material. Your trust has a gagging clause. You can make it safe: you can premoderate and postmoderate things like blogs. You can have a private page on the Internet where patients can post their comments and a member of staff or another trusted person can monitor this. All of these social media tools have privacy settings and it's important that you know how to use them. You can

have a private Twitter account which only allows people you have chosen to follow you.

There is also an issue regarding litigation. Twitter is a publishing platform. The simple rule with libel is if you put something into the public domain in any way that can lower the reputation of the person in peoples' eyes, that is potentially libel, and in the UK the onus is on you to prove that it wasn't libel. In most other countries it's the other way round; the person libelled has to make the case.

Social media can be used to propagate ideas and change people's thinking by various means including a Facebook page. You can share articles that might be interesting to other people

in the SIG. It's like Chinese whispers – you tell somebody who tells somebody who tells somebody. Amazingly, in one meeting at the BMJ the three of us tweeting reached 22,000 people all round the world.

You might say you haven't time for all that but many people do and if you want to share what you are doing these tools are very powerful, and much more useful than a print newsletter as they are interactive. Psychiatrists are using the Internet and social networks as cognitive tools. Doctors are using social media to educate one another. Whatever will come next....?

This is the transcript from the author's talk in Philosophy and Ethics SIG meeting at Launde Abbey.

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A new enhanced surveillance system for Post-Herpetic Neuralgia in Pain Clinics

Philip Keel *Scientist (Epidemiology), Public Health England, Immunisation, Hepatitis and Blood Safety Department, London*

In 2010, the Joint Committee on Vaccination and Immunisation (JCVI) recommended that routine immunisation for Herpes Zoster (Shingles) should be introduced into the UK schedule,¹ and following this recommendation, this occurred on 1 September 2013. The first group of people eligible for routine vaccination were those aged 70 years on 1 September (born between 2 September 1942 and 1 September 1943), this was alongside a catch up campaign for those aged 79 years on this date (those born between 02 September 1933 and 01 September 1934).

Shingles is an infection that is typically characterised by a unilateral vesicular rash involving a single dermatome, with the diagnosis being predominantly made clinically in primary care. It is caused by the reactivation of latent varicella zoster virus infection (chickenpox). Once a person has recovered from chickenpox, the varicella zoster virus lies dormant in the nerve cells and can reactivate at a later stage when the immune system is weakened. Reactivation of the virus is thought to be associated with immunosuppression as a result of a decline in cell-mediated immunity due to old age, immunosuppressant therapy or HIV infection.²

An important and significant complication of shingles is persistent pain continuing after the rash has gone, known as post-herpetic neuralgia (PHN).



PHN is specifically focused in the area affected by shingles and may be a constant burning, itching, stabbing or aching

pain, which is extremely sensitive to touch and is not routinely relieved by common pain killers. The risk and severity of PHN increases with age, with one-third of sufferers over the age of 80 years experiencing intense pain. The annual incidence of herpes zoster infection is about 8 per 1,000 persons in those aged over 70 years (data from the Royal College of General Practitioners sentinel surveillance scheme). In England and Wales, it is estimated that approximately 14,000 cases develop PHN and 1,400 cases are hospitalised each year.

While incidence rates for shingles are captured by various sentinel primary care data sources, there is no established routine national surveillance of shingles or PHN. Public Health England (PHE) has a duty to monitor communicable disease and the impact and effectiveness of all routine vaccination programmes and has

therefore recently introduced a number of new enhanced surveillance systems for shingles and PHN in light of the new zoster vaccination programme.

Although it is accepted that PHN will often be managed in primary care, more severe cases require referral to specialists in pain clinics. Surveillance partnerships, with pain clinics in England, were developed to monitor the impact of the shingles vaccination campaign in preventing PHN.

In an initial scoping exercise, pain clinics in England were contacted last year asking for information on overall clinic numbers, attendance for PHN, staffing levels and an expression of interest in being involved in the enhanced surveillance of PHN. The response to this contact, and the number of cases of PHN seen in pain clinics, meant that the implementation of such a surveillance system would be possible.

Therefore, beginning in September 2013 to coincide with the start of the shingles vaccination campaign, a surveillance system was setup in partnership with a number of pain clinics across England. This enhanced surveillance has three main objectives:

1. Estimate the overall impact of the vaccination programme on reducing PHN in the vaccine targeted age cohorts (those aged 70 and 79 years old on 1 September 2013);

A new enhanced surveillance system for Post-Herpetic Neuralgia in Pain Clinics

2. Estimate the effectiveness (the level of protection to the individual) of shingles vaccination against PHN in the targeted cohort;
3. Compare the severity of PHN in those vaccinated and those unvaccinated in the targeted cohort.

From 31 January 2014, quarterly return forms have been sent to all participating pain clinics in England asking healthcare professionals whether they have seen any cases of PHN in patients aged 70 years or older. The healthcare professional will tick either Yes or No and provide a minimum dataset where they have indicated seeing a case. This will include patient initials, age, gender, hospital number, clinician and pain clinic name in order to link this to a further enhanced questionnaire.

Any clinician or healthcare professional who returns the card with a positive response will then be sent a more detailed PHN enhanced surveillance questionnaire for completion for each individual patient. These questionnaires will be returned to the Immunisation, Hepatitis and Blood Safety department, PHE Colindale for further analysis and collation of data nationally. The data that will be collected will fall into the following categories: *Demographic detail, Clinical details, Co-morbidities, Vaccination history and Pain clinic details.*

An initial retrospective review of cases of PHN in those aged 70 years and

above, who have attended participating pain clinics in England over the past year, will be conducted to obtain a baseline estimate of overall case numbers. Given the time lag to develop PHN and be referred to a pain clinic for specialist management, the data returns for the first two quarters of 2014 will provide additional baseline data as these individuals are likely to have developed shingles and PHN prior to the introduction of the vaccination programme. The size of each clinic will be estimated based on the overall annual attendance for any condition.

The Immunisation, Hepatitis and Blood Safety department, PHE Colindale will produce reports on the evaluation of the vaccination programme. Information on PHN incidence and other data of interest on PHN will be provided as part of this reporting. These reports will be sent directly by PHE Colindale to the participating pain clinics.

The British Pain Society has endorsed the PHE proposal to establish a new surveillance system for PHN. While the surveillance is now up and running, we would still like to encourage any pain clinic not signed up to consider doing so. The more clinics that sign up, the stronger the surveillance system will be and the greater the potential benefit to patients.

We would also like to take this opportunity to thank our participating clinics greatly for their involvement and

continuing support in this new surveillance scheme. The first two quarters of data have now been collected, and while the response rate was good, we would like to encourage any clinics that did sign up but were unable to report in these first data collection periods to try and do so for the next quarter (1 April to 30 June 2014) so that we can begin to analyse the impact of this new vaccination campaign against a severe and debilitating condition.

If your clinic has not yet signed up but would like to be part of the new surveillance network, or would like more information on the new surveillance system, please contact the team at PHE by email at shingles@phe.gov.uk

Full details of the shingles vaccination programme are available from <https://www.gov.uk/government/organisations/public-health-england/series/shingles-vaccination-programme>

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After Tramadol: a closer look at Codeine ?

Sandeep Kapur *Consultant in Pain Management & Anaesthesia, Dudley NHS Foundation Trust*



Between 2003 and 2009, deaths attributed to drug overdose increased by 61% in Florida, with especially large increases in deaths caused by Oxycodone. Florida became notorious

because of the proliferation of what were euphemistically named 'pain clinics' - in reality, no more than 'Pill Mills' - that were prescribing (and dispensing) large quantities of opioid analgesics with impunity and virtually no oversight. These 'pain clinics' drew hordes of people, some of whom travelled hundreds of miles for a 'Oxy' prescription (the media pejoratively termed them 'Pillbillies'). During that period, Florida had the dubious distinction of being home to 98 of the 100 physicians who dispensed the highest quantities of oxycodone in the USA. In response, Florida's legislature enacted and enforced several laws as part of a comprehensive effort to address the problem. Law enforcement agencies began a crackdown ('Operation Pill Nation') on rogue physicians and pharmacies. The state legislature prohibited physicians dispensing opioids and other controlled drugs from their offices. A mandatory prescription drug monitoring program was enforced. The result? During 2010-2012, the number of drug overdose deaths in Florida decreased 16.7%. Death rates for prescription drugs decreased 23.2% overall, the biggest decline being in

overdose deaths from oxycodone (52.1%). Florida's experience eloquently demonstrated the effectiveness of strict regulation and monitoring of the prescribing and dispensing of controlled substances in reducing prescription drug overdose deaths.¹

In contrast to prescribed and illicit drugs, non-prescription, or over-the-counter (OTC) medicines are generally perceived to be relatively safe. However, while easy access to OTC medications has helped empower patients, there is also increasing concern about the potential for OTC medicines to cause harm associated with codeine addiction and side effects of additional ingredients, such as ibuprofen and paracetamol, which have led to fatalities. A study found that OTC medicine addiction often arises from genuine medical reasons and is maintained by the ease with which these drugs can be obtained.²

While the scale of the problem is unclear, a report by the National Treatment Agency for Substance Misuse (2011) stated that overall, 16% of people in UK drug treatment services present with problems due to prescription-only or OTC medications. The report highlights an alarming increase in the community prescribing of opioid analgesics from 228.3 million items in 1991 to 1,384.6 million items in 2009. The report states 'while national treatment data does indicate slight year on year increases in the number of individuals in treatment who report the problem use of prescription only and over the counter opioids, the rapid increase in the prescribing of opioids does not seem to be fully reflected by the increase in treatment demand'³

It is worth noting that the annual number of deaths attributable to codeine has almost tripled, from 46 in 2001 to 120 in 2012, compared to the 154 deaths caused by Tramadol in 2011 (rising to 175 in 2012), though the majority of Tramadol related deaths are in cases where it has been obtained illicitly. Now that Tramadol (as of 10 June 2014) has been reclassified as a schedule 3 controlled drug, it begs the question: What is the future of codeine? However, OTC painkillers are big business to the pharmaceutical industry: in 2013, sales of painkillers hit an all-time high of more than 25 million packs-at least 754 million pills.⁴ Big Pharma are therefore likely to mount a vigorous campaign to prevent any changes to the status quo.

So how do we reconcile our duty of care with the potential risk of harm? Evidence from the USA (in addition to the Florida example) demonstrates that prescription monitoring programmes (databases that contain prescriber and patient data pertaining to drugs with potential for abuse) help mitigate opioid abuse and misuse trends.⁵ Indeed, it is high time we follow the US example and establish a national prescription monitoring system for opioids and other controlled drugs in the UK. In the meantime, some experts have suggested mandatory coding of opioid use in electronic patient records, thereby providing data on the use of opioids nationally, which could also be cross referenced against their other coded diagnoses, including alcohol or substance dependence.⁶

Moore et al, in an elegant analysis of the opioid prescribing problem (BMJ 2013) state: "Pain relief is not normally

After Tramadol: a closer look at Codeine ?

distributed but usually bimodal, being either very good (above 50%) or poor (below 15%). Using averages is unhelpful and misleading, because “average” pain relief is actually experienced by few (if any) patients, and it tells us nothing about how many patients will experience clinically useful pain relief.....We believe that pain medicine has now reached a degree of maturity where it can confront its failings. We propose a radical transformation in how we establish analgesic efficacy and harm.....measure pain in individual patients, expect analgesic drugs to fail to provide a good response in most patients, and prepare for the next step when failure occurs”⁷

So where does that leave us, as clinicians treating patients with long-term

pain conditions? As Cathy Stannard noted in her 2013 editorial in the BMJ “As prescribers, we must keep in touch with the current debate, so that we can balance the competing imperatives of ensuring a pragmatic and compassionate approach to supporting patients with pain and avoiding the risk of creating problems for individuals and society”⁸

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The early days in Seattle and the birth of the IASP: a history of the pain movement

John Loeser *Professor Emeritus, Neurological Surgery and Anesthesia and Pain Medicine, University of Washington*

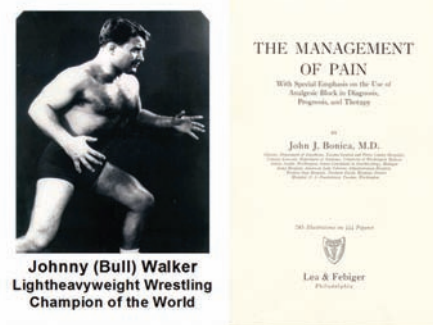
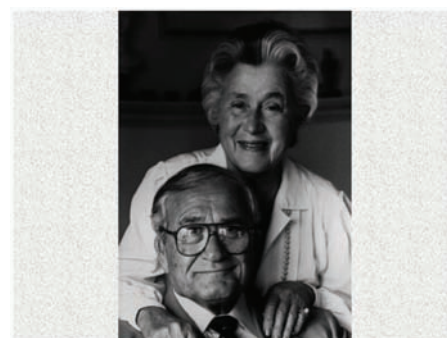
This was an informal session at the 2013 meeting of the philosophy and ethics SIG and included many fascinating portraits of and anecdotes about other pioneers of pain medicine, for which there is no space in this article. The full text of this, and transcripts the rest of the proceedings, including the important discussion, is available as a free booklet from pwgorman@btinternet.com, and as a download from the SIG page on the BPS website

The pain world started with one person. That man was John Bonica. He was born on the island of Filicudi near Sicily and brought to the USA by his family when he was ten years old. He worked from the age of ten but managed to get a scholarship to go to college where he became a successful college wrestler. He then went to Marquette medical school and graduated just before the United States entered World War II. He was drafted into the army and had an internship in a big army hospital not far from Seattle in Madigan called Fort Louis, where they told him he was going to do anesthesia. He literally self-taught himself what there was of anesthesia at the time and spent the entire war at Madigan. He became concerned there about issues of pain as Madigan received a lot of injured soldiers from the Pacific theatre, with problems like phantom limb pain and neuropathic pain. When his first child was born his wife almost died from

the anaesthetic, and the management of pain in childbirth remained one of his lifelong interests. After 15 years of private practice in Tacoma, John Bonica was appointed as the first Chairman of Anesthesiology at the University of Washington in 1960.

He immediately set up a pain clinic in cooperation with a neurosurgeon and a nurse. I was a resident from 1962 so I saw the early days of the pain clinic. Bonica hired a primary care practitioner who saw two new referrals on Monday and decided what consultations were needed. During the week they were seen by other consultants in neurosurgery, orthopedics and psychiatry. If appropriate some sort of diagnostic blocks were done, and on Friday the group would convene and a group formulation of the problem was arrived at. Dr Bonica would make his formulation; he would sometimes agree with the group; there were two votes, Bonica and everybody else! Then he would explain to the patient what the group felt and what treatment options were available and what should be done. To my knowledge the group never again saw the patient. They went off to the surgeon or the psychiatrist and there was very little feedback.

Bonica was also secretary general of the World Federation of Societies of Anesthesiology (WFSA). He used that as a platform to go all over the world talking about how he was doing pain management. People from all over the



world asked to spend time in the department, learning about pain.

The International Association for the Study of Pain

By 1973 Bonica - and I really think it was just him - decided that it was time to organise the world to do something about pain. Having raised the necessary money, he used his knowledge of people all over the world to invite some 300 people to a meeting in Issaquah, outside

The early days in Seattle and the birth of the IASP: a history of the pain movement

Seattle. Bonica was a genius – this place was totally inaccessible; the only way you could get there was by a chartered bus or a taxi. So he had 300 people there *and they couldn't leave!* We worked a 14 hour day. This meeting brought together people Bonica and his colleagues thought would be suitable to start an international pain society. The last event on the Friday was an assembly in which the question was asked: where do we go from here? We agreed that we should start an association which should have a journal, and Pat Wall agreed to be its editor. Pat was a well-known neurophysiologist by then and the seminal Melzack Wall gate theory was already well-known. Bonica realised that one of the problems was that if this organisation remained a Bonica/Seattle organisation it was never going to become internationally acceptable. And so it was agreed that we would form a society and that the first congress would be in Florence two years later. So the IASP was launched and took off like a rocket, in no small part because of Pat Wall and the journal *Pain* which was a high status journal and at that time the only journal with the word pain in its title.

The first IASP congress was held in Florence. Everybody assumed that Bonica would want to be president and everybody would vote for him, but it was fascinating the way Bonica fixed things. He and Mme. Denise Albé-Fessard decided that she would be president for three years and past president for three. So who would be president-elect? John Bonica, so he got nine years of basically running the organization. The first council meeting after Florence was held at a town near Innsbruck, and I will never forget - Denise Albé-Fessard stood up and said that there were not enough French people holding office in this organisation. And Bonica looked at her and said: "Madame, when the French do something worthwhile we'll get them into offices."

The second IASP conference was in 1975 in Montreal because Ron Melzack

had added his name to the organization and we were getting both Melzack and Wall.

By the late 70's there were pain clinics springing up all over the world. From the early ones in Oxford, Jerusalem, Sydney, Los Angeles – about a half-dozen around the world - it just exploded. In the early days we said we were going to have a governing council with the elected officers: president, secretary etc. and then we will have a council consisting of six elected councilors and six regional vice-presidents. But although representatives for Europe, Africa and North and South America were acceptable, when you go to Asia (which includes Australia) none of the major countries would accept vice presidents from others so we abolished the VP's and just had twelve elected councilors, and we schemed - and still scheme - so there would be adequate representation geographically, discipline-wise, gender-wise and we have a good balance.

To me the most rewarding thing of the whole IASP story was going to some country where they were trying to start pain clinics and societies and helping them to get things going. I was able to do that in China and the Philippines, Thailand, Bulgaria, Rumania and what is now the Czech Republic. And there was a wonderful group of people in the IASP who shared a common purpose and a common goal. We were a family. As it has evolved and the original family has died or left office it has been sad.

The numbers have grown from about 500 in Florence to 1100 in Edinburgh and straight upward since then.

One person in the pain world who was not actually a provider but who orchestrated everything was Louisa Jones. IASP would never have been the same without her. She progressed from being John's secretary to becoming the administrative secretary of IASP and ran it until she retired about five years ago or so. She was amazing: first of all IASP's overhead costs were incredibly low

because she organised everything so efficiently. She was the mother of the society – seeing to everybody's needs.

Michael Bond pushed IASP into helping developing programmes all over the world was when he was president. Each president gets to push the resources towards the things they feel are most important; mine was to establish chapters all over the world.

The journal *Pain* is still the best pain journal measured by the conventional criteria and it's harder to get something published in it than any place else. The mission of the publishing arm is to produce cheap books. We distribute books and journals in developing countries on a free basis.

In the 70's it was like being a pioneer pushing westward in the US to try and bring roads, railroads and civilisation into the wilderness. What we were trying to do was new and unheard of. It's still true in some countries but by and large the ground has changed. Now the question is how do you bring modern knowledge be it technical, psychological or whatever, and information about pain to people that don't have it. Pain management is part of healthcare and we have learnt the hard way that you can't go to someplace where there is no healthcare and try to bring them pain management. You don't have the infrastructure and providers. So the focus has changed from bringing the issues of pain to people who never saw them to getting people to allocate resources to pain management that are appropriate to their system. You can't just export sophisticated pain medicine. The challenge is to fit in your concept of pain management into someone else's culture and the resources they have.

Another issue is that young men and women want to come to the USA for training. The question I always ask them when they apply is what are you going to do when you're done with your training, and only accept them if they are going to use this for the benefit of their own

country. Why the US should suck up all the brightest and best of every other country of the world I don't understand.

Bonica the man

Nobody was too low in status to deny his attention. He paid attention to anybody who was interested in pain. He'd talk to students, nurses – if you were doing anything to do with pain he was interested in you. He was a very multifaceted person. He could be the most arrogant “*****” you ever saw. He did not tolerate snobs at all, and if he thought you were pulling rank or whatever he was merciless. There was one phrase of his that if you heard it you would know it was time to get out of his way. If he ever said “*listen friend ...*” you knew the trigger was about to be pulled. Although he wasn't very tall his aura was huge.

When he was an intern and in the army he wrestled professionally to make money. When his Commanding Officer decided that it was unbecoming conduct for an officer to be a wrestler and told him to stop, Bonica became the Masked Marvel! He continued to wrestle with this identity for several years and won many prizes. He stopped when he went into practice. He paid a price for his wrestling as he had terrible hips, knees, ears and other damage that cost him dear in later life.

There are lots of legends about Bonica but the family story is that he would

come home from the hospital, say a few words to his wife and children over dinner and go up to his office and work until 3 or 4 in the morning, and go off again after two or three hours of sleep. In 1953 he produced the book entitled *The Management of Pain*, which to my knowledge was the first comprehensive book on pain.

John's wife Emma was a saint. They had four children and she waited on John like no other wife I have ever seen, and took care of everything he did other than his profession. She was an example of the adage that behind every great man is a great woman. She raised the children as he was never home. She cooked, she cleaned... He loved her very much in terms of kindness and respect, but for a man whose focus was on something other than the mundane and the business of day-to-day living, you need a wife and family and the support system that allows you to do it. As they were growing older some of us thought that it would be nice if John died first so Emma could have a little time to herself, but unfortunately Emma died first, only a few months before John's death in 1994 at the age of 77.

I was one of Bonica's foot-soldiers. I was fortunate in that I was not in his department because he could definitely exploit people whose lives he controlled. He worked twenty hours a day and would be angry with you if you didn't work as hard or didn't get a job done as fast as he could. He liked to call junior

members of his faculty to go out to his house to inject his hip after work. I tried very hard not to be his neurosurgeon but shortly before Christmas one year he acutely herniated a disc and had major neurologic deficit, so I had to operate on him, and for the next twenty years I was his spine doctor! He was not a good patient!

Bonica retired from clinical activity in 1978 and the pain centre didn't prosper the way he wanted it to. In 1982 I became director of the pain center. I was very fortunate because Bill Fordyce who was without doubt the psychologist who did the most to put pain into a reasonable perspective was looking for an opportunity to expand his activities. He and I got a whole ward in a hospital and we constructed an inpatient and outpatient service with a group treatment programme of some 20 patients for three weeks at a time. That served as a model for pain clinics all over the world.

One thing that helped was that Bonica was the secretary-general of the World Federation of Anesthesiologists. And that put him into every developed country in the world.

He wrote a textbook on obstetric anesthesia and analgesia. He wrote the second edition of the *Management of Pain*, and I edited the third edition because six months before he died he made me promise that I would bring out another edition.



The challenge of pain in older people

Dr Pamela Ball, Chair of the Pain Alliance of Northern Ireland



The number of older people in Northern Ireland is steadily and consistently increasing. Between 2011 and 2012 the number of adults aged 65 and over increased by 2.6% to 272,800; the largest year-on-year increase since 1981. Over the ten year period between 2002 and 2012 the population of this age group increased by 20.3%.¹ This trend is expected to continue; the number of adults aged 65 and over is projected to increase by 12.2%, from 272,800 to 306,000, between 2012 and 2017, and by 63.5% (to 445,900) between 2012 and 2032. The median age of the population is also projected to increase over the same period, from 37.6 to 42.4.¹

With this in mind, the Pain Alliance of Northern Ireland held two events this year to raise awareness of the problem of pain assessment and management in older people.

Pain and dementia

The first of these events, held by kind invitation of Mr Jim Wells MLA, Deputy Chair of the NI Assembly Health Committee in the Long Gallery, Parliament Buildings, on 26th March, aimed to raise awareness of the burden of pain in those who suffer from dementia.

Key note speakers were Prof. Pat Schofield and Prof. Peter Passmore.

Four Seasons Health Care reported on the benefits of robust assessment and management of pain in residents of their care homes as part of their PEARL project to improve the lives of residents. Perhaps the most memorable presentation came from a son of a gentleman with dementia. He reported how his father's distress behaviour was alleviated, not by psychotropic drugs but by simple analgesics, and how relief of his pain allowed his wife to continue to care for him at home.

Currently we estimate that there are over 20,000 people in Northern Ireland who suffer from dementia.

64-86% of all older people have CHRONIC pain², while people with dementia are EQUALLY at risk of having painful conditions as the general older population³. The more severe the dementia, the more likely the person is to be in pain⁴.

Pain is devastating to people with dementia who are unable to explain their pain⁵. Pain makes people miserable and it affects what someone can do and makes them appear more impaired than they really are. It impacts on functional and mental capacity, social interaction, quality of life, appetite, sleep, agitation, depression and anxiety. Changes in behaviour can indicate the presence of pain⁶. However in the absence of pain assessment, the response to behavioural symptoms in a person with dementia is often the prescription of sedatives and anti-psychotics⁷. Treating pain can reduce the use of anti-psychotic drugs⁶.

One study, done in local nursing homes, showed that the main barriers to

Consequences of pain for those with dementia

Appearing more disabled than they really are.

Feeling disempowered, distressed and feelings of not coping.

Poor quality of life.

Increased pressure and stress on carers.

Increased likelihood of behavioural symptoms as a pain response.

Behavioural symptoms not recognised as potentially related to pain.

Inappropriate treatment becomes more likely, e.g. anti-psychotics.

Anti-psychotics are harmful to many people with dementia increasing likelihood of stroke, fatality, and exacerbating symptoms of dementia.

Increased likelihood of premature admission to higher level of care – nursing/ residential home/ hospital/ detention under the mental health order thus increasing the cost of care.

Human rights infringements.

successful management of pain in nursing homes were:

- Knowledge of pain management (82%)
- Getting an accurate report from the patient (76%)

- Lack of standard approach to treating pain (71%).

The meeting called for the following process to improve the care of those with dementia who suffer pain:

- Recognition of pain as a cause of difficult or challenging behaviour in those with dementia;
 - Training of healthcare and social care staff – Public Health Agency (PHA).
 - Public awareness campaign – PHA.
- Pain assessment as a routine upon admission to a healthcare facility or when behaviour changes;
 - Training of healthcare and social care staff in the use of appropriate tools - PHA.
 - System of recording and tracking changes in pain following interventions – Northern Ireland Social Care Council (NISCC), Regulation and Quality Improvement Authority (RQIA).
- Quality assurance of pain management;
 - Pain assessment and management to be a quality standard for healthcare facilities -NISCC, RQIA.

in the belief that recognition of pain as a cause of distress and challenging behaviour and its appropriate management will:

- Reduce inappropriate prescription of psychotropic medication.
- Reduce inappropriate admission to hospitals and care homes.
- Permit those with dementia to remain at home in their community for longer.

A further meeting was held with the Regulation and Quality Improvement Authority (RQIA – this organisation has a role similar to the Care Quality

Commission) Head of Nursing Home, Independent Healthcare and Pharmacy Regulation and two Inspectors/Quality Reviewers to discuss these issues. An assurance was received that formal pain assessment, record keeping and management form part of the standard inspection of all nursing and care homes for the past eighteen months and that this will continue to be monitored and reported upon in future.

Pain management in frail elderly people

Following the success of the Pain and Dementia meeting, the Pain Alliance held an evening meeting on 26th June at Mossley Mill Conference Centre to highlight the challenges of managing pain in frail elderly people.

Dr Bernadette McGuinness, Consultant in Geriatric Medicine, Belfast Trust, provided a comprehensive overview of the assessment and management of pain including the contribution that pain makes to falls, exhaustion and feebleness, social isolation and loss of dignity. She reviewed the algorithm for assessment of pain and a number of tools appropriate to older people and raised awareness of how visual and cognitive impairment may influence choice of tool. Following presentation of the evidence for treatment modalities, including drugs, interventional procedures, physiotherapy, psychological therapies and self-management, she presented a case study of a frail elderly lady with back pain, which demonstrated how susceptible such patients are to the adverse effects of pain and to the inappropriate use of medication.

Mr Simon Higgs, Lead Nurse for the Acute Pain Service South Eastern Trust, spoke of the difficulties in management of pain in elderly people with cognitive impairment in a busy trauma ward and how a change management project had improved understanding of the impact of

pain, the need to anticipate pain, even when it is not reported, and the use of the Abbey Pain Scale. The introduction of the Butterfly system to identify and record those with diagnosed dementia and those with possible dementia or delirium resulted in improved patient care which was reflected in a high degree of satisfaction on the part of relatives and carers.

Dr Michael McKenna, GP, West Belfast, presented a case study of an elderly lady with polymyalgia rheumatica who illustrated all the problems of long term steroid and analgesic use. During repeated hospital admissions for complications, including multiple pathological fractures of dorsal vertebrae, her analgesic medication was changed to short-acting drugs resulting in dose escalation and the need for regular review in primary care to restabilise on long-acting preparations. He called for better communication between hospital teams and GPs.

Claire Lasini, Senior Physiotherapist in an ambulatory care unit, Belfast Trust, demonstrated the advantages of movement for frail elderly patients to their pain managements as well as a wide range of other modalities that alleviate pain. She cautioned against the belief that rehabilitation is impossible for frail elderly people, stressing that given time and a very gradual increase in the intensity of movement/exercise significant benefits accrue. Posture correction can help to reduce stress on joints, improve balance and confidence, and reduce the risk of falls, as does therapeutic exercise.

Dr Pamela Bell, spoke very briefly about the Programme of Care for Older People in the Commissioning Plan for 2014/15. Although the plan has been agreed by the Public Health Agency and the NI Health and Social Care Board, the budget for delivery has not yet been agreed. However the Regional Commissioning Priorities for 2014/15 are as follows:

- Complete consultation process regarding statutory residential care

The challenge of pain in older people

and agreed Trust proposals for service reform.

- Undertake review of domiciliary care services and revised contractual arrangements
- Development of enhanced safeguarding arrangements.
- Agree service development for dementia services with associated performance targets.
- Regional implementation of e-NISAT including the functionality to share information within and across Trusts.

and the Local Commissioning Groups will have responsibility to deliver on

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers can take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experiences by carers as supportive.

- Access to more options for carers in the provision or arrangement of their respite/short breaks.
- Increased uptake of direct payments.
- Working with Integrated Care Partnerships to improve the care of the frail elderly.
- Enhancement of dementia services.
- Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.
- Continued roll-out of targeted Public Health Agency preventative health and well-being improvement programmes.
- Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact.

Pain is not mentioned specifically in relation to the care of older people,

however elsewhere in the Commissioning Plan the Health and Social Care Board has undertaken to lead on a scoping exercise to define the current provision and future requirements for pain services in NI.

Finally, Ms Helen Ferguson, Director, Carers NI, closed the meeting with a plea to all healthcare professionals to consider the needs of those who care for frail elderly friends and relatives; to share as much information as possible within the constraints of professional confidentiality, and involve them actively in decisions about care so that they can work in partnership to achieve the best quality of life for their loved one.

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How do musculoskeletal physiotherapists make sense of the language that they use when explaining persistent pain to their patients? An Interpretative Phenomenological Analysis

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Introduction

The clinical landscape for persistent pain management is changing. The prevailing paradigm shift away from a dualistic, biomedical understanding of pain, towards a more complete biopsychosocial model has led to a multitude of challenges for musculoskeletal physiotherapists (Sanders et al., 2013). As clinicians adapt their perception of pain, they also need to develop communication skills in order to educate sufferers (Warmington, 2012).

Considering the broad, idiosyncratic nature of biopsychosocial practice and the perceptual definition of pain¹ (Moseley, 2003), this article sets out to discuss Interpretative Phenomenological Analysis (IPA) as a qualitative research method to explore how clinicians make sense of their use of language when explaining pain to patients.

Several key factors for using IPA will be discussed. These include phenomenological and hermeneutical considerations, IPA's compatibility to the biopsychosocial model (Reid et al., 2005) and its regard for qualitative validity (Yardley, 2000) and rigour (Pringle et al., 2011). In addition, IPA's ability to capture implicit and explicit linguistic nuances will be discussed (Snelgrove & Liossi, 2009).

Phenomenological & Hermeneutical Considerations

To adequately explore the meanings that clinicians attach to their use of language when explaining pain, it is important to collect in-depth accounts of their clinical encounters. Compared to more descriptive phenomenological

approaches, IPA's acknowledgement of the researcher as an interpreter of the participants interpretations, distinguishes it as an inclusive method for capturing and interpreting meaning (Wagstaff & Williams, 2014). Smith et al., (2009, p.3) term this concept the "double hermeneutic".

IPA's capacity to enable researchers to engage within the interpretative reasoning process is considered a fundamental methodological strength (Pringle et al., 2011). However, Radder (2003, p.16) suggests the double hermeneutic poses a multitude of philosophical, epistemological and social problems for research, with the unresolved question being: "Who is entitled to define the nature of human beings: the scientists or the people themselves?"

With this question in mind, although the double hermeneutic presents significant methodological challenges, in order to best explore how clinicians make sense of their language when explaining pain, a dialogical interpretative approach as outlined by Smith et al., (2009) provides a more rounded phenomenological stance. When

How do musculoskeletal physiotherapists make sense of the language that they use

comparing IPA to discourse analysis (DA) Reid et al., (2005) argue DA is concerned with the function of language within restricted, specific contexts. Although DA might enable linguistic deconstruction to uncover meanings, IPA's double hermeneutic, although questionable, permits a deeper exploration of phenomena (Biggerstaff & Thompson, 2008).

Pringle et al., (2011, p.21) suggest that when compared to other phenomenological research methods, "IPA tends to interpret belief and accept participants' stories, albeit in a questioning way." Whilst this provides a questioning foundation for study, IPA's lack of adherence to critical interpretative frameworks (Koch, 1999) has been highlighted by Pringle et al., (2011). However, Larkin et al., (2006) suggest that rather than seeing IPA as a definite method, we should view it as a 'stance' from which we may approach in-depth analysis of qualitative data.

Biggerstaff & Thompson (2008) suggest the holistic nature of IPA allows researchers to explore implicit meanings contained within texts through their own explicit interpretations. IPA acquires insight into individual perceptions through which we can make sense of the wider world (Pringle et al., 2011). This ability for IPA to offer broader, contextual interpretations makes it an ideal methodology for exploring the idiographic nature of linguistics when clinicians explain pain.

Metaphoric Interpretations

Pringle et al., (2011) suggest IPA seeks to go further than standard thematic analysis. This makes IPA an ideal choice to explore participant generated metaphors. Snelgrove & Lioffi (2009) used IPA to explore the lived experiences of chronic pain sufferers. They suggest the method's dual use of emic and etic perceptual questioning enabled richer analysis of implicit nuances contained



within the data.

Shinebourne & Smith (2010) suggest patient generated metaphors offer a 'safe bridge' through which they express emotions that are too distressing to communicate literally. If so, we must also consider the possibility that whilst clinicians grapple with the complexities of explaining pain, they might also use metaphors to communicate hidden obstacles they encounter within practice. IPA provides opportunities to capture covert agendas (Snelgrove & Lioffi, 2009), and permits further interpretations of their meaning to comprehensively explore this research question.

Clinicians and patients rely on metaphors to make sense of abstract neuroscientific concepts (Loftus, 2011, Moseley, 2007, Stewart, 2014). However, whilst metaphoric expressions to explain pain are noted throughout the literature, a phenomenological knowledge gap exists regarding their use by clinicians. IPA will seek to explore the meaning that clinicians attach to their use of metaphors when explaining pain.

This poses a methodological dilemma: the suggestion that metaphors will inevitably form part of the proposed data collection is at odds with IPA's inductive

approach. Whilst acknowledging the role metaphors play within pain education, I must avoid any prior assumptions or hypotheses (Pannucci, 2010, Reid et al., 2005).

Validity & Rigour

To gain a detailed understanding of this particular research question, the chosen methodology must adhere to sensitivity to context, commitment and rigour, transparency and coherence, impact and importance, as outlined by Yardley (2000). Smith et al., (2009) suggest IPA fulfils these principles, whilst highlighting the need for tailored evaluative methods for assessing qualitative work.

Larkin et al., (2006) suggest IPA researchers require support as they grapple with the dilemma of balancing individual accounts against interpretation and contextualisation. Alongside opportunities for independent audit through a reflexive diary (Smith et al., 2009), IPA's depth of data production also enables opportunities to strengthen validity and rigour through the use of peer debriefing (Erlandson et al., 1993) and triangulation (Biggerstaff & Thompson, 2008). However, the use of 'bracketing' (Husserl, 1999) within IPA has been disputed by Biggerstaff & Thompson (2008) who argue that by aiming to allow researchers to temporarily suspend judgments, the bracketing of data is in conflict with IPA's acknowledgement of the researcher's role as an interpreter.

Hale et al., (2007) suggest IPA's popularity is, partly, due to the detailed, cyclical process of data collection. Scott-Dempster et al., (2009) outline four iterative stages of IPA from the initial exploration of text to the formation of emerging thematic clusters from which higher conceptual groupings evolve through the search for superordinate and master themes. This process demonstrates a sensitivity to the data, and enables use of substantial verbatim

extracts from participants in order to substantiate my interpretations (Smith et al., 2009).

To represent the biopsychosocial paradigm, we must modify current research bias towards qualitative data, whilst safeguarding increased rigour in future studies. Loftus (2011, p.228) suggests many researchers follow the prevailing metaphoric idea that “evidence is numbers” without considering “different purposes require different types of description.” To further our understanding of this research question we must embrace a broad spectrum of methodologies, whilst synthesising pain research findings with linguistic analysis.

Compatibility to the biopsychosocial model

Whilst IPA permits in-depth exploration of experience, it is also noted throughout the literature for an affinity to the biopsychosocial model. Reid et al., (2005, p.21) suggest, “IPA’s increasing popularity within health psychology may well stem from its ability to contribute to biopsychosocial perspectives.” Whilst this compatibility strengthens the argument for IPA’s use to explore this particular research question, I must aim to capture the participants’ biomedical voices to gain overall perspective. The use of a reflexive diary, triangulation and peer debriefing would help identify and avoid bias (Pannucci, 2010).

Biggerstaff & Thompson (2008) suggest IPA promotes a greater understanding of the intricacies of biopsychosocial phenomena within practice. Similarly, IPA’s depth of analysis enables comparative exploration of any existing epistemological differences between the participants. This is vital when we consider the influence that contrasting technical rationale and professional artistry (Fish & Twinn, 1997, Schon, 1983) practice beliefs have on our use of language when explaining pain.

Conclusion

To further understand how clinicians make sense of their use of language to explain persistent pain to patients, we must first acknowledge the cluttered complexities of biopsychosocial practice (Loftus, 2011, Moseley, 2007). To adequately explore this research aim, IPA offers an in-depth approach that’s capable of capturing a broad spectrum of ontological and epistemological beliefs.

Whilst IPA’s acknowledgement of the researcher’s role as an interpreter of meaning offers a dual analysis through the double hermeneutic, we must remain mindful of the plethora of disputes present throughout the literature (Radder, 2003).

Reid et al., (2005, p.23) suggest IPA is “particularly suited to researching in ‘unexplored territory,’ where a theoretical pretext may be lacking.” The present knowledge gap that exists in our understanding of how clinicians make sense of their use of language when explaining pain, calls for the use of an in-depth, interpretative exploration of their linguistic choices. Although debate continues regarding IPA’s methodological approach, it provides a valuable method of exploration to further our understanding of this critical aspect of practice.

Note

1. “A multiple system output activated by the brain based on perceived threat” (Moseley, 2003).

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Where is your pain?

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Richmond originally trained as a Registered General Nurse, and developed an interest in pain whilst observing the varying

responses in recovery after operations. Richmond continued to train as a physiotherapist and has a further degree in Sport Rehabilitation and a Masters Degree in Pain Science. His passion is providing the latest in treatment for chronic and complex pain and seeing people relieved of symptoms, develop healthy habits and change so that they may lead normal and fulfilling lives once more.

Every day clinicians ask this question, guiding the patient to indicate where they hurt. For many years we have known that despite being able to point to a body part or region, this is not the full story. Thankfully for patients, the day when a knee pain or a back pain is considered simply a knee or a back problem has gone. Researchers, scientists, philosophers, writers and sufferers have shown that we must think more widely about the problem of pain if we are to have success in changing for the better what is often described as a sensory and emotional experience. Fortunately, this is starting to happen in the healthcare setting.

Each patient has a story to tell. Their narrative emerges as they attempt to describe something that they feel without necessarily being able to find the words that convey the essence of their suffering. The clinician listens and observes to gain an insight, but of course without ever truly 'knowing' the person's pain, as pain is personal, unique and owned by the individual. The common way to indicate pain is to point and say that it 'hurts here', the verbal expression of pain being accompanied by body postures, facial expressions and utterances. The language of pain tells us about the way in which the painful part, e.g. the back, is being experienced right now, even though the back itself is not 'pain'. The language of pain conveys a public warning for the observer to behold as much as the person communicating the private suffering.

Pain is about protection with the purpose of defending a part of the body but also the self. In the case of phantom limb pain, this can occur even if the body part is no longer in existence, or never existed. We can argue the mechanisms of pain are an essential and a phenomenal survival device, particularly when we have an acute injury. The individual has to know that something dangerous has happened or may happen, and be motivated to think in the right way and then to take appropriate action. On determining that a threat exists, there is a compulsion to protect oneself due to the unpleasant attention-drawing experience that is pain. This is accompanied by a concurrent change in the way we move, a stress response and

an immune response to name but a few. Pain will then be present for as long as there is a perceived threat of harm to the whole person. Whether or not there is an actual threat matters not, for pain is not an accurate yardstick for determining tissue damage.

The discussion of pain and from where it emerges is one with a great history. Science and philosophy are increasingly merging when it comes to pain, and rightly so, for we have to continue to change our thinking about this universal experience. There is no better example than when we are faced with a patient who comes to learn about their problem, what they can do about it, and how long it will take. This is a huge responsibility for the clinician and the reason why we are obliged to be able to answer the questions: why is this person in pain? What is the impact of this pain? What can I do to help this person? Much of the information resides within the narrative, the remainder to be elucidated by simple clinical tests and investigations – tests to be used wisely. One only needs read Oliver Sacks' great books to understand this notion. He urges us to consider the person as much as the condition; wise words and pertinent in the light of the more recent thinking on first-person neuroscience. First-person thinking considers the subjective experience, the meaning and impact of the pain, and not over-valuing third person data. After all, the result of an MRI scan is clearly not pain and does not adequately explain the subjective experience of pain.

So, where does pain come from? Surely if we can answer this



question, we will be able to reduce suffering immeasurably. It will always be important to have pain in response to an injury or pathology, but what about persisting pain beyond the normal healing time that disrupts living and the sense of self?

Our attempts to discover the origins of pain have taken scientists on a journey into the brain, the immune system, the endocrine system, the gastroenterological system, the autonomic nervous system, genetics, memory and into what we know about consciousness. Surely then, we are delving into the nature of pain that lies within the essence of who we are as human beings – and can we ever discover the absolute truth behind who we are when it is us doing the looking? In

reality, no body system works in isolation, and certainly not in isolation to the self, which consists of all systems as a whole.

The research focus upon the nervous system (peripheral and central) helped immeasurably to enhance our understanding of the role of the brain in pain. However this paradigm has been superseded by the knowledge that a large part of the brain is made up of immune cells and their significant role at the synapse. The immune system is responsive to how we feel and hence how we think, relating this to the sense of self, our purpose and beliefs about ourselves and the world around. Dr Mick Thacker has plausibly hypothesised that perception of threat evokes multi-system responses that are inter-reliant and manifest via the whole person, including the experience of pain. Pain, he contends, emerges from the whole person on this basis, a view to which I wholly subscribe (personal communication). This framework is allied with the belief that pain can and does change when the right conditions are created for the whole.

The contemporary approach to the problem of pain is one that recognises the person as well as and the condition. The pain emerges from the individual (Thacker & Moseley, 2013), within the context of their life to date yet in the present moment, and not any one part, but that of the whole. The shift in sense of self that defines suffering is created by the impact of the pain: the inability to work, play and socialise. In some cases the impact is due to the

individual simply not knowing how to go about living their life. The fear and anxiety that develop drive over-protective behaviours and the vision of the future narrows. As Henry Ford stated, 'Whether you think you can, or you think you can't, you're right', and I believe that this is true for patients, so many of which have received negative messages from themselves and others that hinder their sense of self and self-worth, funnelling their beliefs into limited choices. The reality is that all patients can improve and move forward with the right understanding, an appropriate and flexible set of strategies and a clear vision that is meaningful for them.

A priority within the pain community must be to continue to answer the question, 'Where is your pain?', and communicate this to patients and society. The costs of persisting pain continue to rise financially, socially and personally, and only by changing our thinking will we be able to deal effectively with the problem. This can start by considering the whole person, and continuing to draw upon science and philosophical thought for the benefit of society at large and the individuals who come to us for a meaning for their pain and a way to move forward and re-engage with their lives.

*** I dedicate this article to Dr Mick Thacker, Dr Lorimer Moseley and Louis Gifford who have profoundly influenced my thinking and work. I thank them whole-heartedly for opening my eyes.*



Teams in Pain Management

Bronwyn Lennox Thompson *Senior Lecturer, Department of Orthopaedic Surgery and Musculoskeletal Medicine, University of Otago, Christchurch*

When chronic pain management programmes were introduced, and especially during the heady days of the 1980's and early 1990's, teamwork was the best way to manage the complex needs of people who had experienced chronic pain for many years. Sadly, as commentators have pointed out, this is no longer the case in many countries (Loeser 2006, Gatchel, McGeary et al. 2014), and increasingly people with chronic pain are seen by a single professional working independently (Manchikanti, Pampati et al. 2010). Moreover, in the situations where a team does exist, the mode of working may be far from an interprofessional (interdisciplinary¹) approach, and instead be what is called a *multi-modal* one – where the style of interactions between team members represents what I have heard called *serial monotherapy*. In this approach, each discipline or profession provides their preferred intervention drawing from a model that may not be shared by any other team member, with differing goals that may not take into account another team member's contributions.

While not wanting to hark back to the golden olden days, it might be useful to review the rationale for interprofessional teams, and what contributes to making a team effective. This could help generate arguments for retaining an interprofessional approach for people who have chronic pain.

History of interdisciplinary pain management teamwork

Beliefs and models of pain have been part of human history as long as humans have experienced pain. Possibly the most remarkable change in beliefs about pain arrived with the introduction of the gate control theory (Melzack and Wall 1965), paving the way for innovators with a psychology background to introduce behavioural pain management (Fordyce 1976), shifting the prevailing model from a biomedical one, to the inclusive biopsychosocial model. During the 1970s, awareness of the impact of chronic disease on the individual living with illness supported the move towards addressing not only pain intensity but also distress and disability associated with pain. Notions of suffering as distinct from pain have emerged more recently (Cassell 2011), but chronic pain management programmes of the 1980s can be credited with turning the focus towards helping individuals reduce suffering as they restored their sense of self-identity by re-engaging with valued occupations² and relationships in their world.

During the late 1980s, when these programmes were possibly at their height, the International Association for the Study of Pain drew a taskforce together to generate guidelines defining pain management centres. This taskforce recommended that interdisciplinary teams should be involved to



“comprehensively address the biopsychosocial model of pain” (2014), and stated that centres should include:

Health care providers capable of assessing and treating physical, psychosocial, medical, vocational and social aspects of chronic pain. These can include physicians, nurses, psychologists, physical therapists, occupational therapists, vocational counsellors, social workers and any other type of health care professional who can make a contribution to patient diagnosis or treatment (2014).

IASP emphasised the need to address both physical and psychosocial aspects of pain.

Over time and even during the 1980s, challenges were faced by teams working in this way. Funding was, as always, a major limitation. Time dedicated to training and fostering an interdisciplinary team was difficult to find. Finally there was the lack of a clear model to guide



when it is time to stop attempting to reduce pain and turn to helping an individual accept the “new normal”.

Over time, in many parts of the world, interprofessional teams have given way to an upsurge in biomedical interventions, sometimes provided within a multidisciplinary team but seldom integrated within an interprofessional approach. The reasons for this increase are unclear, although Manchikanti, Pampati et al. (2010) speculate that a combination of greater numbers of providers, better physician judgement, convenient locations and short waiting times all contribute. Whatever the underlying reasons, the rationale for an interprofessional team approach to chronic pain management in the 1980s was that no single discipline possesses all the answers for reducing both disability and distress for an individual with chronic pain. This has not changed.

Teamwork challenges

I suspect that along with the three major challenges of funding, time and models, a fourth problem has contributed to the decline of interprofessional teamwork. This is the relative lack of attention within

healthcare management to implementing processes that develop and maintain an effective interprofessional team. The research on interprofessional teams has grown extensively over the past 15 – 20 years, but while the literature may have grown, implementing these findings in the real world of busy healthcare practitioners may not have progressed nearly as quickly.

Impediments to effective interdisciplinary teamwork include turf wars over role boundaries, for example, where both the occupational therapist and the psychologist believe they have the required skills to provide activity management (pacing), or where no-one chooses to address self-identity or self-concept issues because “they’re not my role” (Brown, Crossley et al. 2014).

Housing teams in separate buildings or facilities contribute to less coherence in a team. It is corridor conversations, and the tea room discussions that cement relationships, bridge between different perspectives, and provide a sense of belonging that are necessary to effective teamwork.

Limited attention to induction can create undercurrents within teams as new members settle in. Induction is particularly important for ensuring new team members understand the treatment model, the contributions made by clinicians from different disciplines, and for some, reconceptualising their understanding of chronic pain. The problems arising from inadequate induction to the pain management approach is compounded when each discipline has a separate line manager and professional department and little understanding within these departments of the unique interprofessional approach adopted in chronic pain management teams.

Teams can implode when members fail to agree on goals or approaches. When teams do not have effective, transparent and fair processes for resolving differences, teams can splinter. It is not

just a matter of electing a team leader who can tell others “what to do”, because this reverts back to a hierarchical model. Interdisciplinary teams work because they hold common goals, take the time to reach alignment, and respect one another’s contributions to the whole. O’Neill and Allen (2014) define task conflict resolution as “the extent to which different opinions, viewpoints, and perspectives [are] resolved (p. 160)”, and found that resolving task conflict is significantly related to team task performance as a whole, mediating between the negative personality trait of secondary psychopathology (Paulhus and Williams 2002) and team task performance. This finding suggests that teams need to develop ways to resolve task conflicts, and “team members holding strong views about their discipline’s perspective may impede this, particularly if those team members tend towards using strategies that arouse negative emotions in others” (O’Neill and Allen 2014).

Strategies to improve teamwork

Youngwerth and Twaddle (2011) conclude that effective teamwork requires attention to communication, interpersonal relations, team composition and structure, and organisational factors. They point out that leadership is often task-dependent, defined by each situation, with the team collaborating to develop innovative solutions to unique problems. Naming a single person as leader with responsibility for directing the team is unlikely to work as teams navigate rapidly changing situations.

Communication refers to both formal and informal opportunities to share unique information, with studies showing that “sharing of patient and family information as psychosocial stories, as opposed to biomedical data, has been shown to help build positive relationships between team members” (Youngwerth and Twaddle 2011, p. 651). In a recent

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study Howarth, Warne et al. (2012) identified that *collective efficacy*, or the belief a team will achieve their intended goals, influences a partnership between people attending a chronic pain management team, and the team itself. The level of confidence each team member holds for their own skills and the skills of other team members strongly influences the sense of collective efficacy, so that team members know the contributions they can expect from other team members, know when to include one another, and how to support one another. This in turn contributes towards establishing *team credibility* as a whole. This finding suggests that team members need time together to appreciate what one another brings to the team. Mesmer-Magnus and DeChurch (2009) completed a meta-analysis of information sharing and teamwork and found that groups mainly discuss information already shared, but groups that share *unique* information make better decisions. Paradoxically, groups that talk *more* tend to share *less* unique information. Teams are more able to share unique information when using a highly structured, focused method of discussion, and finally and particularly relevant in pain management, groups have more trouble achieving consensus than solving a problem with a specific answer (Mesmer-Magnus and DeChurch 2009).

A second finding from Youngwerth and Twaddle's study identified *team maturity* as a key factor (Youngwerth and Twaddle 2011). This refers not only to the length of time team members have worked together (on average three years or more), but also to the maturity of the individuals themselves. An important aspect of this factor is that the credibility of each individual as a professional and a person with life experience contributes to the overall sense of confidence within the team. This suggests that when recruiting for professionals to join the team, the team should be involved in the selection

process because the team will inevitably judge the credibility of a newcomer.

Finally, being located within the same building appears to provide necessary opportunities for team members to access one another and to develop social relationships. Howarth, Warne et al. (2012) call this *negotiated space*, or a place where team members could learn about one another, readily exchange ideas, and develop a relaxed atmosphere where team members feel comfortable to ask questions, or challenge one another.

Who belongs in a chronic pain management team?

While many publications suggest that a core team of medical, psychology and possibly physiotherapy professionals should work together, there is equally considerable literature showing that other health professionals such as nurses, occupational therapists, and social workers can all be involved in delivering an effective interdisciplinary chronic pain management approach (Shannon 2002, Wells-Federman, Arnstein et al. 2002, Colon and Otis-Green 2008, Moon, McDonald et al. 2012). What matters is not so much the professional discipline, as that team members hold a common model of chronic pain and its management. This notion has been recently supported in the book *Pain-related fear: exposure-based treatment for chronic pain* (Vlaeyen, Morley et al. 2012), where rather than indicate specific professions, the authors have identified the skills required to conduct this approach.

There is little agreement as to what constitutes an effective pain management programme, and the "black box" of a cognitive behavioural approach remains fairly opaque. This means that it is not possible to argue for, or against, any individual discipline being involved. It seems far more important to ensure that a biopsychosocial model of pain is held by every member of the team, that ways

of resolving team task conflict are developed without resorting to a hierarchical decision-making structure, that each professional is confident in every other team member's ability to contribute effectively, that members like and trust one another, and that ways to meet both formally and informally are encouraged. This finding is echoed in interprofessional chronic care teams (Fouche, Kenealy et al. 2014).

Finally there is the need to establish agreement between team members about when it is time to shift from focusing on pain reduction to pain management. This is possibly the thorniest issue of all, but for the people who look to interprofessional teams to help them solve their problems with chronic pain, it is critical. Knowing that "returning to normal" is not possible is a vital part of the transition from seeking pain reduction to accepting chronic pain and working towards developing a new sense of self-identity (Asbring 2001, Gullacksen and Lidbeck 2004). This is difficult to achieve while there is a promise of pain abolition. This issue is also one of the most divisive amongst clinicians involved in chronic pain management. It challenges clinicians to acknowledge the limitations of our knowledge of pain, and it forces the less glamorous contributions of allied health professionals such as occupational therapists and physiotherapists into the spotlight.

A personal thought

I originally trained in occupational therapy, graduating in 1983. Since then I have been mentored by clinical psychologists, physiotherapists, nurses, social workers and medical doctors. I have a Master of Science degree in psychology, and I have just completed my PhD looking at the ways of coping used by people living well with chronic pain. My original clinical orientation remains focused on helping people do what is important in their lives,

but I use a wide range of tools to help them achieve this.

When I am part of a team, I hope the three years I spent training in occupational therapy all those years ago has left a mark on what I offer to a team. At the same time, I think I may have learned a great deal in the intervening years. This knowledge and experience influences what I can contribute to an interprofessional team. I'm not alone in this: clinicians working in chronic pain management have often worked elsewhere, and been influenced by life events, other professionals, and literature. Even within a discipline, individuals develop specialised interests and skills that make their individual contribution different from another within the same profession. This means a simplistic representation of whatever original profession he or she trained in probably does not hold true. My hope is that interprofessionalism in chronic pain management will recognise, celebrate and support contributions from individuals who choose to work in this field. I also hope that by holding a common model of pain, interprofessional teams can develop ways of working together to meet the rising tide of people who need our help. Finally, I hope organisational development and teamwork research can help interprofessional teams become even more successful and perhaps supported by health funding authorities.

Notes

1. I will use these term interchangeably, although the Australasian Interprofessional Practice and Education Network argues that the term interprofessional denotes a

greater depth of collaboration between individuals Stone, J. (2014). "AIPPEN - Australasian Interprofessional Practice & Education Network." Retrieved 03 July 2014, 2014, from <http://www.aippen.net/what-is-ipe-ipl-ipp>.

2. Occupations are "the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do" WFOT. (2010, 2011). "Definition "occupation". Retrieved 05/09/2013, 2013, from <http://www.wfot.org/aboutus/aboutoccupationaltherapy/definitionofoccupationaltherapy.aspx>.

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A Nation in Pain: Healing Our Biggest Health Problem by Judy Foreman (ISBN 9780199837205)

Published by Oxford University Press

**Reviewed by Muna Adan, PH.D.,
School of Pharmacy, Nottingham
University, UK**

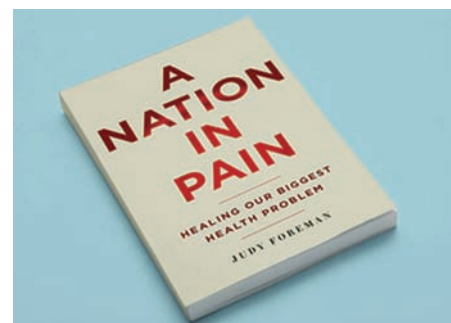
A Nation in Pain is a masterful chronicle of chronic pain and its devastating impact on individuals and society alike. This well researched book, co-published by the International Association for the Study of Pain (IASP), aims to provide an account of reasons behind the chronic pain crises in the 21st century and takes a critical look at some of the wide range of treatments currently available in controlling long-term pain. Judy Foreman states that the failure to better manage chronic pain worldwide may be described as tantamount to torture.

The 464-page book is organised into 14 chapters, which include a focus on the enormity and complexity of the chronic pain problem, genetic and immunological influences, gender differences and pharmacological as well as non-pharmacological management of painful chronic conditions. The chapters provided are highly referenced and the information included is based on recent research, which is presented in a style that does not overburden the reader with in-depth scientific details, yet allows for a level of objective appreciation of the findings. This makes it ideal for a wider readership.

The initial chapter of the book is a narrative insight into the experiences of

living with chronic pain; the difficulties in its diagnosis, the unpredictability of pain intensity and the increasing levels of limiting scope it causes. What is apparent is the author's choice of only including descriptions by physicians who have themselves developed persistent pain to perhaps point out that frustrations, disappointments and the insidious experiences of chronic pain is only fully comprehended by someone who has the symptoms. As a dermatologist-turned-patient explains: *"there is a divide between the sufferer and the outside observer, pain brings these boundaries between people into such acute focus."*

The author within the same chapter gives an analytical perspective on the current extent of pain education covered by medical schools compared with pain curriculum topics recommended by working groups from the International Association for the Study of Pain. Although there has been relatively little research focusing on pain education in medical schools, a review of most recent literature on the topic is initially presented and a solid argument is made on the need for stronger support for pain education to endure the incorporation of new knowledge into the curricula. However, the author gives a somewhat limited reflection on possible factors explaining some of the existing pain educational barriers mentioned. Moreover, invariably, as in a lot of the chronic pain areas covered in the book, an American context is mostly evaluated. Nevertheless, given the prevalence of chronic pain worldwide, the subjects raised are as relevant to the situation in



the UK as elsewhere.

The most intriguing and heartfelt section in the book is the chapter on paediatric pain and its management, which is examined in detail due to the author's concerns of deficient attention to the subject. Foreman initially highlights past debates questioning the existence of pain in infants and children and takes a glance at past preposterous paediatric pain management. Examples of pivotal research on neurological reports, for example the fact that infants may even feel more pain than adults due to the shorter travel distance of their nerve impulses from the periphery to the brain even though some nerve fibres may not yet be myelinated, are described.

The chapter on the therapeutic uses of opioids, their safety, efficacy and misuse is most thought-provoking and useful. The author highlights the less clear risk/benefit ratio of opioids in chronic pain of non-malignant nature. However, despite this there is a sense of advocacy of such treatment that comes through in the writing, which spans two chapters. In contrast several crucial therapeutic advances such as serotonin and norepinephrine reuptake inhibitors e.g.

duloxetine, venlafaxine as well as few promising emerging pharmacological agents such as Resolvins and AC1, which are still in clinical trials, are discussed.

Overall, this is an ambitious and far-ranging book, for which the author is to

be commended. The result of years of research into what is known and not known about chronic pain from the author's perspectives both as an investigator and an observer makes it interesting. The only downside of this

book as mentioned earlier is that most of the topics covered are largely looked at from a US healthcare system standpoint.

Having said this *A Nation in Pain* is a thoroughly insightful publication and a delight to read. I highly recommend it.

Book review

Mindfulness for health: a practical guide to relieving pain, reducing stress and restoring wellbeing Vidyamala Burch and Danny Penman (ISBN 978-0-7499-5924-1)

Published by Piatkus, part of Little, Brown Book Group.

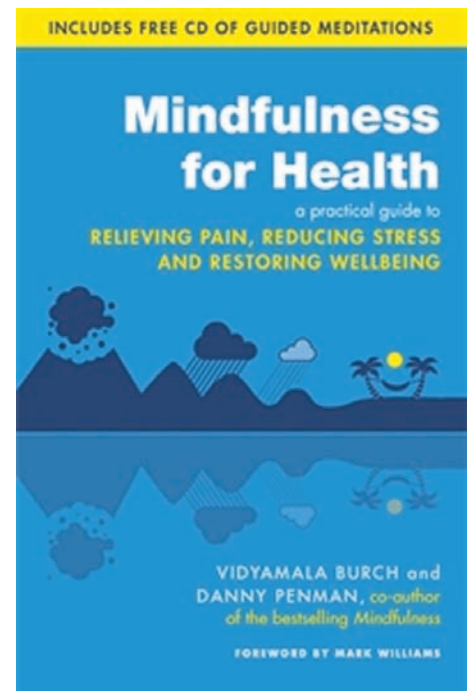
**Review 1 by: Dr Austin Leach
Consultant in Pain Medicine,
Liverpool; British Pain Society
Council member**

Through their association with the *Breathworks* enterprise the authors of this book have previously produced a substantial body of work relating to mindfulness, and its use as a vehicle for self-improvement and self-management of difficult pain symptoms. Vidyamala Burch has been a Buddhist and practitioner of meditation for decades after 'discovering' the method for herself following several significant back injuries. Danny Penman is a medical journalist, currently working as a feature writer for the Daily Mail, who has a PhD in biochemistry.

Mindfulness for health has been written for a lay audience who have taken on board the idea that individuals can assume responsibility for managing

their difficult symptoms, and that this can lead to more significant improvements in quality of life than can be achieved by relying solely on health professionals' advice. It is a step-by-step guide through the basics of learning a method of meditation using breathing and progressive muscle relaxation techniques. Using well-established cognitive behaviour therapy principles, the authors invite the reader on a course of self-discovery and introspection which is designed to encourage commitment, alter potentially unhelpful behaviour, improve flexibility and most importantly, to recognise negative emotions such as anger and fear and use the simple physical skills on offer to reduce the impact of unpleasant symptoms.

The authors have a deep understanding of pain and its impact on the human psyche. This reviewer did not particularly like the reinterpretation of the IASP definition of pain as the painful sensation itself being described as 'Primary Pain' and the unpleasant emotional component of pain perception that accompanies it as 'Secondary Suffering'. While Patrick Wall has endorsed the word 'suffering' in relation to pain, I feel that it has been rather over-used more recently, and as a result the word's impact has been lessened; it may encourage a victim mentality in the mind of the 'sufferer'.



However, this is still a useful, methodical and practical book that makes its points gently and logically. I had a sense of being led by the hand through the mindfulness process, with no particular sense of urgency, and the text uses the 'three R's' (Remind, Reinforce, Repeat) method of education to ensure that important details of technique are not missed.

Key to the whole process, and this idea underpins the text, is the allocation

Book review

of set periods each day for some kind of mindfulness activity, with a gradual progression in complexity as the weeks go by. Those who succeed in incorporating regular sessions of a few minutes' duration into their daily schedule are, by definition, imposing self-control on a situation which might otherwise encourage chaotic thinking. By following the guidance and relaxation regime the 'sufferer' will be strengthening his or her own locus of control.

For those who don't really understand what mindfulness is, I rather liked this quote:

"Virtually everyone's mind wanders while meditating. This is entirely normal... Becoming aware of your wandering mind is a sign that mindfulness is beginning to take root."

The book is accompanied by a CD with the eight weeks' exercises narrated by a gentle female voice.

The main criticism of the book is that it is one among many similar offerings by the same and other authors. But it does do 'exactly what it says on the tin' and the reader/student should, if the programme is adhered to, be able to develop useful skills that can be deployed against troublesome issues such as joint and muscle pains, anxiety,

physical deconditioning, low self-esteem and tiredness.

Rating: 4 stars out of 5

Review 2 by: Geraldine Granath, a patient

Interest in mindfulness is growing, there don't seem to be many areas where it isn't being recommended; be a better leader, reduce stress, become more productive and improve your health.

This book explores the use of mindfulness in pain management by outlining an initial eight-week programme which will help you to establish a lifetime practice. The book and the programme is based on the work of Jon Kabat- Zinn of the University of Massachusetts Medical Center, used by Vidyamala Burch to develop a Mindfulness-based Pain Management programme.

The book is wide ranging and reflects a considerable body of work but I think it could be daunting for the reader who is new to the topic. Access to mindfulness training is variable across the UK and personally I would find it very difficult to only use the book without some ongoing face to face support. The case studies that run through the book are a mixed bag, overall I didn't find them particularly helpful or illuminating.

As a practical introduction my own preference would be for one of the

simple phone apps available for people very new to the topic. The book gives a lot of additional support and information of more use once simple relaxation and focus is achieved. Usefully there is downloadable audio and suggestions for a "mindfulness toolkit" that may be useful as a starter for 10 or a reminder, and an online presence for those who would find this helpful. Advice on gentle movement and comfortable positioning is also helpful.

The ubiquity of mindfulness at present may cause professionals to view it as a fad with a trajectory of unbridled enthusiasm, uncritical acceptance and eventual disillusion. I would like to see acknowledgement that some patients will find this approach less helpful and appealing so there becomes less of a view that this is an approach for the self selecting few.

My own experience of mindfulness is largely positive, having practised on and off since the late 80's I find it gives me the ability to relax muscle tightening and avoid painful spasm. The body scan technique helps to focus on areas of pain and "turn down" intensity; recognising my own response to pain helps me to face flare-ups with more equanimity.

Please do try mindfulness, but look outward as well as inward and press for the best care, treatment, education and research possible in all areas of pain as well.

Spotlight



In this issue of Pain News we chat to the Chair of the Patient Liaison Committee – a vital committee that provides patient representation at all levels within the BPS, from Council level right down to SIG committees and attendance at BPS events. We would like to thank Antony for the time he has taken to answer our questions.



Antony Chuter
Haywards Heath
West Sussex
Chair – Patient
Liaison Committee

Q *What first brought you in contact with the BPS?*

I was Chair of the Patient Partnership Group at the RCGP and I was able to put forward ideas for the Clinical

Committee (PLC) and I love being able to make a difference to people who live with pain. The role I see is looking after the other members of the PLC and making sure they are supported and happy. We then have to focus on the work which comes up for the PLC from the work of the BPS. I like looking after people and I really like making a difference for people living with pain.

Q *What do you feel is the role of the PLC within the BPS?*

I feel that the PLC offers a number of patient perspectives to the work of the British Pain Society. I think we have a unique chance to help make things just a bit better for people living with pain.

Q *If you were President of the BPS for a day, what would you do?*

I don't think I could do a better job than William. But if I were in charge of the NHS for a day I would setup up a task force to revolutionise how pain is treated in the UK throughout the population. Pain would be measured at every opportunity where someone could be in pain and then treated quickly. Pain clinics would be

mainstream and in the community, reaching out to more people and allowing the public to self-refer. Pain management courses would be available to anyone living with pain and people would be able to get ongoing support, so that no one would feel alone with their pain. Older people would be especially targeted to meet the huge amount of unseen and under-reported pain in older people. There would also be a public awareness campaign on how people living with pain want to live normal lives but need support and understanding.

Q *What are you known for professionally?*

I am not sure that I am a professional in any particular area as I didn't work for a long time due to my long term pain and the effects of living with pain. I think I am good at facilitating a group of people, which is what I do with the PLC, but I have no professional qualifications in that or in anything really. Work wise, I accidentally landed on my feet in healthcare research a couple of years ago. I kept saying that if research was to be patient centered, it needed patients as lay members on the

Champion Programme which the College runs. Council members are also able to put areas forward for consideration, but I was not that hopeful for pain as there are usually lots of ideas each year. I was also on the committee which selects the champion area and pain is so personal to me. So I did encourage pain being one of champions just a little bit! I was delighted when Martin was made the Pain Champion for the RCGP and was invited to join the stakeholder group which met with Martin a couple of times a year

Q *What is your role in the BPS? What excites you about this role?*

I am the Chair of the Patient Liaison

Spotlight

project themselves. I am now a co-applicant on five research projects. I really love my work. I don't just work in isolation but find other people from the community to work with me. It's a bit like looking after a PLC on each project. I like looking after people, happy people work better!

Q *What are you most passionate about professionally?*

I enjoy and get a great deal of satisfaction from knowing that a group of patients and members of the public have made a piece of research better, perhaps more relevant for patients. I love listening to peoples' experiences and find focus groups fascinating. I enjoy recruiting people for them and looking after them on the day. Most of all I like to then use their experiences to help make changes, this happened recently with a 'Quality Measure' for use in General Practice.

Q *What do you have a knack for?*

Recruiting people for research, be it to join me on a project team or for a focus group. I enjoy the challenge of filling a day. Recently I needed to find 10 women for a focus group but they had to be between 18 - 45 and living with Bi-Polar or Schizophrenia. It was a challenge but I did it!

Q *What are you passionate about personally? What do you really enjoy? What can't you stop talking about?*

Three questions in one!!! Ok here goes;

Passion - making a difference for the time I am on this earth, we are only here one time!

Enjoy - FOOD, I love food, eating it and cooking it for other people.

Talk - now it depends on if you ask me or Andy. I would say I talk about politics and fairness. Inequality bothers me as does a lack of generosity and kindness in the world around us. Andy would say I just talk too much and that he switches off.... Pah!

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

When I get home from a day working away, I love nothing more than spending time with my chickens. I have 6 girls and they are so funny. It is a lovely way to unwind at the end of the day. At weekends, my partner and I are often found on a preserved railway, the Blue Bell Line. It is only a couple of miles away and there is no mobile signal, so I have to switch off - plus the tea and muffins are a treat!

Q *Any other volunteer activities apart from the BPS that you're passionate about?*

It has to be Pain UK, I am the Chair of the charity and it means a lot to me that I do the best I can in that role.

Q *Any favourite non-profit organisations that you support and why?*

I used to sail a lot when I was younger and I loved the sea (I lived my whole life next to it until 5 years ago). When I was 22 I was on a yacht which sank in the English Channel on a stormy afternoon. We were only 3 miles out but it was far enough to be really scary and the skipper had no radio or flares. We did have life jackets on. By chance, someone in a block of flats had been watching up with binoculars, they saw what happened. My life was saved by the

RNLI. I would have to say, I have deep gratitude towards the men and women of the RNLI.

Q *What would be impossible for you to give up?*

I have lived with pain for 22 years, so that would have to be my pain medication. I have handled the most extraordinary amount of pain but knowing I have the means to control it is key to my sanity.

Q *How do you want to be remembered?*

I would like to be remembered for having made a difference for people living with pain, improving patient safety (one of my research interests) and for having a happy life with my partner Andy.

Q *Any life achievements you are particularly proud of?*

I could easily say the day I married Andy. In my teens and 20s, I never thought that we would be able to do that. Or I could say it was when I was given Hon. Fellowship of the RCGP. That was a deeply special day too. But I think my proudest life achievement is surviving what's been thrown at me and how I have gone through the mill and survived. Getting ill, losing everything including my hopes and dreams, deep depression and hopelessness for 12 years and then the slow rebuild over the last 10 years - I am proud of me!

Q *Anything else you'd like to tell people about yourself?*

I am half man, half labrador - I am very food driven! Sausages, steak, good burgers and bacon and egg sandwiches. Never be between me and the buffet!

Thank you for your time Antony!



Word search

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

ACUPUNCTURE

ACUTE

ANXIETY

APATHY

BELIEFS

CBT

CHALLENGE

CHANGE

CHRONIC

CONCENTRATION

CONFIDENCE

DEPRESSION

DISABILITY

DISTRACTED

EDUCATION

EXERCISE

FAILED TREATMENT

Pain News addendum

Obituary on Dr Andrew Lawson in June 2014 issue page 77 had contributions from Simon Barton and Glyn Towleron.

Karin Cannons Author of the article published in June 2014, page 94, works at Frimley Park Hospital, not John Radcliff Hospital



Allegories of Change; the poetry of Ted Hughes and Images of the natural world

Ian Stevens

"Go Fishing

Join water, wade in underbeing

Let brain mist into moist earth

Ghost loosen away downstream

Gulp river and gravity

... Lose words

Cease

Be assumed into glistenings of lymph

As if creation were a wound

As if this flow were all plasm healing

Try to speak and nearly succeed

Heal into time and other people

By Ted Hughes, *River**

Ted Hughes poetry - the natural raw elemental landscapes, animal themes and in some cases such as the allegorical journey described in writer have influenced me greatly. Ted Hughes uses the allegorical river journey using Celtic symbolism of water, turmoil and a process akin to a shamanic ritual of immersion and renewal. I have used the poem as a vehicle to reflect on aspects of change and stasis typically encountered in many aspects of chronic pain.

*The full text of this poem is printed in the transcript booklet of the proceedings of the 2013 meeting of the Philosophy and Ethics SIG, available from pwgorman@btinternet.com

Context and pain

In many cases of chronic pain and unexplained somatic distress

understanding the human condition and aspects that conspire to either enhance or suppress the instinctive healing capacity of an individual may prove fruitful.

Pain science suggests that activation of nociceptors is not 'pain' – and that pain is largely a threat response dependent on meaning and context. Many years ago, I was asked by an orthopaedic surgeon to see a young man who couldn't walk. He was a prisoner from Barlinnie, prison near Glasgow where all the hard men are sent. He was thrown from an upstairs gantry and had bilateral os calcis fractures. His heels were too painful to put any weight on and because he couldn't walk the prison officer took off his handcuffs. While the officer was engrossed in his paper he had crawled under the bed, got out by the fire escape, climbed over the wall, summoned a taxi and escaped! So the power of context in pain cannot be overlooked! I have often reflected on how the environmental context (in terms of setting/interactive process and empathy) may often be the source of the alleviation or amplification of suffering in many chronic pain problems. We have heard about patients on Jumbulance holidays normally dependent on medication for severe pain who were enjoying themselves so much they didn't miss it at all when inadvertently separated from it. It seems that a window view, friends, kindness and care are as powerful as opiate medication in some instances.



In a simple experiment with patients with complex regional pain were told to look at their painful and oedematous limb though the binoculars the 'wrong way round' As the perceived threat 'shrank', a patient's physiology changed: inflammation, oedema and reported pain all decreased, showing that 'pain' and perception are 'neuroplastic' phenomena and potentially malleable.

Movement and change

"From a whisper in the forest, to the felling of a mighty tree, 'tis all movement'."

William James (brother of the novelist Henry)

My greatest interest in life is movement in nature. More and more of us live out of contact with nature and often-prolonged pain and suffering seem to encourage isolation, immobilisation and stasis. People often lose or have limited

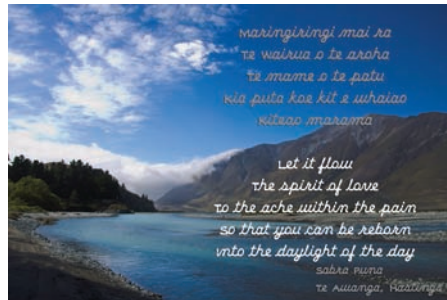
proprioceptive balance, exteroception and interoception and sensory experiences. Many non mainstream approaches that involve mindful movement such as tai chi, 'feldenkrais', forms of yoga, dance or even deliberate walking practice may modulate and alter 'defensive' motor activity.

We have increasingly come to forget that our minds are shaped by the bodily experience of being in the world; textures, sounds, smells and habits as well as the genetic traits we inherit and the ideologies we absorb all affect the brain neuromatrix.

We are losing touch and becoming disembodied to a greater extent than in any previous historical period. Nan Shepherd wrote, "one should use the whole of one's body to instruct the spirit. This is the innocence we have lost: living in one sense at a time to live all the way through." Sensory experiences changes people.

The poem by Ted Hughes reveals that the loss of words and immersion in a dangerous unpredictable environment leads to transformation. It has been my rare experience that some individuals seem to have replicated this allegorical narrative. In some instances it has been necessary to cease believing in the medical process, inadvertently nocebo as this may sometimes prove, and to seek fresh challenge and commit to activity. As a physiotherapist I have seen patients embark on this process and thrive.

The metaphor for change suggested by the evolutionary psychologist Nick Humphrey of a balloon caught in a tree hitting the same branch until the wind changes and it floated higher. This seems to be a good one for chronic pain; you can bounce on the bottom branch over and over again, but to experience big change you need a different stimulus. As Humphreys suggests: "we too need to have a whirlwind blow through our lives before we will start over again and give ourselves the chance to move on to a new level."



Change therefore often requires a spirit of experimentation, a change of heart, as well as risk and in some cases reflection. Approaching a complex multifactorial problem such as chronic pain and suffering with linear reasoning and solution (either as a patient or clinician) is probably akin to the schizophrenic world described by Iain McGilchrist in *The Master and his Emissary*. Linear thinking, stereotypical motor activity, an inability to understand allegory and metaphor or to see the value of poetry and fiction, or respond to rhythm in music, are synonymous with excessive left brain lateralisation and are extremely common in chronic stress. The way out of this situation is not more of the same or a repetition of the metaphor of the balloon on its lower branches. Clinically this is akin to the repetition of procedures and approaches which have failed previously. This scenario is all too common where the dominant ethos is 'doing' rather than understanding and interacting with patients in chronic pain. The 'way out' of complex defensive strategies such as chronic pain often needs a 'whole brain' approach. McGilchrist suggests narrow focused attention - the effects of excitement, fear and stress actually inhibit the neuronal spread of information into the right hemisphere. The danger in the modern world is that the prolonged activation of this response without respite prevents the scene being experienced afresh or for new information to be processed or healing/recovery to occur. In terms of poetry and metaphor the harder a person tries to understand a

poem literally, the less likely we are to make sense of it or gain any value from it. Similarly, in some aspects of health care and illness, approaching a problem head on or attempting to find solutions solely through logical algorithms often reduces our possibility of finding fresh or novel solutions to a problem.

In her books *The Balance Within* and *Healing Spaces* Rheumatologist Esther Sternberg describes the temples of healing in Greece and suggests that we often worship the wrong gods. The two gods of healing are Aesculapius, the god of intervention whom we tend to over-worship and Hygieia who is more concerned with self-care. Perhaps in the modern era we need to value Hygieia a little more and understand in many cases that the certainties promised by 'techno medicine' are often illusory.

Patients who face a window often require less medication and natural scenes are beneficial and promote calm. Pain clinics I have worked in are often airless and windowless and more like Barlinnie than a healing temple of Hygieia!

Water as a metaphor

In dealing with chronic pain, insight from the humanities, poetic allegories and lessons from nature may lead to experiences being experienced afresh. This contrasts with the prevailing mechanistic approach to interpreting and adjusting bodily dysfunction.

We can use the picture of a river in spate as an image of biomedicine. When you have to hand over yourself in trauma or acute disease, (as you can't do anything to stop that huge flow of water) biomedicine is appropriate and works well. But another picture, that of smooth water running over a weir, is a metaphor for chronic pain. If you are a canoeist in danger of getting caught up in the middle of the turmoil the only escape is to get to the side to find natural respite. Man made weirs often offer no such respite and are more like a washing machine

Allegories of Change; the poetry of Ted Hughes and Images of the natural world



stuck on a perpetual spin cycle. In some situations of chronic pain, medicalisation and iatrogenic disability, people often get caught up in the middle of this 'weir'. The way out of this common scenario is to embark on a journey using different path, sometimes with a guide or helper who follows a different narrative.

Ted Hughes' poetic imagery suggests that when words cease and forces overwhelm you, you are the allegory of the shamanic journey when you move

from the known into the unknown and subsume the forces that you can't control. My own experience with body therapies and meditation is that when words cease senses change; that can be metaphysical and complex or very simple.

"The nature of things is intrinsically hard to seek out using the tools with which we normally equip ourselves for the task. Our natural assumptions and our common ways of thinking will lead us astray and we need to be both wary and indefatigable in our seeking of the truth. All things flow; stability in the experiential world is always stability provided by a form through which things continue to flow. As they step into the same rivers other still waters flow upon them. One cannot step twice into the same river;

it is always different and always the same."

Heraclitus

In this too our bodies are like rivers. Stasis, which is the allegory of chronic pain and the opposite of flux, is incompatible with life and leads only to separation and disintegration.

So be optimistic; neurogenesis is possible with the right mix of ingredients be it watching images or Tai Chi. But sitting still ruminating about our problems doesn't achieve very much. So get out there and do something different - give it a go!

This presentation done at Philosophy and Ethics SIG meeting, concluded with a slide-show of photographic images of nature, many of exquisite beauty, to be found by following this link: <http://www.flickr.com/photos/ianstevens/sets/72157638243787946/>



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Snap and chat

newsletter@britishpainsociety.org

It is what it says – Snap and Chat. If any of you have any photos or artwork, which reminds you of BPS, pain or its treatment, please send it to us with your comments. The comments should convince us that the 'Snap' you send is 'Chattable'. Go on. Look in to your old photograph collections or snap while you are out and about. You will win a prize if your snap and chat really excites the editorial team. Every month there will be one prize to win! Send your snaps to newsletter

To start the ball rolling here we have some photographs taken from ASM. We have two competitions.



2. Story competition: There are a couple of photographs, again taken at ASM. Let your imagination run wilder, become more creative and write a short story. The story should not exceed 500 words. The most creative and entertaining story will win a prize. Come on. Why are you still reading this? You should have started writing the story already.

1. Caption competition: Let's see how creative you can be. Please send us your caption on this photograph. The best one wins a prize!

The entries should be sent to newsletter@britishpainsociety.org It should reach us by midnight, October 10th 2014. Editorial board decision is final.



1. Caption Competition Image



2. Story Competition Image



New members

Ratified at the February and July 2014 Council Meetings

Name	Position	Institution
Mrs Hanan G. Ali El.Tumi	Research Student - Pain Physiology	Leeds Met University
Miss Claudia Poynton	3rd Year Biomedical Scientist	Leeds Met University
Ms Andrea Louise Cain	Highly Specialist Physiotherapist in Chronic Pain Management	Salford Royal Hospital
Dr William Rea	Consultant Anaesthesia	Royal Orthopaedic Hospital
Miss Sophie John	Physiotherapist Pain Rehab	Nuffield Orthopaedic Hospital
Mrs Helen Marie Firth	Highly Specialist Physiotherapist - Pain CTR	Salford Royal Hospital
Dr Udaya Kumar Chakka	ST6 Anaesthetics, Advanced Pain Trainee	Royal Victoria Infirmary, Newcastle upon Tyne
Miss Esther Sieff	Clinical Specialist Nurse in Chronic Pain	Stepping Hill Hospital
Mrs Harriet Barker	Lead Nurse - Pain Services	St Peter's Hospital, Chertsey
Mrs Cindy Thomas	Specialist Nurse Practitioner - In-patient Pain Services	Nuffield Orthopaedic Hospital
Dr Sailakshmi Murugesan	ST5 Anaesthetics	Royal Preston Hospital
Mrs Rachael Barton	Staff Nurse, Day case Neurology & Neurosurgery	The Walton Centre
Dr Navtej Sathi	Consultant Rheumatologist & Acute Physician	Wrighton Hospital, Wigan
Dr Ruth Cowen	Pain Fellow	Chelsea and Westminster Hospital
Mrs Maureen Booth	Clinical Nurse Specialist - Acute Pain	Torbay General Hospital
Kristina Zhivkova Grancharska	Assistant Prof. Physiology; Kinesitherap	Faculty of Public Health and Sports, South - West University "Neofit Rilski", Bulgaria
Dr Andrew Levy	General/Dentist (also research assistant at Birkbeck college)	Align & Smile, London
Dr Lucy Ann Miller	Anaesthetic SPR/ Pain Fellow	Bristol Royal Infirmary
Dr Margaret Lorang	Surgical Assistant	Private Hospital, Sydney
Dr Jennifer Thomas	Consultant in Rehab	University hospital of Wales
Dr Shaun Clarke	VMO/Consultant in Anaesthetics	Coffs Harbour Health campus, Australia
Dr Hari Sankar Ankireddy	Registrar (ST6) Anaesthetics	Royal Gwent Hospital
Dr Anand Natarajan	Pain Fellow	Arrowe Park Hospital
Dr David Waluube	Retired Associate specialist - Anaesthetist	William Harvey Hospital
Dr Sachin Rastogi	Consultant Anaesthetist & Pain Physician	Royal Victoria Infirmary, Newcastle
Mrs Omimah Said	PhD Student	Centre for Psychological Research, University of Derby
Dr Azfer Usmani	Consultant Pain	Forth Valley Royal Hospital
Miss Katheline Jolly	PhD Student	Centre for Neuroimaging Sciences, Kings College London
Dr Duncan Hodgkinson	Postdoctoral Researcher	Centre for Neuroimaging Sciences, Kings College London
Dr Matthew Allsop	Research Fellow in Applied Health	University of Leeds
Miss Kathryn Anderson	Lead Nurse	Royal Free Hospital
Dr Hugh Antrobus	Consultant Anaesthetist & Pain Management	Warwick Hospital
Dr Robert Atkinson	Consultant Anaesthetist	Pontefract General Hospital
Dr Gaurav Chhabra	Specialist Registrar Anaesthetics	Royal Victoria Hospital
Miss Rachael Docking	Research Fellow Acute and Continuing Care	University of Greenwich
Mr Rory John Todd McMillen	Director	The Maymask Healthcare Group Ltd
Mrs Madeleine Anne Nicholson	Clinical Specialist Physiotherapist	Abergale Hospital
Mrs Janet Norton	Chronic Pain Nurse Specialist	Medway Maritime Hospital
Dr Kavita Poply	Clinical Lecturer in Pain	The Royal London Hospital
Mrs Shivaun Rackham	Chronic Pain Specialist Physiotherapist	Waters Green Medical Centre (linked to Macclesfield Hospital)
Mrs Gillian Simon	Clinical Nurse Specialist up to 2013	Addenbrookes (last place of work)
Mrs Kate Wyatt	Specialist Nurse	Norfolk & Norwich Hospital
Dr Ben Huntley	Consultant in Pain Medicine and Anaesthesia	Queen's Hospital, Romford
Dr Sarah Ciechanowicz	Specialist Registrar Anaesthetics	The Lister, Stevenage
Dr Melanie Smith	Clinical Psychologist	Salford Royal Hospital
Dr Hannah Twiddy	Specialist Clinical Psychologist	Walton Centre
Mrs Roseanna Brady	Psychologist	Milton Keynes Hospital
Dr Michael Downton Croft	GP	Care UK, HMP Isle of White
Dr Joanna Renee	Advanced Pain Fellow	Western General Hospital
Mr Marcus John Beasley	Research Assistant	University of Aberdeen
Dr Roy Miller	Consultant in Anaesthesia and Pain Medicine	Colchester General Hospital
Dr S Caroline Cochrane	Consultant Clinical Psychologist	Astley Ainslie Hospital
Mr William J Cottam	Research Assistant/Radiological Sciences	University of Nottingham