

DECEMBER 2014 VOLUME 12 ISSUE 4

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

Merry Christmas and a Happy New Year

Things they don't tell you about depression
Pain medicine training - a trainee's perspective
Can you feel my pain?
Should placebos have a role in clinical practice?
New BPS Trading company announced



THE BRITISH PAIN SOCIETY

ISSN 2050-4497



Start to unlock severe chronic pain with Palexia SR



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

Tapentadol is a Controlled Drug, Schedule 2

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PALEXIA® SR Prescribing information

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

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

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

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

References:

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

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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 January 2015**

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



Calendar of Events

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

Study Day – Topic TBC (35th Study Day)

Friday 12th June

Churchill House, London

Philosophy & Ethics Annual Meeting

Monday 29th June – Thursday 2nd July

Launde Abbey, Leicestershire

Details TBC

Pain Management Programmes 15th National Conference

Thursday 17th & Friday 18th September

Manchester

Details TBC

Study Day – Topic TBC (36th Study Day)

September

Churchill House, London

Details TBC

Study Day – Topic TBC (37th Study Day)

Monday 23rd November

Churchill House, London

Details TBC

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

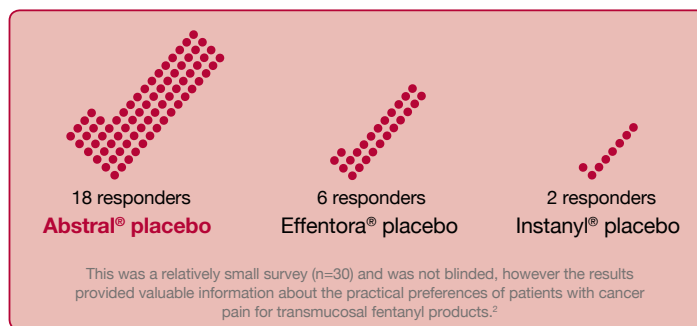
*The decision to use a specific opioid preparation should be based on (in particular) the **patient's preference** for an individual preparation¹*

Association of Palliative Medicine

In a survey of user opinions of transmucosal fentanyl product placebos, **Abstral** was rated most preferred²



It was easier to access, easier to administer and more palatable than the other placebos.



Because time is precious

PRESCRIBING INFORMATION. Please refer to the full Summary of Product Characteristics before prescribing.

Name: Abstral 100 micrograms, Abstral 200 micrograms, Abstral 300 micrograms, Abstral 400 micrograms, Abstral 600 micrograms, Abstral 800 micrograms sublingual tablets. **Active Ingredient:** Each tablet contains 100µg, 200µg, 300µg, 400µg, 600µg or 800µg fentanyl (as citrate). **Indication:** Management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain. **Dosage and administration:** Only use in patients tolerant to opioid therapy for persistent cancer pain. Administer directly under the tongue, and allow to dissolve without chewing, sucking or swallowing the tablet. **Adults:** Initially 100µg, titrating upwards as necessary to establish an appropriate dose. Patients must be monitored closely by a health professional during titration. Patients should be maintained on this dose and should take no more than 4 doses/day. During titration, patients can use multiples of 100µg and/or 200µg tablets for a single dose, taking no more than 4 tablets at any one time. During both titration and maintenance patients should wait at least 2 hours before treating another episode of breakthrough pain. **Elderly and patients with renal and hepatic impairment:** Take particular care during titration and observe patients for signs of fentanyl toxicity. **Children and adolescents:** Must not be used in patients under 18 years of age. **Adverse effects:** The most serious adverse reactions associated with opioid use are respiratory depression, hypotension and shock. The most frequently observed adverse reactions with Abstral include nausea (very common); constipation, somnolence, headache, dizziness, dyspnoea, stomatitis, vomiting, dry mouth, hyperhidrosis and fatigue (common). Other serious but uncommon adverse reactions include: hypersensitivity, tachycardia, bradycardia, hypotension and drug withdrawal syndrome. Prescribers should consult the summary of product characteristics for further details of side-effects. **Precautions:** Instruct patients and carers to keep tablets out of reach and sight of children. Ensure patients and carers follow instructions for use and know what action to take in case of overdose. Before starting Abstral, ensure long-acting opioid treatment for persistent pain is stable. Dependence may develop upon repeated administration of opioids. There is a risk of significant respiratory depression. Take particular care during dose titration in patients with COPD or other conditions predisposing to respiratory depression. Administer with extreme caution in patients who may be particularly susceptible to the intracranial effects of hyperkapnia. Opioids may mask the clinical course in patients with head injuries. Use with caution in patients with bradyarrhythmias, hypovolaemia, hypotension, mouth wounds or mucositis. Monitor use carefully in elderly, cachectic and debilitated patients, and patients with liver or

kidney dysfunction. Possible symptoms of withdrawal on cessation are anxiety, tremor, sweating, paleness, nausea and vomiting. The development of a potentially life-threatening serotonin syndrome may occur with the concomitant use of serotonergic drugs. Serotonin syndrome may include mental-status changes, autonomic instability, neuromuscular abnormalities, and/or gastrointestinal symptoms. Discontinue Abstral if serotonin syndrome is suspected. **Interactions:** Fentanyl is metabolised by CYP3A4. Use with caution if given concomitantly with CYP3A4 inhibitors (e.g. macrolide antibiotics, azole antifungal agents, protease inhibitors or grapefruit juice). Concomitant use of other CNS depressants may increase CNS depressant effects. Respiratory depression, hypotension and sedation may occur. Concomitant use of alcohol or partial opioid agonists/antagonists (e.g. buprenorphine, pentazocine) is not recommended. Coadministration of a serotonergic agent, such as a Selective Serotonin Reuptake Inhibitor (SSRI), a Serotonin Norepinephrine Reuptake Inhibitor (SNRI) or a Monoamine Oxidase Inhibitor (MAOI), may increase the risk of serotonin syndrome. Not recommended for use in patients who have received an MAOI within 14 days. **Pregnancy:** Safety in pregnancy not established. Long-term treatment may cause withdrawal symptoms in newborn infant. Do not use during labour and delivery since fentanyl crosses the placenta and may cause respiratory depression in the fetus or infant. **Lactation:** Fentanyl is excreted into breast milk and should only be used if the benefits clearly outweigh the potential risks for mother and child. **Contraindications:** Hypersensitivity to any of the ingredients; opioid-naïve patients; severe respiratory depression or severe obstructive lung conditions. Treatment of acute pain other than breakthrough pain. **NHS cost:** Abstral 100-400µg 10 tablets: £49.99. Abstral 100-800µg 30 tablets: £149.70. **Legal classification:** CD POM. **Marketing Authorisation Numbers:** PL 16508/0030-35. **Marketing Authorisation Holder:** ProStrakan Ltd, Galabank Business Park, Galashiels, Scotland TD1 1QH. **Date of prescribing information:** July 2014.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to UK ProStrakan Ltd. on +44 (0)1896 664000

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.

Save the date

**Annual Scientific Meeting
21 April – 23 April 2015
Glasgow**



Don't forget to save the date to attend the British Pain Society's 48th ASM in Glasgow 21 April – 23 April 2015

Why you should attend:

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

We look forward to seeing you in Glasgow.



THE BRITISH PAIN SOCIETY

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THE BRITISH PAIN SOCIETY

Pain News

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SAGE



*"October
extinguished
itself in a rush
of howling
winds and
driving rain
and
November
arrived, cold
as frozen iron,*

*with hard frosts every morning and icy
drafts that bit at exposed hands and
faces."*

*J K Rowling, Harry Potter
and the Order of Phoenix*

December. It's cold and dark. The trees are bare. Days are shorter with less sunlight. Shorter days and lack of sunlight can lead some people into depression. It is called Seasonal Affective Disorder. It usually starts around autumn and improves during spring. As pain management professionals, we come across and treat patients with depression secondary to chronic pain. We talk to them, assess their depression scores to come to a conclusion on whether to treat or not. Do you know what it feels like when you have depression? In this edition of *Pain News*, we have an article, 'Things they don't tell you about depression', which gives us a first-hand description of that feeling and experience from one of our members. It is an article

with very useful information about depression, as the author informs us that even though depression improves, it takes a long time and it is not an easy process. The article also questions whether we do enough suicidal risk assessments routinely on depressed patients. In addition, it also describes how difficult it is to get professional help when you are depressed.

Empathy and compassion are very important when treating patients, and there are three wonderful articles in this *Pain News* edition, which enlighten us about empathy and compassion. Tom Shakespeare asks 'Can you feel my Pain?' to explain the role of empathy and compassion in health and social care. Revd Dr Jeremy Swayne advises us that to be compassionate, you need to pay deep attention using two beautiful examples. First is of Etty Hillesum, a young Jewish woman who showed compassion and care to her fellow Jewish community in the midst of adversity, in the Auschwitz concentration camp. The second is from Simone Weil who showed her compassion to the poor during the Spanish Civil War. Another author, Michelle Briggs questions, 'Compassion: fundamental to nursing or are nurses too fatigued to care?'

Another article poses an important clinical question: 'Should placebos have a role in clinical practice?' The author

Felicity Bishop gives us a clear logistic, ethical and clinical account of the use of placebo in practice. It is enlightening to know that one of her surveys showed that a minority of UK general practitioner (GP) respondents used 'pure placebos' (sugar pills) in clinical practice. Some use 'impure placebo' (multivitamins) as placebo. It is common practice in the developing world to use multivitamin tablets as part of a treatment regime of various diseases. I used to question the ethical aspect of this practice; nevertheless, after reading the article on placebo, I doubt I will question again.

Language is important in communication. Kevin McCarthy details therapeutic metaphors in paediatric pain in his article 'Language matters'. How do you assess the pain if your patient doesn't talk? Kate White, Clinical Associate Professor of Anaesthesia, University of Nottingham School of Veterinary Medicine and Science describes how she assesses chronic pain in animals in 'Art of assessment of chronic pain in animals'. I hope you will find it interesting.

I do not want to go on. You may have shopping to do, presents to pack and parties to attend. Enjoy the festive period. Have a wonderful Christmas and a Happy New Year; however don't forget to send your articles for *Pain News*!



Dr William Campbell



BPS Pain Business Ltd

Over the past year or so, our Honorary Treasurer has been keeping a close eye on our VAT status when dealing with trade

income and grants. With the expert advice from Les Howard, a VAT Consultant, and Viv Trump (Independent Examiners), the Executive Members of Council, and Jenny Nicholas have spent many hours on emails and teleconferences trying to decide whether or not the British Pain Society (BPS) needed a trading arm.

We agreed that there was the need for this, but to have the new trading arm set up and running in time for the next Annual Scientific Meeting in 2015 required an immense amount of work from Jenny within a very short time. On 16 September 2014, BPS Pain Business Ltd, company number 9220078, was registered with Companies House. This is purely a trading arm of the BPS. Jenny achieved this within about 10 days – a fantastic job and well done!

Of course a company needs directors, and these were required within days of the decision to go ahead! The majority of directors for the new company should ideally not be Elected members of the

BPS Council. For the immediate future, Dr Andrew Baranowski and I are elected to be directors from the current Elected BPS Council, but we needed three directors who are not from our current Elected BPS Council.

Three previous Presidents of the BPS agreed to be directors in the first instance: Dr Douglas Justins, Dr Joan Hester and Professor Richard Langford. I did ask two other non-Elected Council, including non-medics, but there were no ‘takers’ by Monday 15 September, the date by which the papers had to be submitted.

There will be opportunities for further directors in due course, and naturally, we expect that the current names will change every year or so. Again, many thanks to Dr John Goddard, Dr Andrew Baranowski, Dr Martin Johnson and, of course, our Secretariat Manager – Jenny Nicholas – for making this all happen. Thanks are also due to the rest of the Secretariat for their extra work while Jenny concentrated on establishing the company during the first 2 weeks of September.

Undergraduate training in pain

Without a decent undergraduate training in pain, what chance is there of a general knowledge in pain developing at a postgraduate level? Over the past few years, Dr Emma Briggs has highlighted the very small number of hours devoted to undergraduate pain medical education. Undergraduate physiotherapists receive significantly more pain education than medics, and vets yet more again! Of course, there will

be some regional variation depending on the university attended, yet pain is such a common complaint in any healthcare setting that it deserves considerably more attention. From the work lead by Dr Cathy Price, we are all very aware of the devastating impact of chronic pain that is undertreated or not treated at all.

In conjunction with others, Emma worked at a major project covering undergraduate pain education in 242 medical schools throughout Europe. France and Germany had a structured teaching programme with some form of final assessment on pain, as part of their undergraduate training. Emma gave an overview of the project to the BPS Council, explaining that attempts made by clinicians in European countries were not fruitful, until several organisations jointly approached the appropriate governing bodies responsible for teaching.

With this in mind, Dr Kate Grady (Dean, Faculty of Pain Medicine), Mr Daniel Waeland (Head of Faculties, Royal College of Anaesthetists) and I, made an approach to the General Medical Council (GMC), about our concerns on undergraduate pain training. We met with Dr Judith Hulf, representing the GMC on 2 September, and we may be making some progress within this area for the United Kingdom. Initially, some pilot work with undergraduates will take place at a few universities, led by Dr Kate Grady. Depending on the results of the pilot work, the GMC may consider emphasising the necessity for more elaborate undergraduate pain training before newly qualified doctors may start their clinical practice.

E-Pain

This project, originally proposed by one of our members, Dr Ann Taylor, five years ago, has developed very nicely, with 90% of the interactive 72 modules now live. The project has been run jointly between the Faculty of Pain Medicine and the BPS. We are very grateful to the multitude of session authors and module leads for the hours of work that they have put into this project. This is a valuable resource, and if you haven't used it yet, please have a look. You will need to register and use a National Health Service (NHS) recognised email address: <http://portal.e-lfh.org.uk/>

Pain Summit

A follow-up meeting of the original stakeholders from the original Pain Summit held in 2011, at Central Hall, Westminster, has been planned for late November 2014, at the House of Lords. The Chronic Pain Policy Coalition have arranged the venue and the following work stream updates are to be covered at that meeting:

- Problematic/complex pain led by the Faculty of Pain Medicine
- Awareness campaign on pain led by the Chronic Pain Policy Coalition
- Commissioning guidance led by the Royal College of General Practice
- Epidemiology of chronic pain led by the BPS

With regard to the BPS component, Professor Gary Macfarlane has carried out some sterling work in developing a forthcoming work programme split into three themes:

1. Data sources (lead, Gareth Jones):
 - a. What data are already available from national surveys or major research studies?
 - b. What have we learnt from this and what do we require (routinely) in the future?
 - c. What core data set should be recommended for such national surveys?
2. Terminology associated with routine recording in clinical practice (lead, Cathy Price)
 - a. Identifying terminology which pain specialists should be using.
 - b. Liaising with other specialties.
 - c. Providing input into new clinical data coding systems for the NHS (e.g. Systematised Nomenclature of Medicine (SNOMED)).
3. Health measures (lead, Candy McCabe)
 - a. What should we measure in different setting; for example, population, primary, secondary care?

I realise that this work will take some time to complete, but the outcome should be invaluable for the future, and on behalf of the BPS, I would like to express my appreciation to Gary, Gareth, Cathy and Candy for their commitment to this project.

BPS website development

Over the past few years, we have become aware of the shortfalls of our current website. Professor Langford started the drive to have this updated, and Dr Raj Munglani led the project initially, to determine what was needed to refresh the appearance and handling of

the website. Over the past year, Dr John Goddard had taken over as lead in this project, and at the time of writing, the project has almost reached its conclusion.

By the time you read this, or soon thereafter, you should be able to view our new website, which will be of a better style, easier to navigate, including a more useful members-only area.

Members publication on pain assessment

As with the last issue of *Pain News*, I would like to showcase some research from one of our members. This relates to a paper written by Professor A Rice, with Drs J Wolrich, A Poots, and colleagues, on the assessment of pain by the use of numbers and how there appears to be a difference in the interpretation in those with acute as opposed to chronic pain. Many pain scales use numbers, so this is an important issue. Support is gained by experiments indicating impaired number sense in one-third of chronic pain patients. These results cast doubt on the appropriateness of the use of visual analogue and numeric rating scales in chronic pain in clinics and research. See <http://bj.a.oxfordjournals.org/content/early/2014/07/31/bja.aeu255.short?rss=1>

e-Petition – now please!

If you have not already done so, could I ask you and your patients to sign up to the e-Petition lead by Jean Gaffin. We need at least 10,000 to sign up for a government response and 10 times this for a debate in Parliament. The link is <http://epetitions.direct.gov.uk/petitions/58377>



Dr Andrew Baranowski



The British Pain Society (BPS) is a member's society. The members and their multidisciplinary and multispecialty needs always have to be at the forefront of our minds when decisions about

the future of the BPS are made.

This year and probably into the next, Council has decided to financially invest in *improving communication with and for the membership*. This includes supporting web education, and potentially discussion. The starting point for this was for Council to agree to invest substantial sums from our reserves to modernise our Information Technology (IT). This modernisation is being led by John Goddard, Vice-President, but has also received input from the membership at multiple levels, including some excellent strategy work by the Communications Committee, led by Nick Allcock. The aim of this work is to improve IT as a whole, including hardware, but specifically the functionality of the website to improve the presence of the BPS on the Web and our ability to interact with the membership as well as those with an interest in our work.

The website is the face of the Society, and for our non-members, it is the main area of the BPS that they may interact with. Getting this right ensures we meet

not only the member's needs but also the BPS' first strategic aim 'Promoting excellence and awareness for the benefit of people living with pain'. As a consequence, I have been proud to support the IT work as Honorary Treasurer.

During my term to date as Honorary Treasurer, other areas of *new investment* have been more difficult to meet as financial resources and opportunities have shrunk. As a consequence, at our strategy day last year, we re-visited what we considered to be the strategic aims of the Society and arrived at the following re-affirmation:

The British Pain Society is an alliance of professionals advancing the understanding and management of pain for the benefit of patients.

We achieve this by:

- *Promoting excellence and awareness for the benefit of people living with pain.*
- *Promoting partnership in pain research, education and management.*
- *Influencing policies relevant to pain.*
- *Nurturing the next generation of pain researchers and healthcare professionals.*
- *Encouraging dialogues about pain.*
- *Contributing to national and international dialogue of pain.*

The British Pain Society is the largest multidisciplinary professional

organisation in the field of pain within the UK.

It is these criteria that we will continue to explore and apply for our membership as we look to the activity and projects that we fund for the future. If you apply for money from the BPS, please ensure you meet some of these key aims and note that money is tight. Unfortunately, there is limited money available for the Society to spend, and this year, we see the BPS taking significant funds from its reserves. Not including the money set aside for the IT review and upgrade, we have a predicted deficit of around £90,000 by end of 2014. That is, we will have around that amount less in our bank accounts and savings compared to when we started the year – we will have spent £90,000 more than our income. Fortunately, due to a number of saving cuts and increased income streams we had in place, this is not as bad as the original predicted £120,000! The main reasons for this deficit relates to reduced income from the Annual Scientific Meeting (ASM), particularly less support from Trade. It will be clear to everyone that if the Society is to survive, significant changes in how the Society works and how we bring in and spend our monies will need to occur.

In previous reports, I have alluded to the fact that as a result of judicious planning by previous executives of the BPS, our reserves are healthy at around £1m and that next year we hope to see less spent as we move to less expensive venues for the ASMs. The Society is in a difficult position where its membership

and attendance at the ASMs are not big enough for the greatest venues and are too big for the university and less expensive venues. Any compromises that we make will not affect the high quality of the ASMs, and I have already seen a very exciting programme for next year; however, the venues for the ASMs in the future may not be as grand as those that we have become used to in recent years. Having said that, these more cosy venues will have positive spinoffs for networking and interaction with Trade – hopefully with Trade's greater support. I do hope that you will support future ASMs with you and your Teams attending both for education purposes and for the networking. *The ASM is the life blood of the Society and of the Society's membership.*

Over the past year, we have tried to tackle unplanned spending within the Society, that is spending not agreed in advance and not in our budget. One aspect of that was to support the Special Interest Group (SIG) Chairs and their committees, particularly around the meetings they organise. The *guidelines for the SIGs* were updated, particularly around setting budgets, VAT rules and time lines for specific actions. Another change introduced to reduce unplanned spending was for me to set up a *Finance Sounding Board*. I am frequently under

pressure to spend a bit here and a bit there not within the budget. Sometimes that comes from senior members of the Society and even the Executive. As a consequence, when under pressure to spend and when I am not sure, I now have three wise persons that I can turn to: Chair of the Communications Committee, Chair of the Scientific Programme Committee and a senior member of Council. To date, I have been able to stand my ground, but it is good to know that I have a team outside of the Execs that I can turn to for advice! I think that is good governance.

For the future, we still need to hone in on what the BPS core activities are that truly meet the aims of the Society as listed above; that is an ongoing discussion within Council but that should also involve the membership as we try to match costs of providing the aims with our income.

In my simple terms, income from membership registration and from the ASM has to be at least equal to spend on core activities. Other activities will need to bring in their own funding. To try and meet my simple aims, we have introduced a *Funding Application Form* for all new projects; please do not be surprised if you are asked to complete such a form when you ask for financial support for a project – we do need to prioritise spending and against our core aims. I also suspect we

will have to turn down many initiatives in the early days as we bed down what Council views as essential for the Society and its membership.

Due to recent changes in VAT regulations, the BPS Executives recently commissioned a VAT expert, Les Howard, to review BPS' finances and specifically the BPS potential VAT liabilities. The discussions around this tasked the best of us, and we have had external advice from Independent Examiners Ltd, BPS Financial Advisors and Andrew Lang & Co, our auditors as well.

The outcome of these reviews, discussions at Council and multiple executive meetings has been that the best option to meet our financial and legal obligations for the Society and its members is that we set up a *VAT registered trading arm*. Those activities that potentially will attract VAT would be managed in that separate trading arm.

From my perspective, over the next few years, the BPS will continue to review and challenge its role, identity and image with the aim to produce a targeted financial strategy with the BPS multidisciplinary and multispecialty membership and their goals at the centre. That strategy needs to minimise financial risks for the Society but also ensure we meet our legal financial obligations.



News from the Neuropathic Pain SIG of the British Pain Society

Dr Bernhard Frank *Chair of the Neuropathic Pain Specialist Interest Group*

The Special Interest Group (SIG) ran its own workshop this year with the title 'Neurological Assessment of Neuropathic Pain' at the Annual Scientific Meeting (ASM) of the British Pain Society (BPS) in Manchester. The feedback was very good with an average score of 3.8/5 for content and presentation. A total of 137 (nearly a quarter of the overall participants) delegates pre-registered for the workshop, which indicated to me that there is still a great interest into neuropathic pain, and this fact is very encouraging for future workshops covering the topic of neuropathic pain. As we had our own dedicated workshop at the meeting, there was no formal time slot for an annual general meeting (AGM).

Since Manchester, we submitted a successful workshop proposal together with the Acute Pain SIG for next year's meeting in Glasgow and should therefore be able to hold an AGM in 2015.

We also discussed future topics for a neuropathic pain workshop and suggestions included 'New Therapies', 'Neuromodulation techniques' and 'Facial Pain'.

There was no formal meeting of the officially formed research group last year, and I suggested looking into the possibility of a neuropathic pain registry in the United Kingdom, which could be used to evaluate the uptake of the new updated National Institute for Health and Care Excellence (NICE) guidelines by a non-specialist prior to referral to a pain clinic, the validation of questionnaires for neuropathic pain including the diagnosis confirmed by a specialist according to the new definition,

epidemiological data collection and treatment outcomes. A standard set of questionnaires, simple bedside quantitative sensory testing (QST) and possible blood sampling for biomarkers and genetic testing were proposed.

The Committee Members agreed on the following officers for the SIG:

Chair: Dr Bernhard Frank, replacing Dr Mick Serpell.

Secretary: Dr Jayne Gallagher, since 2012.

Treasurer: Dr Praveen Ganty, since 2012.

The following elected committee members were confirmed:

Dr Katie Warnaby, Dr Subhash Kandikattu and Dr Abdul Nazal all since 2012.

We all thanked Mick Serpell for his excellent chairmanship during the last 10 years.

The Patient Liaison Committee nominated Mr Colin Preece as a new member of the neuropathic pain SIG, and following his election, Dr Arun Bhaskar is the new liaison officer for the SIG on the council of the BPS.

Since the ASM, the BPS held a SIG Chairs meeting in London, which was very informative and highlighted that next year's theme for the 'Global Year against Pain' by International Association for the Study of Pain (IASP) is going to be 'Neuropathic Pain'. This obviously offers the opportunity to raise the profile of the SIG here in the United Kingdom and get

involved in updating the British pain community on new developments via the different journals and newsletters produced by the BPS.

There is also the chance to intensify the link between the SIG and IASP.

My plan for next year is to prepare an agenda and use email correspondence before the AGM to discuss a constitution, a 5-year strategy including improving co-operation with other societies and SIGs on national and international level (e.g. IASP NePSIG, German Network for Neuropathic Pain Research (DFNS) and the British Peripheral Nerve Society), and to facilitate the exchange between basic science and clinical research in neuropathic pain.

Depending on the availability of speakers and dates, I would like to organise a further study day for neuropathic pain next year. My aim is also to support other health care professionals with a locally run educational day about the assessment and management of neuropathic pain and thereby increase awareness outside the pain world and improve referrals for specialist treatment.

There is also some uncertainty about the current number of members and a large overlap of membership in the Special Interest Group on Neuropathic (NePSIG) at IASP. A regular newsletter with support from the Communications Committee at the BPS and the new website will hopefully increase the participation of members in all future activities of the SIG.

Best wishes from Liverpool.



Pain assessment in older adults: updated guidance

Professor Pat Schofield *Centre for Positive Ageing, University of Greenwich, Chair of the Older People SIG, London, UK*

The joint publication from the British Pain Society and the British Geriatric Society on the Assessment of Pain in Older Adults was published back in 2007. This document highlighted the key approaches to the assessment of pain, which should be adopted when working with older adults with or without cognitive impairment. It preceded the National Guidelines for the Management of Pain published in 2013. Within this original document, we produced an algorithm which provided a step by step pathway on the identification of pain in the older adult. Later, this has been incorporated into the iPhone pain App which is currently being evaluated by the South East Coast Ambulance Service (SECamb).

In 2012, we decided to update the national guidance, and following the review of the literature, we produced the latest document which has been out for consultation. The new assessment guidance contains a number of new recommendations and key points.

Prevalence of pain

As with the prevalence reported in the Management of Pain Guidance (2013), we continue to highlight that prevalence is a complex issue in relation to definition of pain, type, duration and age of participant. Generally, the crude prevalence suggests that the range is between 0% and 93%, so clearly more work to be done in this area. Overall, pain is prominent in knees, hips, back and other joints and increases up to 75 years, then decreases, although Thomas (2007) suggests that pain which interferes with daily life increases with age.

Attitudes and beliefs

If we assume the bio-psychosocial model of pain and the cognitive behavioural approach to management, then the attitudes and beliefs of others play a significant role. It is a long held and classic belief that older adults are more 'stoical' or that pain is a 'normal part of ageing'. Such beliefs are held, even by the older adults. There has been little research carried out with older adults. The available studies point towards an adherence to biomedically orientated beliefs about pain, a degree of fear-avoidance among clinicians in relation to activity recommendations and a negative orientation to chronic pain patients in general.

Communication

The process of communication of pain is complex and often confounded by cognitive impairments or cultural barriers. Time taken for consultations often prevents a further barrier to eliciting the true pain experience from the older adults. Real pain assessment is not about the completion of scales alone, but should involve enabling the individual with the opportunity to provide their narrative pain stories. Social scientists can enhance this communication by helping the clinician to understand the cultural, social, political, economic and communicational aspects of pain and can, therefore, enrich the clinical views.

Self-report measures

The most accurate and reliable measure of pain is the patients' self-report. Pain

that is often denied can be elicited using other words such as '*aching, hurting or soreness*'. As reported previously, verbal descriptors (none, mild, moderate or severe) or numerical rating scales are most appropriate where there is none, mild or moderate cognitive impairment. The key message is to give the older adult chance to respond and provide a tool with larger font or take care to ensure adequate lighting. A number of other scales have been developed for use with older adults that measure other aspects of the pain including disability and function, for example,

- Functional Status Index
- Multidimensional Pain Inventory (MPI)
- General Activity Scale
- Physical Activity Scale
- Human Activity Profile
- Groningen Activity Restriction Scale
- Sickness Impact Profile
- 36-Item Short Form Health Survey (SF36) – specifically in relation to its physical functioning and role limitations-physical scales
- Older Americans Resources Service, which is primarily applicable to a US-based population.

Other scales include World Health Organization Disability Assessment Schedule (WHODAS), Western Ontario and McMaster Universities Arthritis Index (WOMAC) and Roland Morris, while Brief Pain Inventory (BPI), McGill Pain Questionnaire (MPQ) and Hospital Anxiety and Depression Scale (HADS) have also evidence supporting their use.

Pain assessment in older adults: updated guidance

Pain assessment and cognitive impairment

In 2007, we identified a number of behavioural pain tools specifically designed for the measurement of pain in older adults with cognitive impairment. All of the tools to a lesser or greater degree were based upon consistent indicators of pain such as facial expression, body posture and verbal sounds. We recommended the Abbey Pain Scale which has since been widely introduced across practice settings in the United Kingdom. Interestingly, since the 2007 guidelines and with our recent review, we have found that there has

been no further validity or reliability testing on the Abbey scale, and in actual fact, the Pain Assessment in Advanced Dementia Scale (PAINAD) or Doloplus are the scales with the strongest evidence. However, there are two key messages here: (a) from a pragmatic perspective, the scale that is most user friendly is probably the best to use unless carrying out research; (b) as before, we strongly recommend that no further scales be developed, and we need to continue to validate the scales that we have.

In terms of National Guidelines, it seems that the key leaders in the field

are the United States, Australia and the United Kingdom.

Contributing authors

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*Centre for Economic and Business Research (CEBR), February 2014. **HomeLet.co.uk, May 2014. [^]£289.60 figure based on Employment and Support Allowance at £72.40 a week, calculated on a 4-week month, increasing to £350.20 a month calculated on a 4-week month for those eligible for Statutory Sick Pay. DWP Website, April 2014. ^{^^}Please note this offer is subject to underwriting and PG Mutual's terms and conditions, applies to new PG Mutual members only and excludes uplifts. It cannot be used in conjunction with any other offer. PG Mutual is the trading name of Pharmaceutical & General Provident Society Ltd. Registered office: 11 Parkway, Porters Wood, St Albans, Hertfordshire AL3 6PA. Incorporated in the United Kingdom under the Friendly Societies Act 1992, Registered Number 462F. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority, Firm Reference Number 110023.



Acute pain at the International Association for the Study of Pain World Congress

Dr Ruth Day *Co-Chair of Acute Pain SIG*

I felt very lucky to be able to attend the World Congress on Pain in Buenos Aires this October and browsed the online programme to try and identify the key acute pain happenings. I'd had to book my flights before details of the Acute Pain Special Interest Group (APSIG) meeting were available and was slightly disappointed that I was arriving in the morning of the Sunday before the conference began – and just as the APSIG meeting was due to start. However, I booked a place and hoped for the best.

After an acutely painful moment at Heathrow when I thought I was going to get bumped off the flight, I managed to get to the APSIG meeting in time to hear Dr Luana Collacca speak about the modulation of acute pain by negative expectation (nocebo). I had missed the sister presentation on placebo but found more than enough food for thought here. She discussed how conditioning and verbal suggestions affect peoples' responses. One example from a study looking at post-lumbar puncture (LP) headaches caught my interest. It compared the difference of reported headaches between two groups, one of which was told there was a possibility of headaches and the other was not (probably wouldn't get ethical approval today). In the first group of 15 patients, 7 reported headaches, and in the second group of 13 patients, no headaches were reported. This seems to indicate the importance of what we say and how we frame it. Presenting

information to people becomes more complicated by the moment!

Lunch was a chance to meet folk from elsewhere – Nigeria, India the United States and Canada for me – also my first empanadas and an introduction to how much Coca-Cola is drunk here (I later learned that wine drinking in Argentina dropped from 60L per person p.a. to just 24 following some slightly dodgy practices in the wine trade in the 1970s. It is slowly picking up, but cola and beers have gained somewhat).

The afternoon session started by considering how 'big data' can be used in acute pain. This has a particular interest to members of the British Pain Society (BPS) APSIG group who have, for many years, been working on a minimum data set for acute pain (National In-Patient Pain Survey (NIPPS)). Fiona Duncan is continuing with this in the United Kingdom and has been looking at the possibility of a registry as well as applying for research funding. Many of you will also know about PainOut, a European pain registry based in Germany. Marcus Komann, a statistician from that group, introduced their work, reminding us that the PainOut data have research, quality and benchmarking possibilities. A number of the poster presentations at the conference also showcased the possibilities of the data mining with the PainOut data set.

Dr Sean Mackey from Stanford introduced Collaborative Health Outcomes Information Registry (CHOIR), a US-based registry, which, for the last

two years, has been collecting chronic pain data. The patients complete the questionnaires at home on a personal computer (PC) or on a tablet or mobile device. It takes 14 minutes to input the data but it is used to inform the clinicians decision-making. From an acute pain perspective, they are looking at collecting pain information pre-operatively to enable identification of need prior to admission. If you are interested in this, further details can be found at <http://snapl.stanford.edu>. Finally in this section, Deb Gordon reminded us of the need for planning when trying to improve quality and safety in acute pain. For me, her take-away message was that using data to improve systems should generate light, not heat! A nice reminder that finding a way to 'turn on the light' for a ward manager when considering change works better than introducing 'more work'.

After a break for more cola or coffee, we resumed with a personal story from Dr Bob Cohen on the management of the Boston marathon bombings in April 2013. We were all touched by this, and Dr Gallagher continued by telling of the work done with veterans – although this mostly touched on chronic pain rather than acute.

We then had updates from Germany, Australia and the United States. Take-away thoughts from Germany included the idea of giving 'pain free' certificates to hospitals who attain certain standards in acute pain. Made me think that we have 'dementia awareness' certificates on wards which have attained a certain level in training in dementia care. Should

Acute pain at the International Association for the Study of Pain World Congress

we think about the same for pain – or would it be putting the cat among the pigeons? Dr Schug reminded us that the next edition of the Australian and New Zealand College of Anaesthetists (ANZCA) acute pain/scientific evidence book was due in May 2015. Other than giving him many sleepless nights, he also said it would contain more on personalised care, particularly in the areas of pain assessment, pharmacogenomics and consideration of procedure specific pain management. To round the day off, Dr Sean Mackey

described the process which led to the new US National Pain Strategy. Following a report by the Institute of Medicine in 2011, they were asked to develop a strategy on pain with tactical, achievable goals. This document is now out for consultation on the federal website – but he suggested this was only the beginning and a cultural transformation would be needed if it were to become a reality.

The day finished with a drinks reception, more food and making friends. Dr Dan Carr, the current Chair of

the SIG group was roundly congratulated for a good start to the conference, and notes were assiduously taken by our very own Dr Jane Quinlan who is the current Secretary. Her talents were pressed into service during the business meeting later in the week – but you can quiz her about that yourself at another time.

As I went to find my hotel through the pouring rain, I reflected that in this one day, I was likely to have more acute pain input than the rest of the week ahead – and I was right.

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Website redevelopment – an update

Dr John Goddard *BPS Vice President and Consultant in Paediatric Anaesthesia and Pain Medicine, Sheffield Children's Hospital, Sheffield*



I am not a techie. I hate drop down menus that scroll sideways with sub-menus in any webistes; I invariably need two or three goes before I get to where I want to be. I have felt for some time that the content on

the British Pain Society website could be improved and that it provides little in the way of member benefits. Also, as an ex-Treasurer, I felt that some of our third party associated costs were a little steep.

So, it seemed to me, it was time for a website review. Raj Munglani, whilst on Council, was keen to take this on and did a lot of preliminary work around what members wanted from the website. This has been previously reported in *Pain News*. Council were very grateful, but unable to agree a budget to take the work forward.

After a bit of a hiatus, Council were persuaded to use the designated Bainbridge fund to support a full IT review. This was fortuitous as the office PCs were beginning to creak very badly and clearly needed replacing. But, where to start? My experiences within the NHS are littered with failed IT projects, both small and large. And usually there is a significant cost attached!

So, we began at the beginning with our hardware company, Greencorn. And then our database company, Iris. At the same time, I was being persuaded that we did need to employ a Project Manager. Various contacts were suggested; we finally settled with Steve Walmsley who is a founder and Director of Which Medical Device. I was impressed that I understood what he was saying to me and that I think he understands what I am saying to him; a situation that is not always the case when I converse with IT professionals and statisticians.

A small project group was formed: Nick Allcock - Communications Committee Chair, Meherzin Daz - ICT SIG Chair, Antony Chuter - PLC Chair, Ken and Jenny – Secretariat, Steve and I. More recently Christina Lioffi – Pain News Associate Editor, has joined us. I am very grateful to all of them for their input and frequent teleconferences. The initial task for the group was to produce a website development brief which was put out to tender and produced five responses; our current website manager, Yves LeBrec, did not submit a tender. A decision was made to sign a website design, development and hosting agreement with CALM Digital Ltd.

Two themes have needed attention. Back office functions – amalgamating a database with algorithms that will automate membership activities and reduce workload for the Secretariat. Essential if the website is going to

function. The other theme has been more tricky – homepage design and content. Of course it has to be mobile friendly, embrace social media, appropriately direct visitors to content. But which visitors to what content? Right from the outset, Steve has persistently asked what are the vision, mission and strategy of the Society. Who are the stakeholders we wish to engage and communicate with? Adoption of technologies must be for a reason, not just because they exist. Perhaps unsurprisingly this is not as clear as it should be and opinions differ. We are a membership organisation, but many feel that additional membership categories need to be developed if we are to survive as a Society; the Society has a working group looking at this issue. The Communications Committee is developing a communication strategy, but are we trying to be all things to all men? What are our core objectives and priorities?

We have replaced the office PCs with hardware that will meet our future needs. We decided that our current bespoke database is unnecessary and that open source software will meet the Society's needs. We are fast approaching the November deadline we set to enable on-line registration for the 2015 ASM. Our back office functions are being tested and the home page decision day is approaching fast. I, for one, have my fingers firmly crossed!



Things they don't tell you about depression

Author anonymous

I considered myself reasonably informed on depression. I have worked in chronic pain. I also had worked in psychiatry. I had memorised International Statistical Classification of Diseases and Related Health Problems–10th Revision (ICD-10) criteria and learned about antidepressant pharmacology, and different psychological treatments for my pain medicine exams. I dealt with depressed patients during my pain fellowship on a regular basis. I only realised how little I knew when as a senior anaesthetic trainee I developed depression myself. I hope eventually this insight will make me a better pain doctor.

Recovery from depression takes a lot longer than people think

I didn't notice any benefit from starting antidepressants until I had been taking them for eight weeks and even then it was very slight. As my dose was gradually put up, it would take three or four weeks for me to notice an improvement with the increased dose. At six months I still felt a long way from my normal and found this extremely frustrating.

Accessing psychology services can be a challenge in itself

I requested a psychology referral from my general practitioner (GP) on my second appointment. Because of my job, I asked that it be an out-of-sector referral. It took 2 months before my health board approved the out-of-sector referral. The first region my GP practice then contacted said they had a 9-month

waiting list. I was told by my GP's secretary that I would need to myself identify which other psychology service I would like to be referred to. It was only with the help of a close friend who worked in psychology in another region that I was able to identify a service and request referral to them. I was assessed 6 weeks later and started Cognitive Behavioural Therapy (CBT) immediately.

CBT isn't a miracle cure but it is a valuable treatment that requires commitment but does help

My psychologist helped me to understand that my thought processes were disturbed because of my depression. She described CBT as retraining your brain to think the way that it does when you are well. I felt I had become under-confident and over-sensitive, but she helped me to understand mood as a continuum from low to happy that everyone moves up and down, within appropriate context, but in depression (and I would guess chronic pain), the resilience to move back up the scale is far less. CBT isn't about positive thinking, it is about recognising negative automatic thoughts and finding ways of counteracting them so they don't become all consuming and, then, gradually build back resilience.



Don't assume someone else has done a proper suicide risk assessment

GPs only see a patient for 10 minutes. I have found my GP very helpful and supportive. However, she has never asked me specifically about suicidal thoughts. On one or two occasions, I have volunteered concerns about having such thoughts, but only much later in the course of my illness once I felt more comfortable with my GP. Suicidal thoughts are distressing even when you don't believe you will act on them. I have spent hours and hours planning how I would kill myself. Only on a handful of occasions do I think I got even close to doing anything. And it was distressing, in part, because I knew it wasn't the answer but felt so desperate and trapped and I couldn't see how to go on for another day. I couldn't see myself as having any value and felt like I was a burden to my friends and family. Thanks mostly to some incredible friends, I did keep going. Pain doctors are blessed with longer appointments – if your patient appears depressed, please ask about suicidal thoughts. A simple open ended 'Have you ever had any thoughts

of harming yourself' will be enough for many to open up and admit something they may not have told anyone else.

Disturbance in sleep has massive knock on effects

My sleep disturbance presented before I even realised I was depressed. On a couple of occasions, I had to phone in sick to work because I had no sleep and knew I was not safe to give an anaesthetic. This pattern continued following my diagnosis. Every time I phoned into work for this reason, I felt horribly guilty and worried people would think I was just being lazy. But I was protecting my patients. I never slept through the night. I would regularly wake up 2 or 3 times during the night. Sometimes I would get straight back to

sleep, sometimes I would be awake for hours. Other nights I struggled to fall asleep. No matter how much sleep I got, I always woke up tired. Fatigue is one of the most upsetting physical symptoms of depression – it has knock on effects for enjoyment of activities, ability to do one's job, motivation and mood itself. After two night shifts, my sleep disturbance would result in a significant worsening of my low mood and suicidal thoughts, at times resulting in me being off work for a week. When a patient tells you their sleep is disturbed, please do not underestimate the effect this is having on their life.

Recovery from depression is not a straight line

It starts as a few better days here and there. For months, I felt like I was going

around in circles ... feel better for a few days, maybe a week then falling back into the gloom. When my mood was better, anxiety was more of a problem too. The whole cycle was exhausting. Each time, I didn't know whether I could do it again. It was 7 months before I first experienced two whole better weeks in a row. Finally, I felt things were improving. My point is catching a patient on a good day does not mean their depression is gone. Still ask. Similarly a patient on a bad day doesn't mean that he or she can't be reached or encouraged to keep going. Tomorrow might be better, so tell them that. And most importantly, it DOES get better. They may not believe it, but keep telling them. Trust me, it helps.

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The effectiveness of analgesia post-discharge after major colorectal surgery under the Enhanced Recovery programme

EL Teo and K Rajdev *Medical Students, University College London, London, UK*

Dr S Ishaq *Consultant Anaesthetist, Whittington Hospital, NHS Trust, London, UK*



K Rajdev



EL Teo

Enhanced Recovery After Surgery

With the advent of Enhanced Recovery After Surgery (ERAS), there is a great incentive to facilitate rapid mobilisation, reduce the length of hospital stay and provide adequate analgesia postoperatively. The recent focus on 'fast-track' or 'accelerated recovery' programmes aims to minimise complications (such as poor wound healing, venous thromboembolism and hospital acquired infections), and to maximise patients' satisfaction and safety in early discharge for home. ERAS requires a combined effort to optimise the patient preoperatively, prevent intraoperative surgical stress and provide effective operative and postoperative analgesia, along with early mobilisation and oral/enteral

nutritional support¹ (see Figure 1). Given its benefits and encouraging results in rapid postoperative recovery, the ERAS scheme has been adopted in many hospitals across the United Kingdom.

Alleviating pain is central to postoperative recovery from both psychological and physical viewpoints – effective analgesia relieves anxiety and discomfort and also helps to blunt autonomic and somatic reflex pain responses, encouraging a faster recovery and thereby improving postoperative outcome.¹ However, early discharge may increase the possibility of inadequate or excessive provision of analgesics, and with it the potential for a lack of follow-up in the community. Therefore, the current challenge is to minimise excessive opioid prescription in order to prevent iatrogenic opiate dependency and to promote sufficient evidence-based provision of opioids for patients who may greatly benefit from them.

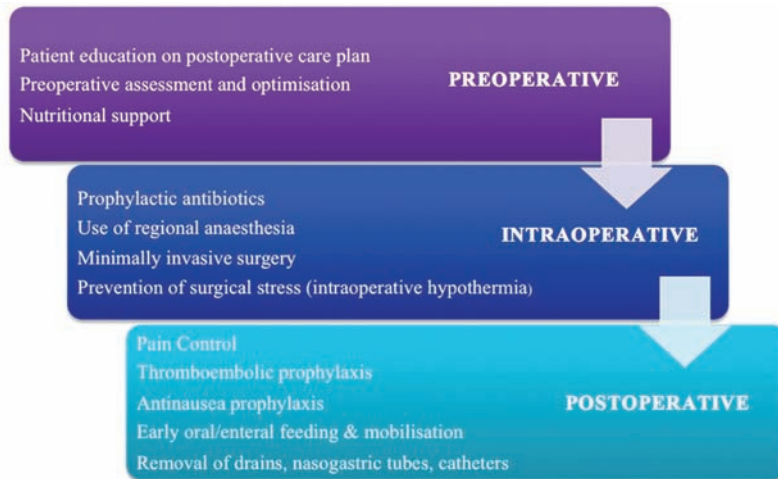
In this article, we aim to focus on the effectiveness of analgesics after surgery and the potential problem of discharge on strong opioids that can fuel opiate dependency. We also present our findings from an audit of analgesics post-discharge on the ERAS scheme at the Whittington Hospital, London.

Misuse of analgesics

The misuse of analgesics has increasingly received attention from all over the world. The opioid epidemic in the United States, where deaths from opioid overdose are second only to traffic accidents in accidental deaths, has provided a cautionary tale for the rest of the world. In 2011, the United Nations (UN) published a *World Drug Report*² that documented a declining world market for illicit drugs but a worldwide increase in demand for prescription opioids. This worrying trend has a major impact on public health and resource distribution of medications to those who truly need them.

There is a growing trend of analgesic misuse in the United Kingdom as well. A cross-sectional study of adults in Scotland demonstrated that the past two-week prevalence of non-prescription analgesic use was 37%. Of this cohort, 21% reported some form of misuse³ – use of multiple analgesics, potential drug interactions and use of non-prescription analgesics – as a supplement to their current medical treatment for chronic conditions. The increased misuse of analgesics has come as no surprise for many reasons. The major factor is easy access to over-the-counter drugs; 24% of over-the-counter drug sales in the

The effectiveness of analgesia post-discharge after major colorectal surgery under the Enhanced Recovery programme

Figure 1. Multimodal concept of Enhanced Recovery in ERAS scheme

ERAS: Enhanced Recovery After Surgery.

United Kingdom (2001) were analgesics, rendering them the most common non-prescription drugs. This was further fuelled by UK government policy in 2001, which reclassified certain prescribed medication, including analgesics, as non-prescription medication in order to encourage self-care of minor illnesses.⁴ Other reasons for analgesic misuse include a more socially acceptable notion for misuse of analgesics rather than illicit drugs, purity of the drug, with predictable effects at fixed doses, and the reduced risk of prosecution.

Aim of audit

Although iatrogenic drug dependence is on the rise across the world, the findings from our cohort did not suggest any abuse of opioid or non-opioid analgesics. Therefore, the main aim of our project was to assess the effectiveness of analgesia post-discharge for colorectal surgical patients using data from telephone call follow-ups. Under the ERAS scheme, Enhanced Recovery (ER) nurses called patients 48 hours after their discharge to monitor their pain control, the effectiveness of the painkillers, any

side effects (nausea, vomiting, constipation, diarrhoea), their ability to carry out activities of daily living, the progress of their wound healing and also to give advice to patients as appropriate. The analgesics prescribed for these patients postoperatively met the acute pain guidelines of the World Health Organization (WHO) analgesic ladder, stepping down from strong opioids in the immediate recovery period until patients could be discharged on a combination of simple analgesics, non-steroidal anti-inflammatory drugs (NSAIDs) and weak opioids.⁵ At follow-up, patients who were still in moderate-to-severe pain were advised to visit their general practitioner (GP) to optimise their pain management, rather than seeking over-the-counter analgesics.

Method

The follow-up records for all patients who underwent colorectal

surgery at the Whittington Hospital between January 2013 and December 2013 were obtained. This retrospective study included both emergency open and laparoscopic operations along with elective operations such as reversals of ileostomies and incisional hernia repairs. Follow-up was made by phone calls to patients by ER nurses 48 hours after discharge, using a set proforma.

Of the 89 records for follow-up calls, 72 (81%) had complete responses from patients and were selected for analysis. Patient responses were coded numerically, for example, with severity of pain being rated as mild, moderate or severe and being ranked on a scale of 1–3, respectively.

The key criteria assessed were as follows:

- Whether the patient's pain was well controlled;
- The severity of their pain (mild, moderate or severe);
- Whether they had taken analgesics;
- The type of analgesic taken (Step 1, 2 or 3 on the WHO pain ladder);
- Whether the analgesic was effective;
- Whether the patient had experienced nausea or vomiting.

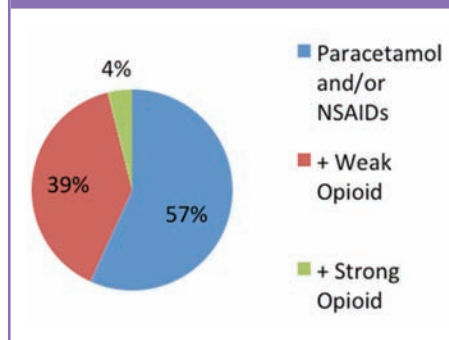
Results

The results of the audit are displayed in Table 1 and Figure 2.



Table 1. Survey results (n = 72)

Taken analgesia	83% (60)
Analgesia helped	93% (56)
Nausea/vomiting	21% (15)
Pain well controlled	88% (63)
Mild/no pain	94% (59)
Moderate pain	6% (4)
Pain not controlled (moderate/severe)	12% (9)
Analgesia not helped	22% (2)

Figure 2. Type of analgesic taken post-discharge

Patients whose pain was described as controlled

Of the 72 patients, 63 (88%) said their pain was well controlled by follow-up, and 52 of them (83%) had taken analgesia. Of those whose pain was well controlled, 59 of the 63 were in mild or no pain (94%), the remainder described moderate pain. Patients with moderate pain had taken analgesics, but it was only effective in two out of the four.

Patients whose pain was described as not controlled

Of the nine patients (89%) whose pain was not controlled, eight said that they had taken analgesia. Moderate pain was reported by seven, and one was in severe pain. The other patient could not take painkillers due to vomiting after taking them and was in moderate pain. Four (50%) of the eight patients

who had taken analgesics had been taking a weak opioid and an additional patient presented to Accident and Emergency (A&E) where she was given oromorph. The rest were receiving paracetamol and ibuprofen, or paracetamol alone. Where appropriate, these patients were advised to see their GP to optimise their pain management.

The types of analgesics taken were recorded for 51 patients (Figure 2):

- 29 (57%) were on paracetamol and/or NSAIDs (WHO 1);
- 20 (39%) were on paracetamol/NSAIDs and a weak opioid (WHO 2);
- 2 (4%) were on paracetamol/NSAIDs and a strong opioid (WHO 3), although in one case this was administered in the hospital setting as oromorph when the patient presented to A&E. The other case was a patient discharged on morphine.

Patients who had felt or been sick post-discharge

Of the 72 patients, 15 (21%) felt nauseous or had been sick after discharge. Two of these patients were not taking painkillers as they vomited after eating anything, and in particular, there was no record of anti-emetics being prescribed on the 'To Take Away'

(TTA) of one of them. Of the other 13 patients, 5 (38%) were on mild opioids. Six (46%) were on NSAIDs or paracetamol, and there were no data for the painkillers taken for two other patients. One patient received advice from the ER nurse to spread out his consumption of analgesics (paracetamol/NSAIDs and a weak opioid) in order to prevent sickness. It is noted that although nausea and vomiting are major side effects of opiates, the symptoms could also be related to the colorectal surgery itself.

Discussion

This audit has shown a very low risk of patients being discharged on strong opioids post-colorectal surgery between January and December 2013 at the Whittington Hospital, with 96% of patients receiving a combination of paracetamol, NSAIDs or weak opioids and only one documented case of a patient being discharged on morphine. While there is little information available to us regarding the implications of this for the patient, the follow-up document records that he did not feel sick at the time of the call, and his pain was well controlled. However, it is important to follow up such patients further to ensure that they are sufficiently weaned off strong opioids and that dependence does not become an issue.

The audit results have also shown that the analgesics provided on discharge were adequate and effective for most patients. In all, 88% of patients said their pain was well controlled, reflecting a successful analgesia regimen for these patients post-discharge. For the remainder, it is important to consider why their pain was not effectively controlled, especially due to the fact that 50% were on weak opioids and one required strong opioids, which may have required a longer stay in hospital, a stronger opioid prescription or further advice to the

The effectiveness of analgesia post-discharge after major colorectal surgery under the Enhanced Recovery programme

patient on how and when to take their medication. As seen from the case where one patient had to be re-admitted and given oromorph, it is important to consider whether difficulty with pain control may be an early sign of a postoperative complication. The ERAS scheme encourages early mobilisation and discharge, but at the same time, it should also keep re-admissions and postoperative complications to a minimum.

Conclusion

Overall, this audit suggests that the majority of patients are receiving effective pain control under the ERAS programme when assessed at a 48-hour follow-up, with suitable advice being offered by the follow-up nurses if prescribed analgesics are not

adequate. While the results of this audit are reassuring, there is still scope to optimise the use of analgesia and anti-emetics in these patients. Increased guidance in a form of leaflet may allow the patients to understand the medications better and use them more effectively. In addition, nurses could be equipped with the patient's discharge summary and medication (TTA), so that they are better informed when giving specific advice to patients. Finally, the follow-up proforma could include the pain scores of patients both at discharge and on follow-up – giving us better, more objective scores for the subjective idea of 'well-controlled' pain. These further changes to the ERAS scheme in the Whittington Hospital may help to further optimise pain relief for maximum benefit to these patients.

Acknowledgements

We would like to thank Dr Samina Ishaq for overseeing this project and the Enhanced Recovery Nurses at Whittington Hospital for follow-up call data and input for future recommendations.

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National Institute for Health and Care Excellence (NICE)

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

Since September 2014, the Society has received over 50 communications from NICE on topics with relevance to pain. Of those, the Society has formally responded to the following topics:

- Physical Health of People in Prisons – NICE scope consultation (submitted November 2014).
- Medicines Optimisation – NICE draft guideline (submitted November 2014).
- End of life care in children – NICE scope consultations (submitted November 2014).
- Naloxegol for treating opioid induced constipation – NICE Single Technology Appraisal (submitted November 2014).
- The safe use and management of controlled drugs – NICE scope consultation (submitted November 2014).



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SAGE

Pain medicine training – a trainee's perspective

Dr Emma Baird *Trainee in Pain Medicine*

I have spent the last two years as the trainee representative of the Faculty of Pain Medicine, and when I applied, I had, I must admit, only a limited idea of what the Faculty did. I fell victim to the presumption that the Faculty, much like all national organisations, was run by the powers that be, who might have little idea what it was like to be a pain trainee or pain medicine provider in the United Kingdom. I couldn't have been more wrong. I found the whole of the Faculty to be completely approachable and driven by a desire to improve the provision of pain medicine in the United Kingdom. Part of this improvement is the implementation of a better, and more robust, training programme. In this article, I am going to describe the main changes that have occurred in the past two years in pain medicine training and how these have been instigated and facilitated.

The biggest recent change to pain medicine training has been the introduction of the Fellowship of the Faculty of Pain Medicine, Royal College of Anaesthetists (FFPMRCA) exam for Fellows of the RCA (FRCA). The exam was introduced in September 2012 and is consistent with the requirements for fellowship of other UK colleges and faculties and established faculties of pain medicine internationally. The exam consists of two parts, an initial Multiple Choice Question (MCQ) paper, which if passed allows the candidate to sit the Structured Oral Examination (SOE). Upon passing the exam and completing

advanced pain training, a pain medicine physician can become a member of the Faculty of Pain Medicine and use the post-nominals FFPMRCA.

Introducing a new exam was never going to be easy for both the Faculty and the trainees taking it. Both setting and taking a new exam take an incredible amount of hard work and dedication, but I, and many of the other trainees I have spoken to, agree that an exam was fundamental to improving the quality of pain medicine training in the United Kingdom. Feedback from candidates who undertook the first sitting of the exam indicated that the standard was felt to be appropriate and The Royal College of Anaesthetists, who were auditing, gave the new exam a glowing report. That is not to say it does not present a challenge to pain trainees. The exam guidance and resources that are available for the FRCA are immense. It is a known quantity and trainees, and their trainers, know what they have to do to pass it. It will take many years before the FFPMRCA has such resources available, especially given the smaller number of candidates that sit it each year. Like most exams, it will develop over time. The Faculty have continued to provide support, guidance and syllabus updates. The Faculty introduced an exam study day and through the new Trainee Rep (Lucy Miller) and the London Deanery, web based teaching sessions are being set up. While the exam, and the infrastructure around it will not remain static, it is essential to the progression of the speciality.

The other major development has been the standardisation of pain medicine training around the United Kingdom. As with the introduction of the new exam, this is an ongoing process and will take time to be fully implemented. Centres offering advanced pain training are now assessed regularly for quality assurance in the adequacy and breadth of training. This will allow the Regional Advisors to ensure training programmes feature the best possible training at the best possible centres. The Trainee Survey, which has now run for two years, and in which the Trainee Representative plays a major role, will help us to connect directly with trainees across the nation and allow the Faculty to find out and consider new areas of quality management. This of course does not mean that we, as trainees, should expect everything to be given to us. As with all advanced years, the onus must still be on the trainee to shape their training to meet their own educational needs. We are encouraged to spend time with allied specialities such as orthopaedics, rheumatology, palliative care medicine and neurosurgery. Part of the advanced pain training year is to seek these experiences out for ourselves and decide which direction our learning will take.

As part of the expanding resource available to help facilitate the new training, the Faculty has redesigned its online content. There are now pages dedicated to helping junior trainees find out a bit more about pain medicine, pages on sitting the FFPMRCA and examples of career stories.

Along with the Board, Professional Standards and the Training and Assessment Committees, there are many other groups that have worked tirelessly to bring about much needed improvements in both training for and provision of pain medicine in the United Kingdom. A special mention has to go to the Faculty administrators who despite being a small and incredibly busy team (shared with ICM, chalk and cheese I feel) do an amazing job.

It has been a remarkable time to be part of the evolution of pain medicine and

pain medicine training. We all want pain medicine training in the United Kingdom to be the best in the world. The only way this is going to happen is if we build the foundations of the Faculty with highly trained professionals. These few will need the knowledge, experience and support of the wider pain community. Finally, I would like to call on all of you to inspire future trainees into a career in pain medicine. Our chosen speciality is often seen as a strange area of anaesthesia to go into, and I am sure we have all been the butt of our non-pain colleague's

jokes. These myths can be challenged by showing our junior trainees what an interesting and rewarding career path pain medicine can be. I was inspired to follow a career in pain medicine by the three pain consultants with whom I did my first pain module (Drs Lowrey, Fryer and Hacking). We need all of the current pain medicine specialists in the United Kingdom to continue to inspire their junior trainees to pursue a career in pain medicine. Only then will the good work of Faculty and pain medicine community be cemented for the future.

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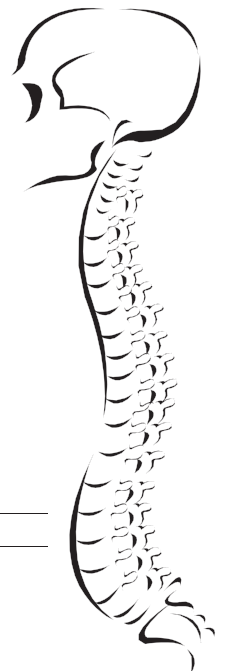
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The Philosophy and Ethics Special Interest Group (SIG) has, in recent years, tended to move away from the specific topic of pain towards that of suffering in general. The following three articles are transcripts of talks from the 2014 meeting which explored the roles of compassion and empathy in the

whole healthcare system, and the ways in which failure of compassion has contributed to unnecessary suffering. More articles will appear in the next issue on the same subject.

The Philosophy and Ethics SIG Next meeting 'The tyranny of diagnosis'

will be held at Launde Abbey from 29 June to 2 July 2015.

Speakers will include Professor Paul Dieppe, Professor of Health and Wellbeing, University of Exeter Medical School and Mr Antony Chuter, Chair of the British Pain Society (BPS) Patient Liaison Committee.

Compassion: fundamental to nursing or are nurses too fatigued to care?

Professor Michelle Briggs *Professor of Nursing at Leeds Beckett University and University Chaplain, Leeds, UK*



In this article, I would like to explore the question 'Is compassion fundamental to nursing?' Compassion is closely connected to nursing practice and is at the core of the National Health

Service (NHS) vision for Nursing as outlined in 'Compassion in Practice' 2012.¹ It is one of the 6 Cs – the fundamental values that underpin the nursing profession (Care, Compassion, Competence, Communication, Courage and Commitment). This is summed up in the quote below from *Jane Cummings, Chief Nursing Officer for England NHS Commissioning Board*:

"As Chief Nursing Officer for England, I want to make sure we give our patients the very best care with

compassion and clinical skill, ensure pride in our professions and build respect. The response from staff since my appointment has confirmed that nurses, midwives and care staff feel the same. The actions set out in this vision and strategy, which has been developed with you, will change the way we work, transform the care of our patients and ensure we deliver a culture of compassionate care."

The compassion Jane Cummings refers to is defined as 'intelligent kindness', and the product of that compassion as treating people with empathy, dignity and respect. In some ways, 'Compassion in Practice' was a three-year policy document in response to reports that clearly highlighted a failure in delivering compassionate care (e.g. Mid Staffordshire NHS Foundation Trust Public Inquiry 2013).

So if compassion is fundamental to nursing ... 'can we lose our capacity to be compassionate in practice?' Is it that nurses can become too fatigued to care? If compassion is 'intelligent kindness', are there circumstances where we stop making intelligent, kind decisions? What this definition lacks in this debate is the

concept that compassion isn't just a value we hold but a virtue we grow; for this reason, I prefer Bradshaw's definition:²

"Compassion is the suffering together with another ... compassion is a virtue that an individual cultivates as part of his or her character ... It involves a strengthening of virtuous intention and practices and a deepening of the disposition to do the right thing even when no one is watching."

Is that what patients say they see? The Francis report and other examples of poor practice suggest that some people in the NHS have lost the ability to 'hold their own and do the right thing even when no-one is watching'. I would like to draw from two recent research projects that I have been involved with to illustrate this point.

Project 1: a meta-ethnography of patients' experience of chronic non-malignant musculoskeletal pain³

Meta-ethnography is a method of drawing together qualitative research analogous to meta-analysis of quantitative data. It



involves reading the research, looking at the findings and recurrent themes and developing a 'meta-synthesis'. This project drew together all the qualitative research exploring what it feels like to be in chronic non-malignant musculoskeletal pain. One of the most important aspects that emerged from this work was that the greatest struggle for a person in chronic pain is the struggle to affirm self – to hold your own in the midst of the pain.

What you are trying to do is to integrate this new unrelenting body; this thing that won't let you be the person you want to be, with the old you. You want healthcare professionals to help construct an explanation of why this is happening to you – not necessarily just find 'a thing' that can be fixed. This includes struggling to negotiate the healthcare system. Often, this involves tests and if patients don't 'pass' those tests, there is no diagnosis and their pain is not 'legitimate'. So if I am a patient, I want you, as the pain practitioner, to believe me as no one else does, to stand alongside me and to *validate and* bear witness to my experience and help me to understand my pain and to achieve a balance between hiding and showing it.

But we are all stuck in a system that does nothing to meet these needs. Expectations are not met. Patients' experience of their health professionals too often involves lack of time to listen, a feeling of lack of concern and not being taken seriously. Being listened to and

believed in itself can be pain-relieving, and sometimes is all that is required.

Project 2: active listening in hospital⁴

Our project 'Active listening in hospital staff and patient perspective' explored that sense of non-judgemental listening. The Acorn Christian Healing Foundation is a charitable trust which among many other things is involved in training hospital chaplaincy volunteers in active listening. This project is exploring the use of active listening as an intervention in a hospital environment. In the first phase, we explored the feasibility and acceptability of hospital volunteers trained in active listening. In a series of focus groups we asked NHS and patient support groups 'If active listening were offered on wards would staff and patients welcome it?' The answer to this was yes; so in phase 2, we are testing the feasibility of delivering the intervention and methods to measure the impact of active listening. This has been working so well on the wards that the Trust has asked us to develop it in an outpatient setting. The seven focus groups for the first phase of this study were key stakeholders who we identified as healthcare academics (researchers and lecturers), postgraduate nursing staff, hospital chaplaincy volunteers, trained active listeners, active listening tutors and patients. We used a DVD example of active listening – it is a very structured technique – and described how it was delivered within the Acorn healing model, and then asked questions such as 'As a patient, or a member of staff, if somebody offered you this, do you think it would be valuable, and if you do, what would be the likely impact on your ward area?'

We analysed the responses qualitatively, and Figure 1 illustrates the results.

There were four elements that people saw as key active ingredients, the first being that listening in itself was a wellbeing generator, and decreased anxiety and vulnerability. There were some difficulties around spirituality and the public perceptions of hospital chaplaincy and spiritual care providers, but there was a unique benefit from having an intervention delivered by volunteers because they were not seen as part of the 'system'. Staff found that Acorn active listening, that had within it clinical supervision, monitoring and

recognised training, carried a sense of being useful and important. For this article, I draw on the project because of the finding of listening being a wellbeing generator. I want to focus on this theme. These are direct quotes from participants:

"... our biggest limitation as health professionals is that we don't spend enough time talking to patients ..." (staff)

"I think it's in stark contrast to the rest of hospitalisation and process in that you're having someone coming to you who doesn't have an agenda at all. Whereas everyone else that has an interaction wants a certain piece of information from you" (patient group)

"... someone makes you feel important, not just a number, not just a bed ... But unfortunately they are so incredibly busy ... I can see why that happens. So someone who has time, they're not pushed for time ..." (patient group)

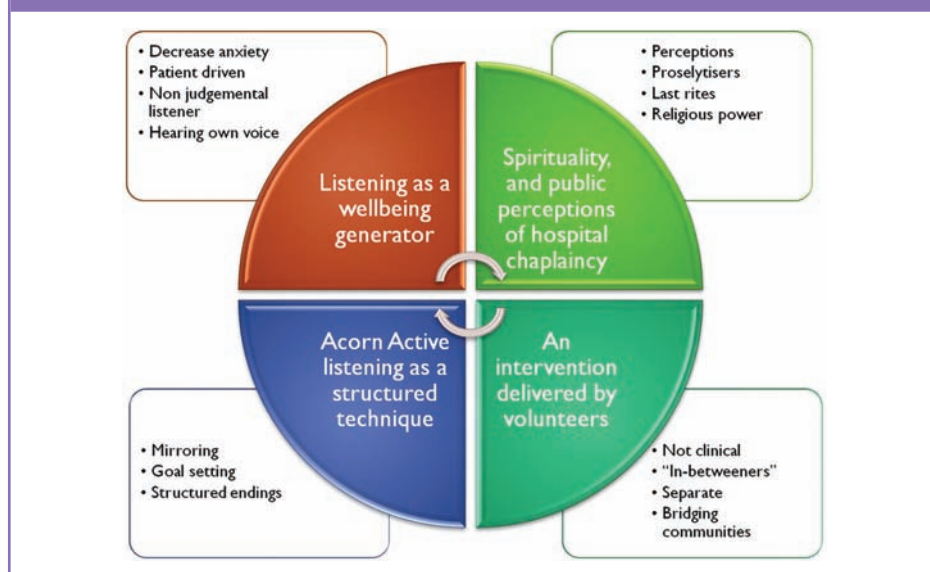
"Sometimes talking to someone, it gives you space to listen to yourself as well."

"... and just knowing that someone is actually listening and heard what you were saying. Because in hospital you can be in a number of days and feel that nobody's really listened to what you've said ..." (patient group)

The transformational power attributed to being listened to was acknowledged across all participants and all groups. Although there is a valuable perception that volunteers are not caught up in the system, they do have honorary contracts, training and supervision and are tied to the same confidentiality as other NHS staff. Time gives space; providing a safe space to be the person you want to be. The tension in that is not just one-sided; nurses appreciate the potential of active listening. There is one quote that sticks in my head: *"sometimes I am discharging patients when I have yet to know their names"*. That was not what that participant came into nursing to do. Having the support of others who were able to fulfil a need, she knew she wasn't able to be seen as incredibly valuable. We concluded from this phase of the study

Compassion: fundamental to nursing or are nurses too fatigued to care?

Figure 1.



that there is a real value in having time to communicate without task or target. And there I think is the link with our challenge to deliver care with compassion.

Time to listen

In a recent study attempting to understand patients' experiences of receiving compassionate nursing care, the first and foremost theme that emerged was 'what is compassion: knowing me and giving me your time'. Those nurses who were seen to make time despite the pressures were considered compassionate.⁵

A famous theological experiment at Princeton theological seminary in the 1970s involved two groups of clergy. First, they completed a questionnaire about their predisposition to compassion, and then one group was asked to write a sermon focussing on the Good Samaritan and the other about something around their experiences of theological training. On the day they were to deliver their sermon, one group were told that they had plenty of time so they were unhurried; the other group were told they were late, that time was short so they were hurried.

On the way to the place where they were to deliver the sermon, they stationed a dishevelled actor who

collapsed coughing and groaning in front of them. The study found that a predisposition to compassion made no difference at all to whether someone stopped, nor did studying the Good Samaritan story – indeed some in this group actually stepped over the person! But 63% of the people who felt unhurried stopped and helped, and only 10% of those who were hurried stopped.

The challenge for me is to discover how we should help nurses in a hurry; how do I help people to *stop* being in a hurry? That comes back to the sense of being able to put aspects into the system that allow you to feel unhurried and hold your own in the environment of modern UK nursing, which is, as Bradshaw writes,

"... increasingly subject to the utilitarian model of healthcare in the UK. A market-driven and bureaucratised approach has overtaken the values of care. Outcomes, measurement and technical rationality predominate."

A system that only values targets, speed and being lean and efficient can act as a counter to valuing compassion. These two things are dialectically in constant tension, and if you live in that tension, the pressure may get to you. Maybe that is sometimes why people

may, as I have heard, said 'get compassion beaten out of them'.

We talk about compassion as if it is something that you are; some people are naturally compassionate and others aren't, or if it is something to be prized. But as defined above by Bradshaw's definition, if compassion involves 'a deepening of the disposition to do the right thing even when no one is watching', then it can be cultivated and can grow. It can be encouraged, watered and nurtured, but it can also be crushed like a weed or ignored. There are said to be three levels of burn-out (for which a better term might be compassion fatigue): the first is dehumanising – not seeing people in a human way. This may lead to a place where you get to a point where you are emotionally burnt out and you too are dehumanised. If you are in a system that allows you to dehumanise others and then you risk becoming dehumanised yourself, the next stage is that the institution is burnt out and the people in it suffer. What we need to recognise and learn from a nursing point of view is that the key factor is to be in a place where we value being unhurried. That is not just saying all we need is more time; but we need the resources and the support to not feel hurried and be able to influence our organisational systems to allow for flexibility and compassionate design.

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Can you feel my pain? The role of empathy and compassion in health and social care

Dr Tom Shakespeare *Senior Lecturer in Medical Ethics, University of East Anglia, Norwich*



"It would be better to die once and for all than to suffer pain for all of one's life."

Aeschylus, Prometheus bound.

In my recent radio talk about disability, I

mentioned the way that people think that people with disability have a poor quality of life and how miserable it would be to be disabled. And yet, when you look at the evidence, disabled people report a quality of life which is as good or better than that of non-disabled people. But I qualified that with the exception of disabled children or adults who are in chronic pain. You can adjust to almost anything: to being paralysed, to a missing limb or whatever. Your quality of life plummets, and then over time, it goes back to pretty much what it was before. But the difficult thing to accommodate to is chronic pain. In her book *The Body in Pain*, Elaine Scarry describes how everything else besides the pain becomes secondary, even invisible.

And yet we have this paradox that it is extraordinarily difficult to feel the pain of others. Nothing is as absorbing as pain but nothing is as boring as someone else's pain, which is always going to be remote to us and impossible to understand fully.

As Elaine Scarry says, the nature of pain is resistant to language, and Wittgenstein gave pain as an example of why private language is impossible; all we have is a social agreement about when we can use the word pain.

Maybe that is too negative – we can all feel pain, so we can have some intuition into what other peoples' pain states are like but it does point to the fact that it is very difficult to *know*. If I say I am having a terrible day of pain, I may have a low pain threshold or may be complaining a lot. There is a tendency to scepticism: 'they're just a whinger and can't know what severe pain is *really* like'.

Pain breaks down the mind–body dualism. Psychological effects on pain perception were demonstrated centuries ago by Lucretius' observation that warriors do not feel pain in the heat of battle and reaffirmed by Beecher's studies in WW2. We know that being distracted from pain means that we feel it less. We know that different cultures display pain in different ways.

Pain, empathy and compassion

Today we are talking about empathy and compassion, and pain presents us with a particular problem in this context. As Joanna Bourke says in her book, *The Story of Pain*, over aeons, medical experts, generally white males, have expressed doubts as to whether slaves, women, children or animals could suffer pain. To paraphrase, people less civilised or socially inferior to you are purportedly less sensitive to pain, while

civilised people not only feel more pain but they keep a stiffer upper lip. That lack of empathy about pain means that folks didn't get anaesthesia even when it was available. One-third of amputations in late 19th century Pennsylvania were conducted without anaesthetics. There are 5.5 billion people living in countries where there is little or no access to opiate analgesia, so if you are in end-stage AIDS or end-stage cancer or recovering from surgery, you aren't going to receive adequate pain relief. That is really shocking.

Although we live in more enlightened times, we still have difficulty in evaluating and communicating pain states. Wittgenstein and Scarry's problems with pain language are reflected in the McGill Pain Questionnaire (MPQ).

The authors say,

"The pain you have is unique, it can't be compared with another person's, only you can know how much pain you have and when you have it."

Melzack and Rogers

But then they do go on to compare it to other peoples'! The words used in the MPQ which came from the clinical literature were classified by experts like doctors and university graduates rather than patients, but are not necessarily words individuals use about their pain. A lot of the time if you're in pain, you probably groan, yelp or cry; it is not so often you use discrete words about pain, at least not that range.

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The MPQ categories sensory, affective evaluative and miscellaneous are not intuitive responses to pain. If we were to ask people to describe pain, they would be more likely to respond with metaphors than words. I would say 'it feels like someone is cutting off my foot' or 'someone is stapling my ankles with a staple gun'.

The medical response to pain

It still seems to me to be really hard to medicate pain. This is your expertise and maybe I've been unlucky, but as well as back pain, I have suffered constant neuropathic pain since I became paralysed in 2008, so I have some personal understanding of what constant and debilitating pain is like and how hard it is to medicate. It seems to me we are not very good at dealing with pain – at least not in general medicine and practice. We are certainly not good at teaching medical students about pain.

So what are people in pain looking for from their health professionals? Are we looking for compassion or empathy and is there a difference? The medical students I interview for Norwich Medical School all tell me that empathy is the ability to put yourself in other peoples' shoes – to feel what they feel (the 'right' answer). But how do we know that we are feeling what other people feel? Iona talked this morning about imagination which is wonderful and important and should be part of medical training. But it is also very dangerous, as Catriona Mackenzie and Jackie Scully (2007) have written. We imagine we know what someone else is feeling, but as I have said, the way that non-disabled people imagine quality of life for disabled people must be dreadful is mistaken. So there is a danger with imagination if it is not rooted in appreciation, maybe from literature, or from talking to people, of what their lives are really like.

We have already had compassion defined as to experience with, similar to empathy. Pequita de Zulueta suggests that compassion combines both emotional (feel with) and cognitive (feel



for) dimensions and that 'compassion is a positive motivation to act', so empathy is a precursor to compassion; perhaps you can't be compassionate without empathy, but compassion takes it further. I was ironic when I called this talk 'I feel your pain' because when people glibly say this, we know they absolutely don't. Empathy is not a substitute for compassion. Raanon Gillon quotes Gilbert and Firth-Cozens' definition: 'Compassion is a sensitivity to the suffering of self and others *and a deep need to try and relieve and prevent it*'.

When I was a real disability radical about 20 years ago, I had a tee-shirt saying 'piss on pity'. Disabled people are sick of bloody pity! They don't want compassion, instead they want equality. Compassion is an individual feeling accompanied by a motivation to do something individual, charitable and good. But if the problems of this group of people are systemic, political or involve rights violations, then compassion is not a substitute for rights. But I want to differentiate myself from my younger self and from the radicals today by saying we need both rights and charity (Shakespeare, 2000). We need both the ethic of rights and the ethic of care, but not one as the substitute for the other.

So what is the compassionate response to pain? Obviously, things like analgesia, care with handling, being solicitous and sympathetic and so on. But the evidence from a report about spinal injury is that *people with more solicitous relatives report more pain*. Paying attention to pain can actually exacerbate it, and sometimes the

best thing to do is to ignore it. So there is a paradox! We want to be empathetic and compassionate and people end up in more pain because we have been kind. But it is very difficult to get the right delicate balance.

Evidence-based medicine is very important, but the weight that is put upon it has brought a problem. As we proceed through the history of medicine, we have had better and better science, but we have moved away from listening to the patient. We don't just trust what the person says; what the body is saying is what their blood results and their x-rays say, not what they say. So the sick person had disappeared and their testimony is not evidence.

Doctors are persuaded by signs, not symptoms. Certain clusters of symptoms are indeed credible, such as those suggesting a heart attack, and there is evidence that these are attached to an underlying pathology. But when doctors encounter symptoms beyond their knowledge and interest, or their competence to treat, and feel uncertain and outside their comfort zone, compassion takes a nosedive.

These problems are worse in relation to certain groups of patients who are at the most distance and inferiority vis-a-vis medical professionals: disabled people, older people, chaotic people (often women), people at the margins, mentally ill people, I/V drug users and people with intellectual disabilities.

I certainly do not think doctors are bad people but to be a professional involves being exposed to suffering all the time and possibly to become inured to it. Perhaps you need psychological defence mechanisms to survive – perhaps even a degree of callousness. Part of the difficulty of living with others' suffering is that it raises fears about your own vulnerability. One response to this existential challenge is a certain amount of denial, emotional repression, distancing – even trivialisation. Perhaps this is why a lot of doctors make good comedians – if you didn't laugh, you would cry.

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Systemic failings

But we need to go beyond the individual. The doctors at the Mid-Staffordshire were unable to act compassionately and were morally distressed by that, but the situation was a systemic problem. One response to systemic failure is that, we think, we have to do better at picking the right individuals. Systemic failure ... better individuals? – that doesn't figure. It is the 'bad apple' explanation. In our search, to do something, we have blamed managers, politicians and even medical schools. But Mid-Staffordshire wasn't about the aggregate of lots of cruel individuals. Health systems can be set up in ways that help or undermine compassion. Compassion is contextual. Faced with lots of patients who are shouting at us, or situations like the Milgram experiments, we might not all behave well. Doctors are admittedly overworked but are well paid and have a reasonable amount of control over their situation – but some of them behaved badly at Mid-Staffs. And then we wonder why people who are poorly paid, undervalued and barely trained get it wrong? Mary Beard said on Radio 4 the other day 'you can't expect sainthood on the minimum wage'. If National Health Service (NHS) staff are exploited, they won't provide effective care. The gap in social valuation between people who work with learning disabled groups and the people in those groups is very slim. If staff feel alienated or if there aren't enough of them, things will go wrong. If there is anxiety, stress or competition, compassion is squeezed out. Poor staffing, high bed occupancy, blame culture, local ward culture and demoralisation militate against good treatment of old people in acute hospital wards.

What can we do about it?

How can we avoid these abuses? Is it realistic to expect more money and more time for patients? We have rising ill-health, mortality is falling but morbidity is rising and we are living longer. The cost of healthcare is rising inexorably. Healthcare is so complex, and subject to so much

political and public pressure. These aren't newly recognised issues. We have had repeated scandals for generations and yet the problems keep recurring. We must not be unduly pessimistic, but it is a very complex problem in a very big complex healthcare system.

Maybe we can improve the ethos. Penny Campling suggests that organisations can have a virtuous circle of 'intelligent kindness'. Ann Gallagher has written about 'slow ethics', something going deeper than value statements, calling for dialogue rather than rapid response. But there is so much pressure in the NHS environment. Things go wrong when there isn't time. Anna Smajdor thinks it is dangerous to rely on compassion:

"Reminders routines and checklists are alternative and effective ways of ensuring that crucial healthcare tasks are undertaken without relying on compassion or other feelings to motivate the staff involved."

She talks about etiquette: it doesn't really matter what people think, it is what they do. Days do go better when people smile at you. George Burns famously said, "sincerity is the most important thing: if you can fake that you've got it made!" Maybe that is all we want from a doctor – maybe they can't be equally interested in every patient.

But conversely, patients do want health workers to give of themselves and not just follow a script. When I was in spinal rehabilitation, it was the way the tasks like manual evacuation were done that mattered – not just either painfully or gently, but also either in a way that demeans someone and makes them feel terrible or in a way that means that they are able to survive it, and look you in the eye afterwards. This is what de Zulueta describes as 'attunement': a lightness of touch, sometimes distant, sometimes close, sometimes informal and sometimes formal. It is about attunement to a person and what they expect or are hoping from you.

People in pain expect advice from a skilled professional with an expert knowledge of drug classes and the rest of it. But they do want recognition and *validation* of the pain they are suffering and connection with the people who provide support. Compassion and competence are not in opposition, we need both.

Conclusion

Pain generates an existential crisis for the person. Victor Frankl asks, 'What is the meaning of my life of which suffering is now an inescapable part?' Suffering makes huge demands both on the individual and on people who want to help them, but cannot fully remove the pain and indignity and can only help them endure it better. Pain makes people impatient, intolerant, bad tempered and querulous. You can't fully feel my pain but you either have had pain or have it one day. So don't run away – don't shun me because I remind you of your own pain. Be prepared for your pain and walk side by side with me in mine.

**From the discussion**

Perhaps part of the problem is lack of respect both of patients and staff.

Compassion may demand an urgent need to make a difference to someone's situation.

Empathy goes beyond compassion. It involves an additional kind of insight. It is a feeling response and can be expressed in complete silence by a quality of presence with the person you are with and at that level can be profoundly helpful and healing.



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SAGE

Compassion in modern healthcare: pay attention! Intention, context and healing

Dr Jeremy Swayne, *Retired GP, Church of England Priest*

Paul Dieppe has been a regular contributor to the Philosophy and Ethics Special Interest Group (SIG) conference. In his time, he has been a pillar of the biomedical establishment, is still widely respected as such and as an academic and has been healthily sceptical of unorthodoxy. Despite my conventional background in general practice, I have always been uncomfortable with the hegemony of the biomedical model and the ‘paradigm paralysis’ that underpins it¹ – most recently challenging the conventional wisdom in the book *Remodelling Medicine*.² But Paul has never been a dyed-in-the-wool paradigm paralytic, as his affection for this group of ‘paradigm pioneers’ demonstrates and has been immensely helpful in my exploration of what we mean by ‘natural medicine’ or ‘natural healing’, and the placebo and contextual effects that induce it.

In ‘The ‘placebo’ response in osteoarthritis and its implications for clinical practice’,³ Paul and Michael Doherty reported a significant placebo or contextual effect accompanying all forms of treatment, and an effect size in the placebo response that in some instances exceeded the effect size of the active treatment. They say, “it is obvious ... that practitioners should capitalise on the impact of context effects to enhance the benefits to their patients as a professional responsibility”. And conclude, “Practitioners of complementary and alternative medicine (CAM) often do

this very well, and seem ahead of us more traditional physicians ... We often label (them) as charlatans and explain their success as ‘just placebo effect’, apparently oblivious of the large effect size of such ‘non-treatment’ benefits”. But if we did learn from the research literature, from practitioners of CAM and from simple observation, and optimise these meaning responses in our clinical practice, the benefits of such ‘contextual healing’ to the population of people with osteoarthritis would be huge.



“The meaning that a patient attaches to illness and suffering, especially in chronic or fatal illness, is critical for the healing process; and that meaning is accessible through the patient’s illness story.”

James Markum

Paul’s refreshing and challenging open mindedness has now reached the point at

which alongside his academic duties as Professor of Health and Wellbeing at Exeter University, he is researching the nature of ‘healing’ in its broadest, and in some instances most esoteric forms. And it is here that our paths have now converged, because of my involvement supporting him in this work. We are of one mind on the matter of the power of compassion in a healing relationship,⁴ and I am interweaving some of Paul’s reflections with my own as I explore this theme.

In the course of his explorations, Paul has encountered a great variety of people, medical and non-medical, who have given him insights into the phenomenon that in one sense or another we call healing. Some have been deliberate, some in the course of attending medical meetings, some sheer chance; the Bulgarian taxi driver, for instance, who told Paul, ‘I know a bit about wellbeing. We all need companionship; to be able to share our experiences with other people who are like us. That’s what makes us well’. Quite a good way of describing compassion don’t you think? A form of companionship that offers what in the context of the doctor–patient relationship Iona Heath has called an experience of our shared humanity.⁵

A very different encounter gave rise to the same insight. Speaking on joint pain at an international meeting, Paul played the orthodox game by reviewing the literature and so on, but decided to go ‘off piste’ and talk about his own

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experience of pain in his arthritic knee. He detected some discomfort in the audience (Dieppe P, Personal Communication), 'Were they perhaps thinking "what is he doing, this is not science; how dare he talk about himself?" Scientists do not do personal disclosure or "experiences"'. He explains that the word 'pain' is inappropriate for most of the sensations that come from his knee, that our ways of assessing pain severity are now meaningless to him and that he deals with the symptoms by behavioural change rather than pills. *More discomfort.* And then he challenges the whole pharmaceutical approach to pain. *Deep discomfort; even anger.* Finally, he says he is now working on caring and healing, which he believes are the most important avenues of research if rheumatologists are to help patients more, and laments the lack of *patient-relevant* progress resulting from the investment in biomedical research on pain.

"Compassion is essential in medicine and in all healing. The physician or nurse cannot heal, that is make whole again, without feeling and knowing the nuances of a particular patient's predicament - - - ."

Pellegrino and Thomasma

"There is a human need to make sense of everyday events; to create a framework of meaning and causality. (It) doesn't have to be scientifically valid, much less 'true', but it needs to work for us as an everyday explanatory model."

David Misselbrook

There is an embarrassed silence. Then someone gets up, thanks Paul profusely and says she also has pain that she can make no sense of, and that medication has not helped. A torrent of discussion and questions follows – mostly supportive, often personal. They want to talk about their *experiences!* They want

to tell their story.⁶ Paul has evoked a sense of wellbeing through the medium of companionship in shared experience; the common human need in adversity, whether we are an immigrant Bulgarian taxi driver or a medical scientist.

"Compassion: A deep awareness of the suffering of another - coupled with the wish to relieve it. Feelings evoked by contact with the patient that shape our approach to care. Something that is felt, beyond simply intellectual appreciation."

Harvey Chochinov

Paul's investigation has embraced a wide variety of context and practice, including individuals and groups who call themselves 'healers'. Some, as in medicine in general, have been egocentric rather than altruistic. But he has been impressed by the majority whose claim to channel healing energy has been motivated by and mediated by 'deep caring' for their patient. One talked about working intuitively 'in the moment', letting go of your ego and working with love for the other. Intuition seemed to be an important part of things for her. Her explanation was evocative of things that others have talked about, of the 'moment when the room disappears' – when you are really just *with* another.⁷

This capacity to be 'with' another person in a particular way is reflected in an encounter on Paul's visit to Lourdes. He spent time with a severely ill woman whose condition could have become acutely terminal at any moment. He relates how she really opened up to him, telling him very personal things about herself, and he wondered why she was doing that to a complete stranger. And then he gives the answer, 'I looked her in the eye and above all else she had my full attention – I listened with all my being, nothing else existed in that room for me as Claire told her story'.

Later he reflected,

"Perhaps the intention is the critical thing. Healers talk of unconditional love for another and the importance of intention as a means of allowing the flow of energy to initiate healing. Doctors intend to help their patients, but perhaps their fascination with reductionist biology and disease blinds them to the wider dimension of health, wellness, wholeness and the soul. And soul-reintegration might be achieved through the simple expedient of being with another; allowing the other person to find new meaning in their dilemma."

which echoes the quotation above from David Misselbrook.⁸

These instances describe something of the landscape of compassion that is not only necessary for true healing to take place but also powerfully conducive to the contextual effect that enhances clinical change. Within it are most of the characteristics you would expect – truthfulness, absence of ego, a non-judgemental attitude – but also the perhaps less obviously '*intention*' and '*attention*'.

True compassion in our professional role has to be predicated on our intention to heal, to make whole, to make well.⁹ It requires not only that we understand and feel for the distress or suffering of the other person, but that we also perceive something of the greater wellbeing or fullness of life that can be available to him or her, and that we intend to do something about it.

In another of Paul's encounters, he was asked what he would do if he was God for a day. In an almost transcendental moment 'Wonder, beauty, perfection', Paul replied,

"I would want everyone to experience something wonderful and special. Something, anything - from art, literature, music, the natural world,

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whatever – that spoke to that individual as a person, allowing them to be uplifted and to feel the joy, beauty and wonder that the world and the humans on it can create. That is what I would do."

Compassion for another person must embrace something of the good that we passionately desire for them. It is that creative and holistic character of compassion that sets it apart from sympathy, and that is essential for empathy.¹⁰ This intention is probably at the heart of most people's vocation to healthcare. But it is very difficult to fulfil – to find the time, insight and emotional space for in our contemporary medical culture.

Even more difficult to achieve perhaps, but indispensable to true compassion, is the ability to give others our full attention.

This attribute is exemplified by two very remarkable young women, Etty Hillesum and Simone Weil, who achieved extraordinary feats of compassion. Etty was Dutch and died in Auschwitz in 1942 at the age of 28, and Simone was French, but died in England of tuberculosis (TB) in 1943 at the age of 34. For both of them, the ability to give others their full attention was the well-spring of that compassion.

Etty Hillesum¹¹

Etty was a young Jewish woman, who grew to personal and spiritual maturity from troubled and atheistic beginnings during the Nazi occupation and persecution in Amsterdam. She refused opportunities and the impassioned pleas of her friends to escape deportation and death – partly out of a sense of solidarity with her Jewish community and their common destiny, partly because to go into hiding would mean to live in fear and she absolutely would not allow her soul to be invaded and eviscerated by fear and partly because of her vocation to use her gifts at the forefront of life where people were hurting, where she could use her skills to relieve some of the pain.

"Empathy: Identification with and understanding of another's situation, feelings, and motives."

Harvey Chochinov

In Auschwitz, surrounded by so many bundles of human misery, desperate and unable to face life, she felt she had what was needed for the huge task of giving support: a deep well of compassion in her heart, skill in the art of listening and the meaning she had found in her own life – the meaning that is so vital to human identity, integrity and wholeness.

It was Etty's practice of paying deep attention which transformed her, strengthening her sense of solidarity with her people and her longing to care for the weakest and most vulnerable. She was determined not to be numbed by the cruelty around her but to go on seeing.

Etty Hillesum: A life transformed
Patrick Woodhouse,
Bloomsbury 2009

Simone Weil¹²

Simone trained as a teacher of philosophy, but felt a compelling vocation to identify with the suffering and hardship of the poor and oppressed; first in the vineyards of the Jura, then, in spite of poor health, in a Renault factory, and later in the Republican army in the Spanish civil war, experiencing in the very depths of her being the utter calamity of war.

Her experience taught her, too, the absolute necessity of attention to release compassionate love for others. She wrote:

"Not only does the love of God have attention for its substance; the love of our neighbour, which we know to be the same love, is made of this same substance. The capacity to give one's attention to a sufferer is a very rare and difficult thing; it is almost a

miracle; it is a miracle. Nearly all those who think they have this capacity do not possess it. Warmth of heart, impulsiveness, pity, is not enough. For this reason it is indispensable to know how to look at him in a certain way. The soul empties itself of all its contents in order to receive into itself the being it is looking at, just as he is, in all his truth. Only he who is capable of attention can do this."

Simone Weil: Waiting on God
- the essence of her thought
Fontana, 1977

These quotations teach us several things: that true compassion is hard and costly, that a vocation to care and a warm heart are essential but not enough, and that the capacity to give another person our full attention, which is the cornerstone of compassion, is a rare attribute, but can be developed.

This is key to the debate about whether compassion and empathy can be learned. American physician Harvey Chochinov has written, "For some, compassion may be part of a natural disposition that intuitively informs patient care. For others, it slowly emerges with life experience, clinical practice, and the realisation that, like patients, each of us is vulnerable".⁹ Eric Cassell¹⁰ insists that the habit of attentive listening can be acquired during medical education, and that insight into the characteristics that strongly affect patients' experience of illness and suffering that attentive listening based on trained observation permits is found to be reliable and consistent.

This quality of attention is essential to Colin Murray Parkes' description of empathy as the ability "to sense accurately and appreciate another person's reality and to convey that understanding sensitively".¹³ It makes possible the insight and wisdom that help us to discern what is going on in the patient's body, mind and spirit. It is essential to a proper understanding of

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the patient's narrative, and powerfully enhances the contextual aspect of the therapeutic encounter.

But this is not easy. When we seek to be hospitable to the person in need, we must remember Jean Vanier's warning that:

"it is always risky to welcome anyone. To welcome is not primarily to open the doors of our house. It is to open the doors of our hearts and become vulnerable. It means accepting the other into ourselves, even if this means insecurity."

The risk is the same if we reverse this pattern of hospitality and accept John Swinton's¹⁴ suggestion that rather than see ourselves as the host and the patient as the guest, we should see the patient as the host, and ourselves as the guest in the story of their life.

When we are *fully aware* of another person in distress, by our presence, attentiveness and absence of self-interest, compassion is the natural response. "If we are attentive in looking and in listening and in waiting, then sooner or later something in the depths of us will respond".¹⁵ That, 'something in the depths of us', is the

compassion that is the indispensable context for healing. It requires the willingness to allow the pain of others to impinge on ourselves; to accept the fear and embarrassment of being present to them as they are; to be hurt, and to *let* the hurt hurt.¹⁶ The discipline of full attention is hard and costly to achieve, but as well as being source of compassion and healing for others is of course a source of healing for ourselves. And it will not crush us if we really do give others our *whole* attention. Because in divesting ourselves of our own preoccupations, needs and prejudices, we can be truly compassionate and empathetic but without becoming so involved and burdened that the milk of human kindness runs dry and compassion fatigue sets in.

If we develop in ourselves and encourage in our colleagues, students and trainees the 'miraculous' capacity to give our attention to a sufferer, and if, a very big *IF*, we can remodel medicine in such a way as to permit it, then empathy and compassion, and their sometimes miraculous power to heal, can be assured.

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Lies, damned lies and medicine

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In 2005, a young researcher named John Ioannidis¹ published a seminal paper titled 'Why Most Published Research Findings Are

False' in the prestigious open access journal *PLoS Medicine*. In this paper, Ioannidis laid out a detailed mathematical model that showed 80% of non-randomised studies turn out to be wrong, as do 25% of supposedly gold-standard randomised trials and as much as 10% of the platinum-standard large randomised trials.² Ioannidis then went further: he examined 49 highly cited original clinical research studies published in high impact factor journals over 13 years; these were articles that helped lead to the widespread popularity of treatments such as the use of hormone-replacement therapy for menopausal women, vitamin E to reduce the risk of heart disease, coronary stents to ward off heart attacks and daily low-dose aspirin to control blood pressure and prevent heart attacks and strokes. He discovered that of the 49 articles, 45 claimed to have uncovered effective interventions; 34 of these claims had thereafter been retested, and 14 of these (41%) had been convincingly shown to be either wrong or exaggerated.^{2,3} As Ioannidis diplomatically put it, "A third of the

most-cited clinical research seems to have replication problems". He opined that publication bias favoured the rapid and prominent publication of 'positive' findings over 'negative' studies and cautioned that 'evidence from recent trials, no matter how impressive, should be interpreted with caution, when only one trial is available in order to limit premature claims for efficacy'.³

I recalled Ioannidis' wise counsel when I came across 'Irlen syndrome' in a recent article by an ophthalmologist, who recounted his discomfiture on encountering a patient given this diagnosis.⁴ Irlen syndrome (also called 'scotopic sensitivity syndrome') was proposed in the 1980s by Helen Irlen, a US literacy instructor, who set up the Irlen institute to treat sufferers using the 'Irlen method'. The company website (www.irlen.com) defines the condition as:

"a perceptual processing disorder. It is not an optical problem. It is a problem with the brain's ability to process visual information. This problem tends to run in families and is not currently identified by other standardized educational or medical tests."

The website goes on to state that "The Irlen Method is non-invasive technology that uses colored overlays and filters to improve the brain's ability to process visual information. It is the only method scientifically proven to successfully correct the processing problems associated with Irlen Syndrome".⁵

Or, as the aforementioned ophthalmologist, Gwyn Williams, put it

candidly and succinctly, "It sells expensive filtered lenses to people with vague collections of symptoms who tend not to trust eye professionals". He also notes that the methodology behind the few published studies shown to support the existence of Irlen syndrome has been found wanting.⁵ The American neurologist Steven Novella is even less charitable, calling Irlen syndrome a 'scientific zombie' and says that 'the syndrome does not appear to exist, the research is shoddy, and the specific treatments (colored lenses) do not appear to work'.⁶

Among other conditions, the Irlen method claims to help fibromyalgia and chronic fatigue syndrome, so, dear reader, do expect one of your patients to walk into your clinic sometime soon demanding to know why you have not screened or treated them for this condition.

I have had patients ask about the efficacy of 'targeted nutritional therapies' for fibromyalgia and chronic pain; websites abound selling supplements containing magnesium, melatonin, Coenzyme Q10, omega 3-fatty acids, multivitamins, zinc, selenium, amino acids, glucosamine ... the list is endless. The answer? Well, the website for the National Center for Complementary and Alternative Medicine (NCCAM), the US government's lead agency for scientific research on complementary and alternative medicine states that 'there is not enough evidence to determine whether these products provide a health benefit'. It goes on to say that:

"Much of the research on complementary health approaches for

fibromyalgia is still preliminary, and evidence of effectiveness is limited. However, some studies have shown that practices such as tai chi, qi gong, and massage therapy may help relieve fibromyalgia symptoms.”⁷

And yet, while we scorn, we also continue to gullibly swallow the results of the latest ‘research’ that claims eating chocolate helps fight cancer, that playing games on our smartphones delays the onset of dementia or that

drinking tea protects us from heart disease. The media, hungry for sound bites, magnify and distort this ‘pop research’, leaving the public ever more confused and hungry for more. To quote Churchill, “We live in the most thoughtless of ages: Every day headlines and short views”.

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An audit of low-dose ketamine infusion as an analgesic adjunct in intensive care and enhanced recovery after surgery

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Introduction

While ketamine is a commonly used analgesic for painful procedural sedation in the intensive care unit (ICU), low-dose ketamine infusions have recently been introduced in the intensive therapy unit (ITU) for analgesia following major surgery or trauma. This is in view of the relatively high incidence of breakthrough pain with conventional regional and systemic analgesia in this patient population. Low-dose ketamine infusion may be used in conjunction with opioids, or regional analgesia, as part of a multi-modal analgesic regime.

Mechanisms of analgesia from ketamine include *N*-methyl-d-aspartate (NMDA) receptor antagonism, reduction in inflammation, reduction in central sensitisation (wind-up), and prevention of opioid tolerance and opioid-induced hyperalgesia. Ketamine has a profound opioid sparing effect, reducing the dose requirement of concomitantly administered opioids and improving the quality of analgesia, such that opioid-related side-effects are minimised. Ketamine is also specifically indicated in situations where neuropathic pain may be an issue. Hence, ketamine reduces both the severity and duration of severe acute

pain, as well as improving the quality of analgesia following major surgery and trauma, by the above mechanisms.^{1–3}

A Cochrane review,^{4,5} as well as nine systematic literature reviews,^{6–14} have concluded that ketamine:

- reduces pain score, morphine requirement, and postoperative nausea and vomiting (PONV), and improves the quality of analgesia, particularly following thoracic, major abdominal, trauma, orthopaedic and burns surgery;
- complements analgesia from epidural and regional analgesic techniques;
- in combination with morphine, patient-controlled analgesia (PCA) reduces pain score, morphine consumption and oxygen desaturation in thoracic surgery patients compared with standard morphine PCA;
- reduces the incidence of chronic postoperative pain (particularly post-thoracotomy and phantom limb pain);
- reduces the inflammatory response to pain, surgery and trauma;
- psychomimetic, airway, respiratory and cardiovascular side-effects are absent or minimal with low-dose infusions or PCA regimes.



An evidence-based provisional guideline was written for ITU use and will be submitted for consideration by the trust guidelines committee for their approval as a formal trust guideline. Hence, this audit was completed to ensure that low-dose ketamine infusions meet the standards of producing efficacious analgesia, have an acceptable side-effect profile in our patient

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population and complement enhanced recovery after surgery (ERAS) programmes for major surgery.

Even though there are no set standards for ketamine analgesia, standards considered appropriate for this audit were based on general principles of good analgesia which are as follows:

1. *Effective analgesia.*

The quality of analgesia must be adequate for patient satisfaction, deep breathing and mobilisation as per ERAS criteria. The technique must provide a consistent level of adequate analgesia and be rapidly addressed if there are periods of inadequate analgesia.

2. *Low incidence of side-effects.*

When used in high doses, for procedural sedation (0.25–0.5 mg/kg) or rapid sequence induction (1–2 mg/kg), ketamine is well known to be a sympathetic stimulant, with a recognised incidence of psychomimetic side-effects. However, when used as a low-dose infusion (0.05–0.2 mg/kg/hour), it has negligible effects on airway patency and reflexes, respiratory drive, heart rate, rhythm, blood pressure or conscious level. Hence, adverse respiratory or cardiovascular side-effects

are highly unlikely to be due to low-dose ketamine infusion, and any change in respiratory status, heart rate/rhythm or haemodynamics should be investigated to identify the underlying cause and treated appropriately. In exceptionally rare cases, low-dose ketamine infusion may result in vivid or unpleasant dreams, or hallucinations – the patient should be reassured and the infusion stopped, particularly if the side-effects outweigh the analgesic benefits – side-effects should subside spontaneously within 30–60 minutes of stopping the infusion. Hence, the purpose of this audit is to identify the incidence of psychomimetic side-effects with a low-dose ketamine infusion in our patient population.

3. *ERAS compliance.*

Effective analgesia is considered an essential component of ERAS; however, this is far from the only contributor.

The desired targets for the ERAS programme are as follows:

- Extubated within 4 hours of end of surgery;
- Awake and sitting in bed on day 0;
- Sitting in chair on morning of day 1;
- Walking by mid-day on day 1;
- Enteral nutrition started on day 1.

However, in complex patients and emergency cases, ERAS targets may not be appropriate or achievable, whatever the analgesic regimen.

Methods

ITU patients, who had been started on a low-dose ketamine infusion within the previous 24 hours by the theatre Anaesthetist or Intensivist, were identified over a 2-month period from November to December 2013. Patients were then reviewed daily for the first 48 hours after commencing low-dose ketamine infusion, by Anaesthetic trainees and ITU nurses, who completed the attached data collection form (please see below). All forms were collated by Dr Desai and Dr Beard, and the results are presented below. Based on a literature review, the low-dose ketamine infusion protocol started at 0.2 mg/kg/hour for the first hour, followed by an hourly step-down regime, reducing by 0.025 mg/kg/hour over the next 4 hours, until the maintenance infusion rate of 0.1 mg/kg/hour, which was continued for 24–72 hours. In the event of unpleasant psychomimetic side-effects occurring, it was recommended that the infusion was stopped, and the patient reassured that the side-effects would be expected to resolve spontaneously within 30–60 minutes.

Data Collection Sheet: Ketamine Analgesia Audit November–December 2013

Patient ID:

Operation:

ANALGESIA

Day of Surgery (day 0)	Rate of infusion (0.05–0.2 mg/kg/hr)	Quality of analgesia (poor/ ok/good/excellent)	Episodes of moderate to severe pain (frequency and management)
AM			
PM			
Night			

Next day (day 1)	Rate of infusion (0.05–0.2 mg/kg/hr)	Quality of analgesia (poor/ ok/good/excellent)	Episodes of moderate to severe pain (frequency and management)
AM			
PM			
Night			

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Day 2 – if still running	Rate of infusion (0.05–0.2 mg/kg/hr)	Quality of analgesia (poor/ ok/good/excellent)	Episodes of moderate to severe pain (frequency and management)
AM PM Night			

SIDE EFFECTS (AT ANY POINT DURING INFUSION)

Excessive sedation:	Nil/Drowsy but easily responsive/Hard to rouse/Sedated
Delirium:	Yes/No if Yes CAM score = likely cause?
Hallucinatory effects:	Nil/Vivid (but not unpleasant) dreams/Unpleasant dreams/Awake hallucinations
Nausea and vomiting:	Nil/Responds to single anti-emetic/Requiring multiple anti-emetics
Respiratory depression:	Nil/Respiratory rate 8–10/Respiratory rate <8/Naloxone required
Was the ketamine stopped at any point due to side effects?	Yes/No

MEETING ERAS CRITERIA

Is the patient part of the ERAS programme?	Yes/No
Were they extubated within 4 hours of end of surgery:	Yes/No
If 'No' is this likely due to the ketamine? (please specify below)	Yes/No
Awake and sitting in bed on day 0:	Yes/No
If 'No' is this likely due to the ketamine? (please specify below)	Yes/No
Sitting in chair on morning of day 1:	Yes/No
If 'No' is this likely due to the ketamine? (please specify below)	Yes/No
Walking by mid-day on day 1:	Yes/No
If 'No' is this likely due to the ketamine? (please specify below)	Yes/No
Enteral nutrition started on day 1:	Yes/No
If 'No' is this likely due to the ketamine? (please specify below)	Yes/No

ANY OTHER COMMENTS

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Results

Data were collected during November and December 2013 on 11 patients. The types of surgery and indications for low-dose ketamine infusion are summarised below (Table 1). Of the 11 patients, 4 received ketamine as part of a planned multi-modal analgesia strategy, 6/11 patients received ketamine for rescue analgesia following epidural failure, and in 1/11 patients, the reason for the ketamine infusion was not stated. No patient experienced delirium,

disorientation, sedation, hallucinations, hypotension or respiratory depression. Of the 11 patients, 2 requested their low-dose ketamine infusion to be stopped, due to a sensation of dizziness and feeling tense/agitated, respectively, and 1/11 patients experienced nausea/vomiting, which resolved following a single dose of anti-emetic.

ERAS compliance

Of the 11 patients, 10 were planned to follow an ERAS pathway after

elective surgery (see Table 2), and 1/11 patients required a redo thoracotomy following an oesophagectomy. However, overall ERAS compliance was low, for a number of reasons, including emergency/complicated surgery, failure of the primary intended analgesic regime and recent introduction of the ERAS programme in our hospital. Low-dose ketamine infusion was not thought to contribute significantly to the low overall ERAS compliance rate.

Table 1. Type of surgery, indications for low-dose ketamine infusion and outcomes per patient (N = 11)

Type of surgery	Reason for ketamine	Maximum rate recorded (0.05–0.2 mg/kg/hour)	Episodes of moderate to severe pain	Did infusion stop due to side-effects?
Oesophagectomy (minimally invasive)	Planned analgesia	0.1	Nil	No
Re-exploration post-oesophagectomy	Planned analgesia	Not recorded	Not recorded	No
Oesophagectomy (minimally invasive)	Planned analgesia	0.1	Occasional – responded to morphine	No
Oesophagectomy	Planned analgesia (with paravertebral catheter)	0.1	Nil	No
Oesophagectomy	Failed epidural	0.2	Nil	No
Nephrectomy/urethotomy	Failed epidural	0.2	Nil	No
Liver resection	Failed epidural	0.2	Nil	Yes – mild head spinning (quite pleasant and better than morphine) and epidural effectively resuscitated.
Liver resection	Failed epidural	0.2	Nil	No
Whipples	Failed epidural	0.2	Nil	Yes – patient request as felt tense and anxious and did not like it. No hallucinations.
Retroperitoneal ganglioma	Failed epidural	0.2	Yes at 0.1 mg/kg/hour – settled at 0.2	No
Elective AAA	Not stated	0.1	'Poor' analgesia day 1 but no rescue analgesia recorded	No

AAA: abdominal aortic aneurysm.

Table 2. ERAS compliance rates (N = 10)

Extubated within 4 hours of end of surgery	7/11 = 63.6%
Awake and sitting in bed on day 0	5/11 = 45.5%
Sitting in chair on morning of day 1	1/11 = 9.1%
Walking by mid-day on day 1	0/11 = 0%
Enteral nutrition started on day 1	9/11 = 81.8%

ERAS: enhanced recovery after surgery.

Conclusion

The following conclusions can be drawn from this audit data. Low-dose ketamine infusion met all the required standards of the audit, including the provision of effective analgesia, safety and a minimal side-effect profile, and it did not

significantly impede ERAS compliance. This is in keeping with the published literature.

Low-dose ketamine infusion was observed to be an effective analgesic adjunct, when combined with conventional opioid or regional

analgesia. It was particularly efficacious as a co-analgesic with morphine, in the context of epidural failure. There were no adverse incidents recorded with respect to sedation or respiratory depression. In addition, psychotropic effects were largely absent or mild. Several patients failed with respect to ERAS compliance prior to ketamine being commenced, in view of failure of the primary intended analgesic modality, the nature of the surgery and the relatively recent introduction of the ERAS programme into our hospital. Low-dose ketamine infusion was not thought to significantly impede ERAS compliance, and in many cases, it significantly improved analgesia,

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allowing patients to undergo effective physiotherapy and mobilisation. Definite conclusions cannot be made on this evidence, and further audit of low-dose ketamine infusion as an analgesic adjunct in ERAS patients will be required as the technique becomes more commonly used, and the ERAS programme becomes more established.

Recommendations

The following cautious recommendations can be made, based on the limited number of patients in this audit:

1. The protocol appears to be safe and can be formally adopted for low-dose ketamine infusions in critical care. However, following this audit, we have since moved to a fixed rate infusion at 0.1 mg/kg/hour for 24–72 hours, with no loading dose or step-down regime, in an effort to further limit the incidence of psychomimetic side-effects. This may result in a slightly delayed onset time for effective analgesia and require further audit.

2. It may be safe to consider the use of low-dose ketamine infusions in ward-based settings outside ITU, as an analgesic adjunct to PCA opioids. However, administration via a locked controlled infusion device is recommended. Patient monitoring should be as for a standard PCA.
3. It may be reasonable to consider routine use of low-dose ketamine infusions as an analgesic adjunct in ERAS patients; however, further audit will be required as its use becomes more established.

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Language matters: therapeutic metaphor in paediatric pain

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"Fairytales are more than true: not because they tell us that dragons exist, but because they tell us that dragons can be beaten."

Neil Gaiman, *Coraline*

Mind your language

Language is a tool¹ and, like any tool, can achieve very different outcomes depending upon how it is wielded; a guitar can be anything from the source of beguiling music to an instrument of cartoon violence. As a means of communication, human language has several unique properties not seen elsewhere in nature.² One such property is displacement, the use of words to describe things which are remote in space and time but that can be understood because they exist in the shared imagination of both the speaker and the listener. It is this property that allows individuals to communicate information about their internal environment to the outside world. Language is also the medium through which those internal processes acquire names and meaning, which we then internalise as we grow and mature. Pain may be 'what the patient says it is', but 'what the patient says it is' had an origin outside the patient and was filtered

through the lenses of sociocultural responses and past experiences. Children, who may lack the linguistic skills and cognitive maturity to give a multidimensional representation of their pain, are vulnerable to the personal biases and interpretations of guardians and clinicians, as it is we who echo meaning back to them.

Scaffolding

Just as figurative language may be used to describe the shape and qualities of pain, it can also be of therapeutic value in reframing and reconceptualising pain. In parallel with models of pain, theories of learning and cognitive development have also evolved to incorporate a social and cultural context. As skills training and activity management are an integral aspect of the successful management of chronic pain, every interaction with healthcare providers is transactional and a learning opportunity for children and adolescents. Adherence to treatment by children with chronic pain can be as low as 47%.³ In response to this, attention has turned to avenues such as peer support networks and the use of mobile and Internet-based technology to improve functional outcomes. These innovations implicitly incorporate educational processes that originate within social

development theories of learning where the student, or in this case patient, plays an active role in learning. Examples of such learning processes include instructional scaffolding, whereby the level of support is maintained within the zone of proximal development (ZPD) (Figure 1), that is, the difference between what a child can do without aid and that which they can do with assistance.⁴ 'Scaffolding' may both describe this application of the social development theory of learning and also function as a metaphor for the role of a multidisciplinary team in guiding children and young people with chronic pain towards self-management; we support the patient as they initiate the work themselves and as they progress, the levels of support are gradually reduced.

Funds of knowledge

Although metaphor and analogy are frequently used synonymously, metaphor

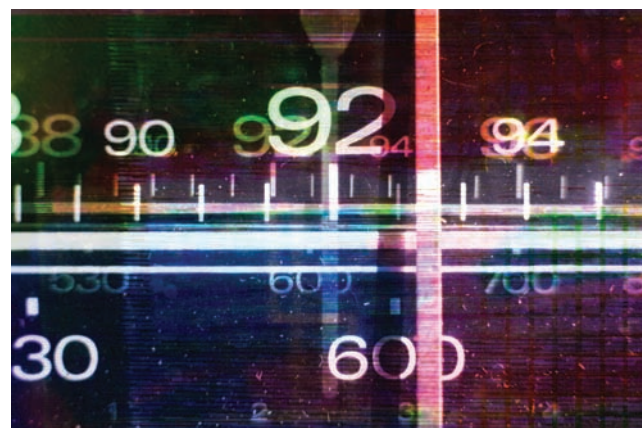
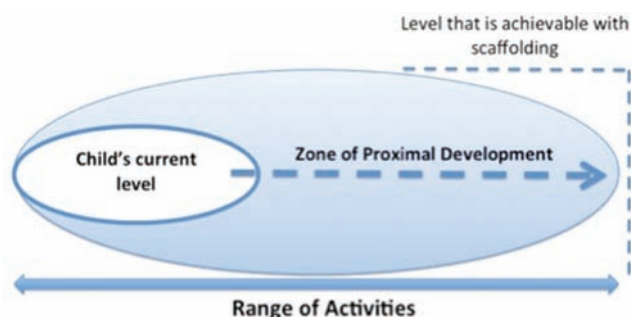


Figure 1. The Zone of Proximal Development (ZPD) is the difference between what a child can do without aid (current level) and what they can achieve with assistance. Instructional scaffolding refers to the process of guiding a child and focussing attention slightly beyond current capabilities to that the inner limit expands outward.



Source: Adapted from Kail, R.V. (2010). *Children and their development* (5th ed.). Pearson Education, Inc., Upper Saddle River, New Jersey, USA.

is a specific type of analogy. A comparison between two things that emphasises a similarity in order to illustrate or clarify is an analogy: '*Pain is like an alarm ...*'. An analogy may be a lead-in to a metaphor, which goes one step further and requires those similar items to be substituted for each other and placed within a narrative that moves towards an outcome, in essence telling a story:

There's one house on a street where the alarm is going off non-stop and it keeps everyone else on the street awake at night. The families in the other houses get tired and grumpy with each other. They get angry with their neighbours where the noise is coming from, but nothing changes. A friend comes to visit one house and is surprised that the family who live there are now getting angry with each other as they have not done anything bad to each other. They realise that they are cross because they are not sleeping well. Since they cannot change the noise from their neighbours' house but they can change how they react towards each

other, they agree to be kinder to each other and help each other feel better.

Therapeutic analogies and metaphors are those that employ such words and imagery to guide a patient towards a desired outcome, either through an alternative viewpoint or adding depth or detail to existing knowledge and beliefs. There is some evidence that the use of metaphor may in fact be more beneficial than 'standard' advice in reconceptualising pain and reducing catastrophising.⁵

However, for an analogy or metaphor to be effective, they must be tailored to the individual and draw upon their 'funds of knowledge', the knowledge and skills contained within their family and household and that help it function,⁶ for example, the information that children know as a result of their parent's occupation or their cultural background. Acquiring this information through a detailed family and social history may be difficult with the time constraints under which many of us work, but doing so will greatly enhance the likelihood of anchoring your analogies and metaphors with a

reference point that taps into existing competencies and knowledge.

'Funds of knowledge' is to analogy as 'scaffolding' is to metaphor. The analogy may describe a function or process that is occurring, now reframed in a more accessible way. An efficacious metaphor then adds momentum to that imagery and uses a narrative that guides the patient towards a desired outcome, for example, activity pacing.

Suggested analogies and metaphors

A well-chosen metaphor can aid in engagement with a management plan focused on functional recovery without implying that decreased activity or psychological factors were causal in the onset and maintenance of pain.⁷ The following analogies and metaphors may be helpful in explaining the source and impact of pain and are not intended to be prescriptive. Experienced practitioners will have their own techniques and a discussion of individual and regional variations would no doubt generate a colourful compendium of anecdotes, both of those that have been successful and those that were less so. For examples of analogies and metaphors, see the excellent commentary by Coakley and Schechter.⁷

On the nature of pain

Pain transmission as an electronic system

Pain is a warning signal but sometimes there might be a glitch and that warning signal keeps going off even when there is nothing wrong. Some treatments, such as a nerve block, are like pressing 'Ctrl+Alt+Delete' and rebooting the system; they switch it off and when it starts up again, it goes back to working the way it should. Sometimes new physical or thinking skills have to be learned and these are like a

software update that are added to help the system fix itself.

Pain as signal-to-noise

Some times we feel sensations in our bodies that are a normal part of eating and drinking and doing activities. For different people and at different times, it's like the volume gets turned up too loud on these signals and they become painful. It can be helpful to notice things which turn up the volume on the pain and which turn it down. Some treatments, like a TENS machine, increase the background noise or static so we notice the pain less. Sometimes, just doing more activities gives our bodies more signals to deal with and the pain signal does not stand out so much and over time it gets quieter.



get grumpy because the noise keeps them awake. There is nothing wrong with your head/house, but it still affected by the pain. Pain affects sleep and mood, so it is helpful to talk about those. We are not saying the pain is imaginary or 'in your head' but that your head can still be affected by pain.

On the rational use of analgesics

Pain and medications are like cereal and milk

Taking the right medication at the right time can help us do more of the things that we want, like doing activities with our friends and family. Pain is like cereal in a bowl and taking medication is like adding milk. Sometimes we have more pain and that is like having different amounts of cereal in the bowl at different times. If you add the milk when there is no pain/cereal, then it sloshes around and might spill over. This is partly why we sometimes get unwanted effects from medications. When you have pain, there is more cereal in the bowl that soaks up the milk/medication like a sponge. This is why the timing of medication matters and how you can get the most out of medication and avoid some of the side effects.

On rehabilitation and activity pacing

Fuel in the petrol tank

When you have pain, it can be stressful and tiring and feel like it's



weighing you down. That's a bit like a car or bus trying to travel whilst carrying lots of people and luggage; it will run out of fuel more quickly. That's why it's important to make sure you sleep and eat properly and do fun things that you enjoy, as these put fuel back in your fuel tank. After a while, you get better at planning journeys/activities according to the amount of fuel you know you have in the tank that day. This way you avoid running out of fuel and can then learn to manage longer and longer journeys/more activities.

Nerves need food too

Sometimes if our arm or leg is sore, we want to wrap it up to protect it and keep it safe. Over time, our arm or leg can actually become more sensitive because it doesn't feel the normal day-to-day things that it usually would. This is a bit like staying indoors all the time and never feeling changes in the weather like light breezes and rain showers. Eventually, you would start to feel cold indoors too and need to wear a big heavy coat to stay warm, even on a sunny day. Just like our tummies need different-tasting foods, our nerves need different types of sensations, like warm and cool, wet and dry, rough and smooth. Giving them this helps turn some uncomfortable sensations back into normal pleasant feelings.

On the rationale for multimodal strategies

Only exercising one body part

Medications are helpful but are just one part of managing pain. If you only exercise one part of your body, such as just one arm or just one leg, then you would have one very big strong arm or leg and the rest of your body would be weaker. You would not be balanced and you would fall over when you tried to move. To move and do more things, it is better and more balanced to also use physical and psychological ways of managing pain.

A noisy house on your street

Imagine your body is a street with houses and your head is the house that you live in. Having chronic pain is like having one noisy house down the street that keeps you awake all night by playing music too loud. After a while, the people living in your house

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Discussion

By the time a child or young person with pain is sitting in front of you, they may already be saturated with information gleaned from family, friends and the Internet, and they and their parents will have formed their own beliefs about the cause and meaning of their pain. Addressing those beliefs need not be confrontational or contradictory and can draw upon the funds of knowledge already available to them. Prior to identifying a zone of

development and working towards personal goals, it is important to establish trust, and using language that is familiar and draws upon their own experiences is vital in doing so. Constructivist learning theories suggest that learning is ongoing, active and that knowledge is constructed rather than acquired.⁸ Moreover, social development

theory suggests that it is language and learning that drive cognitive development and intellectual adaptation, not the other way around.⁹ In essence, waiting for the child to be 'ready' underestimates the capacity of children to internalise information from their social environment, including their interactions with healthcare. Language and metaphor are tools that, if used appropriately, initiate a process that is not so much about demolishing

existing schemata, rather it is about aiding in renovation and outward expansion.

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Should placebos have a role in clinical practice?

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This article examines the controversial topic of whether placebos should be used in clinical

practice. I will begin by introducing placebo and placebo responses, before briefly outlining recent work on novel ways of using placebos to help patients. I will then describe research findings on patients' and doctors' views about placebos before suggesting key areas for future research in this comparatively new field of translational research.

Placebos and placebo responses

Factors other than the active ingredients of treatment can have substantial effects on pain¹ as well as other symptoms and conditions including irritable bowel syndrome,^{2,3} depression,⁴ Parkinson's disease⁵ and common colds.⁶ One very important contributor to such 'non-specific' effects is the placebo response, which can be defined as beneficial changes in a person's body that result from the meaning that person attributes to a procedure or event in a healthcare setting.^{7,8}

Placebo responses can be triggered by placebo treatments, such as the archetypal 'sugar pill' used to control for placebo responses in randomised clinical trials of new drugs. However, this is a

very limited way of thinking about placebos. Following the definition given above, placebo responses can also be seen to contribute intimately to most if not all interactions in a healthcare setting. They can augment the effects of many different interventions, including, for example, cognitive behavioural therapy, analgesics, physiotherapy, acupuncture and even surgery.

Placebo responses are thus real and potentially clinically meaningful. Furthermore, they operate through increasingly well-understood mechanisms. Key psychological mechanisms include conditioning, expectancy and social learning.^{9,10} Socially, doctor–patient interactions and socio-cultural contexts shape the meanings individuals ascribe to placebos and hence influence their effects.¹¹ Neuroscience can explain how such psychological and social processes trigger symptom improvements. Imaging studies and rigorous experiments suggest the psychosocial context around a patient actually activates similar neurobiological mechanisms to those activated by drugs, thus producing measurable placebo responses.¹² Specific neurobiological mechanisms vary by disease. For example, endogenous opioids, endocannabinoids and areas of the brain responsible for pain processing are involved in expectancy effects underpinning placebo analgesia; dopamine release in the striatum and activity in the subthalamic nucleus mediate placebo responses in Parkinson's.¹³

Using placebos and placebo responses in clinical practice

The notion of using placebos in clinical practice is controversial and has triggered much debate in the literature.¹⁴ Ethical arguments against clinical applications of placebos typically focus on the archetypal placebo as used in pharmaceutical clinical trials. In blinded clinical trials, patients take placebos without knowing for certain that is what they are taking: the superficial characteristics of the placebo (e.g. visual appearance, taste, dosage) are designed to mimic the drug being tested and, in a way, fool the patient into thinking that they are receiving the 'real' intervention. A simple translation into clinical practice for pain would involve a doctor deceptively prescribing a placebo treatment (e.g. sugar pill), while leading the patient to believe that they are receiving an effective evidence-based analgesic. Such a scenario clearly violates the patient's right to autonomy and jeopardises the interpersonal trust that is so important in doctor–patient relationships. (In clinical trials, the right to autonomy is not violated as patients give informed consent to be randomised to either the 'real' intervention or the placebo control.) However, this direct translation from clinical trial to clinical practice is overly simplistic and unrealistic. Indeed, much more sophisticated and ethically sensitive approaches to clinical applications of placebos are now being developed that could refocus medicine on the doctor–patient relationship, improve patient

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outcomes, reduce unnecessary prescribing and increase the efficiency and thus cost-effectiveness of health services.

Some novel clinical applications of placebo responses involve prescribing placebo treatments, while others use placebo responses to augment the effects of existing, evidence-based treatments. For example, Kaptchuk et al. have tested whether it is possible to elicit placebo responses by prescribing placebo treatments without deceiving patients. Two small studies involving patients with irritable bowel syndrome¹⁵ and depression¹⁶ suggest that this may indeed be possible: clinically meaningful placebo responses can apparently be elicited in patients by giving them placebo treatments and describing them openly as placebos. An example of using placebo responses to augment existing treatments comes from Sandler and colleagues' work on children with attention deficit hyperactivity disorder. In this study, children were prescribed placebos described as 'dose-extenders'. First, children took a full dose of stimulant therapy for one week; then, they took 'dose-extenders' alongside a reduced dose of stimulant therapy for one week. The idea was to prolong the effect of the full dose and thus reduce the overall amount of stimulant therapy needed, and the results suggested this was indeed successful.¹⁷

Translational research on placebo responses is undoubtedly at an early stage and more (and larger) studies are needed. The range of conditions that have been examined in this work remains narrow and little has been done so far to develop novel clinical applications of placebos for pain, despite the focus on placebo analgesia in the experimental psychology literature. However, this work could ultimately generate controversial recommendations concerning the use of placebos in clinical practice. Because of this potential for controversy, the views of clinicians and patients are of utmost



importance for ongoing development in this area: even if clinical applications of placebos are found to be effective and safe, if they are unacceptable to clinicians and patients, then any potential benefits will not be translated into practice.

Clinicians' and patients' views

Clinicians already use placebo responses in practice. Our recent online survey showed that a significant proportion of UK general practitioners (GPs) use placebos clinically.¹⁸ Of 783 respondents (response rate = 46%), a minority used 'pure' placebos (e.g. sugar pills): 12% had used them at least once, and 1% used them weekly. However, 97% had used 'impure' placebos (e.g. vitamins without vitamin-deficiency) at least once, while 77% used them weekly. Most, but not all, found placebos ethically acceptable in some circumstances (66% for pure, 84% for impure); intriguingly, some GPs found placebos acceptable but never used them while others found them unacceptable but had used them. These findings are broadly consistent with surveys conducted elsewhere, many of which also focused on primary care settings.^{19,20} While there is some evidence that placebos are used for pain management,^{21,22} new studies are needed to better understand clinicians' views on placebos in UK pain settings.

As part of our survey, we also asked a number of open-ended questions, responses to which we analysed qualitatively.²³ This analysis told us more about why GPs do and do not use placebos and suggested key obstacles to clinical applications of placebos, including the belief that placebos are lacking a known mechanism of action, a lack of awareness of scientific evidence of the beneficial effects of placebo responses and the assumption that it is necessary to deceive patients in order to elicit placebo responses in practice. GPs also expressed concerns about the ethical and legal ramifications of using placebos in practice, suggesting that official clinical guidance could facilitate the use of safe, effective and ethically appropriate clinical applications of placebos.

Patients seem to have varied and complex attitudes towards placebo treatments.^{24–26} We recently completed a qualitative study in which a purposive diverse sample of 58 adults recruited from community settings took part in 11 focus groups.²⁷ We used vignettes describing different clinical applications of placebos in order to stimulate discussion and found that participants came up with a large number of diverse harms and benefits of using placebos in clinical practice. Participants considered not only the potential harms and benefits to individual patients but also the potential impact of placebos on carers, clinicians, health services and society. They espoused two main perspectives on clinical applications of placebos. The first perspective (which we labelled 'consequentialist') focused on the outcomes of placebo-prescribing: from this perspective, participants who thought placebos would be effective accepted their use in practice, while participants who thought placebos would be ineffective argued against their use in practice. The second perspective (labelled 'respecting autonomy') involved assuming that placebos would have to

be prescribed deceptively in order to be effective; this led participants to focus on the negative consequences of such deception for patient's autonomy and doctor-patient relationships; placebo-prescribing was thus deemed unacceptable. The very word 'placebo' also appeared to have negative associations for our participants (e.g. of trickery and ineffective 'treatments'), supporting earlier suggestions that 'placebo as fake' may be a dominant discourse in society^{28,29} which would strongly militate against any clinical applications that involve using the word 'placebo'.

Overall, there seem to be some key misunderstandings, persistent myths and knowledge gaps that may hinder efforts to translate the science of placebo responses into clinical practice for patient benefit. In particular, it seems that people may be unwilling to accept clinical applications of placebos; (a) when they are unaware of the scientific evidence that placebos can be effective and work through known psycho-neurobiological mechanisms and/or (b) when they assume that effective clinical applications of placebos require the clinician to deceive their patient.

Future directions

Well-targeted and informed guidance would be welcome, both for researchers and clinicians. Guidance for researchers would be particularly timely in the current early stages of the translational research endeavour and given the current lack of consensus in the field. Guidance for clinicians would be welcome to address legal and ethical concerns and uncertainties and to facilitate appropriate practice regarding placebos.²³

More research is needed in two key areas. One, it is necessary to develop an evidence-base around novel clinical applications of placebo responses. Existing evidence is promising, and the science of placebo responses is ready for a translational focus, but more

investment is now needed to develop effective and safe clinical applications and prevent the misuse or abuse of placebos in practice.³⁰ Two, we need a better understanding of clinicians' and patients' views on placebos (particularly in relation to pain management) and new approaches to addressing common misunderstandings, myths and knowledge gaps. To begin to address this need, my research group has recently developed a new web-based educational resource to inform patients with back pain about placebo effects (funded by Arthritis Research UK). If you would like to find out more about this project, or are interested in helping us to recruit patients with back pain to test our new educational resource, then please contact the study co-ordinator Dr Maddy Greville-Harris on M.L.Greville-Harris@soton.ac.uk.

Conclusion

In conclusion, yes, placebo responses (and possibly placebo treatments) should have a role in clinical practice. Concluding otherwise would be like locking the stable door after the horse has bolted – placebo responses are already ubiquitous in clinical practice! However, more translational research is required to generate the necessary evidence-base for novel clinical applications of placebo responses. Furthermore, this work must continue to attend to the views of key stakeholders, not least clinicians and their patients.

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New members

Ratified at the September 2014 Council Meeting

Name	Position	Institution
Dr Suzanne White	Specialist Clinical Psychologist	Whitegate Health Centre, Blackpool
Dr Harriet Wordsworth	ST4 Registrar & Academic Clinical Fellow	Pain Research Group, Imperial College, London
Dr Robert Gregory	FY1 Doctor: Acute Medicine	King's College Hospital, London
Ms Aileen Sheehan	B6 Physiotherapist	City Hospital, Nottingham
Dr Alison Mitchell	Consultant in Palliative Medicine	Beatson West of Scotland Cancer Centre, Glasgow
Mr Andrew Graham	Osteopath	Private Practice
Miss Rhiannon Edwards	PhD Student	University of Bath, Bath
Dr Ilona Obara	Lecturer in Pharmacology	Durham University, Durham



Understanding patients' faith and pain: six questions

Professor S José Closs *School of Healthcare, Baines Wing, University of Leeds*

Professor Karl Atkin *University of York*

Dr Ganesa Baranidharan *Leeds Teaching Hospitals NHS Trust*

Professor Michael Bennett *University of Leeds*

Professor Michelle Briggs *Leeds Beckett University*

Dr Jill Edwards *University of Leeds*

Dr Chris Swift *Leeds Teaching Hospitals NHS Trust*

Background

Three-quarters of the UK population profess a religious belief,¹ yet little is known about how faith may influence the wide-ranging issues related to pain experience, expression and management. The complex interplay between ethnicity, language, faith and gender make them a challenge to study, and the different ways in which these factors may impact on health service usage and management of pain are not well understood.

To date, ethnicity has been the main cultural lens through which inequalities in healthcare have been viewed, and scant attention has been given to how different faiths may result in disparities in pain management. Little is known about the influences of religious faith on the experience and expression of pain, or how to assess these. A comprehensive literature review served to confirm this as a gap in current knowledge.²

The National Health Service is committed to providing patient-centred and holistic care which embraces diversity. More and more, spiritual and religious concerns are being recognised

as important for health and healthcare, and professional bodies are increasingly advocating the need for spiritual awareness. Evidence suggests that assessing the religious needs of patients is challenging for health professionals,³ while the Royal College of Psychiatrists has suggested a general structure for spiritual assessment.⁴ The assessment of the spiritual or religious needs of patients is an area governed by uncertainty and hesitancy in terms of how the topic should be broached with patients, and how those who express need can be best supported. This hesitancy may be, in part, due to a lack of understanding about the influence of faith on illness and clear guidance on how these needs are best addressed.⁵

Here, we provide a brief overview of a study designed to increase the understanding of the experience, expression and management of pain among older people across the most common five faith groups in the United Kingdom (Christians, Hindus, Sikhs, Jews and Muslims). The study focused on people 65 years and over as they are more likely to experience chronic pain

and have it poorly assessed and/or treated.^{6,7} Using the findings from this study, we produced a set of questions which have the potential to be integrated into a general pain assessment. The intention of these is to support health professionals in the assessment of any pain-related religious needs of patients.

Methods

In-depth qualitative interviews were used to capture a rich picture of how faith influences the self-management, expression and experience of pain with older people. The interviews explored participants' experiences of pain, their self-management and interactions with health professionals and whether their faith influenced the way they managed their pain.

Participants were 65 years and over and had chronic pain (for 3 months or more) and identified with one of the five faith groups. Recruitment was labour intensive, involving contact with over 70 groups and individuals, producing a diverse sample of 44 participants across the five faith groups (Table 1).

Understanding patients' faith and pain: six questions

Table 1. Overview of participants by gender, faith group and ages (n = 44)

	Sikh	Hindu	Muslim	Jew	Christian
Men	2	4	6	3	4
Women	4	5	7	3	6
Age range	65–82	65–79	65–82	65–80	65–91

Participants spoke a range of languages including English, Hindi, Bengali, Urdu, Punjabi, Sylheti and Gujarati and were aged from 65 to 91 years.

Data collection

Ethics committee approval was gained, and written, informed consent was obtained from all participants prior to the interview. When consenting participants whose first language was not English, interpreters were used to read through the consent forms and ensure the participants fully understood the purpose of the study and the interview.

The interviews were semi-structured, using a thematic topic guide which contained questions and probes that functioned as triggers to encourage participants to talk. The majority of the interviews were completed in the homes of participants or a location of their choice. Interviews lasted between 20 and 60 minutes depending on how much each participant wished to say.

Participants whose first language was not English were offered the support of a language interpreter. In these cases, the interviews were conducted in real time, where the interpreter simultaneously translated the interview questions and responses on behalf of the researcher. Interviews were audio-recorded, and the English dialogue transcribed verbatim.

Data analysis

The analysis of the interviews was undertaken using a modified framework approach (Ritchie and Lewis, 2003). A sub-sample of the transcripts was read

and re-read (by J.E.) to familiarise herself with the data and begin the process of identifying recurrent and significant themes in the accounts of the participants. Notes from the transcripts were then used to inform the creation of a thematic coding framework. The framework was then discussed with other members of the research team (S.J.C. and M.B.) who independently read through a sub-sample of transcripts and applied the thematic coding frame to them prior to the discussion. The remainder of the transcripts were then coded (indexed) using the software programme NVivo 8. During this process, J.E., S.J.C. and M.B. met regularly to discuss the ongoing indexing and to refine the coding.

Summary of findings

It is important to bear in mind that a person's faith belief is articulated within the context of other aspects of their identity as well as in response to their experience of pain. As a result, many common themes occurred, irrespective of faith. All participants described the nature of the quality and impact of their pain, but in a way that was not discernibly different from the general population. Religious beliefs and practices, however, played a varied role in the overall experience, communication and self-management of chronic pain in older people across the five faith groups.

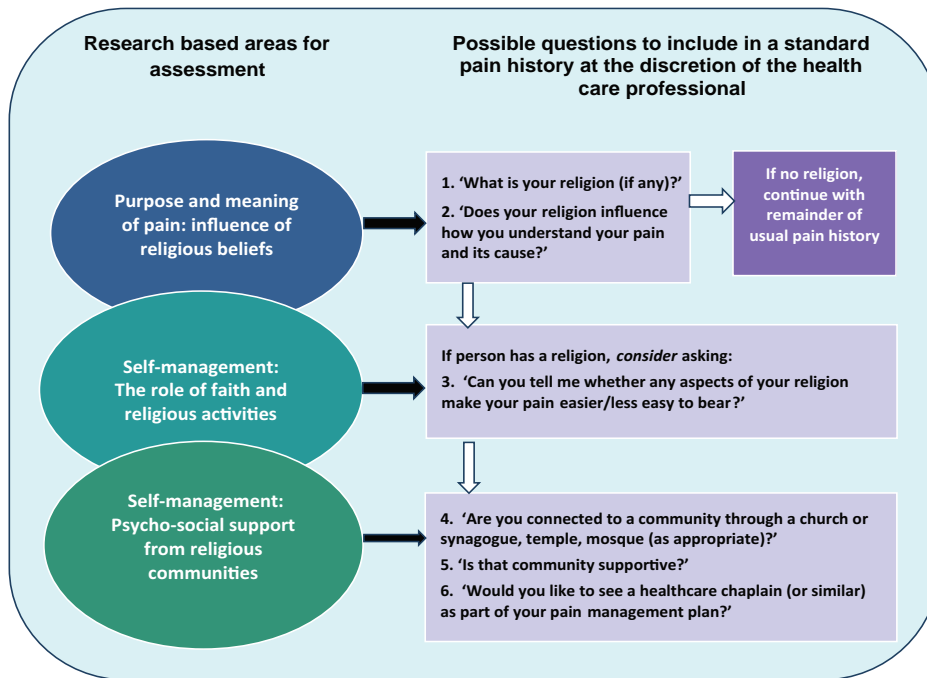
Where faith specific issues were raised, they fell into the following five themes:

1. Understanding the meaning and purpose of pain through faith;
2. Faith, medical treatment and health professionals;
3. Managing pain: social and cultural contexts;
4. Managing pain: the role of faith and religious activities;
5. Impact of pain on religious practices.

Faith did not play a dominant role in the nature of pain experience for most participants, but it sometimes gave meaning and purpose to pain. Many felt that their faith was irrelevant to their consultations with professionals about their pain. A range of faith and culturally based self-management strategies was used to complement prescribed pain medication, including yoga, meditation, herbal remedies and other practices. Being of a particular faith did not appear to affect the interaction between participants and health professionals when consulting with them about pain, though faith-related issues such as diet and gender affected treatment preferences. For example, vegetarian diet made some medications unacceptable, and some Muslims were not comfortable with being treated by healthcare professionals of the opposite sex. Attendance and activities at places of worship enabled psychological and social support. From these data, three additional themes which cross-cut the five above were identified, where faith may impact on the care needed for effective pain management. These were the following:

1. The purpose and meaning of pain: the influence of religious beliefs;
2. The self-management of pain: role of faith and religious activities;
3. The self-management of pain: social and practical support from faith communities.

Using these findings together with input from our expert Patient and Public



for use with other conditions where faith may influence understanding, treatment and outcomes.

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Involvement advisory group comprising members of the five faiths, a brief and focused set of (up to) six assessment questions was developed. For most individuals, faith was just one of many topics requiring consideration, so it merits inclusion within a wider assessment rather than standing alone. The following set (or part of the set) of questions could usefully be introduced into a standard pain history.

Question 1 simply establishes whether or not religion is an issue to consider. Questions 2 and 3 allow for discussion of topics where negotiation may be needed to agree a suitable medication regime (or other treatment) and where religion may be influencing how pain is reported (or not) or self-managed. Questions 4 and 5 could add to the understanding of any psychological and social support which may be needed. Question 6 provides an opportunity for patients to discuss aspects of their proposed care with a member of their own faith, if desired.

Clearly, the use of these questions should not be prescriptive, but should be selected and used with the expert clinical judgement of healthcare professionals. They should not be the first questions asked in an assessment, but should be embedded and presented at a suitable point, depending on the individual.

Conclusion

This study was exploratory, but generated a preliminary set of assessment questions from a diverse sample of older people from five faith groups. The questions may improve the open communication of faith-related issues relevant to the optimum control of pain. They now need to be tested for their acceptability and clinical utility in practice. They have the potential to help in the achievement of NICE's aim that 'health and social care professionals are able to acknowledge spiritual issues among patients and carers and to respond in a flexible, non-judgemental and non-imposing way.⁸ If the questions are successful, they might be adapted



The art of assessment of chronic pain in animals

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“The question is not, Can they *reason*? nor Can they *talk*? but, Can they *suffer*?”

Jeremy Bentham, *The Principles of Morals and Legislation*

Introduction

The nature of pain in animals has many similarities to humans. It is generally agreed that not all aspects of animal pain are likely to be the same as in humans, but the physiology and pathophysiology of pain are remarkably similar and relatively well conserved across the mammalian species. The capacity of animals to suffer from pain has been recognised for centuries in many cultures, but the alleviation of chronic pain and suffering still remains an unmet clinical need in many companion and farm animals. In human chronic pain, there appear to be a range of risk factors including age, genetics, gender, prior painful events and stressful environmental influences contributing to the pain profile.¹ It is probable that similar factors occur in animals too. Pain exposure and environmental stress in early life can cause hypersensitivity in adulthood in some animals.² Understanding pain variety and individual vulnerability will contribute to pain prevention and development of

intervention strategies to reduce the pain; notwithstanding elucidating these mechanisms, it must also be remembered that the nonlinear and stochastic factors play a part in the human pain experience and will also undoubtedly feature in animals too.

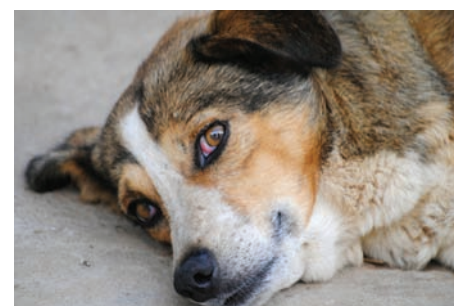
Assessing chronic pain in companion animals

In view of the fact that our patients are unable to self-report, we are reliant on scoring systems that depend on the subjective assessment of pain by a proxy. The owner, the veterinary surgeon or nurse/technician make assessments, and all will have a degree of variability when assessing the patient. The pain evaluation is affected by many observer-specific factors such as age, sex, clinical experience, year of graduation and also personal experience of painful procedures or conditions.³

In 1985, Morton and Griffiths⁴ published a proposal to develop validated and robust pain scales, and a year later, the Association of Veterinary Teachers and Research Workers produced guidelines for overall pain assessment.⁵ These guidelines suggested that the assessment is based on observation of the animal by someone who can distinguish subtle changes in demeanour, behaviour and locomotion (in companion animals, this is usually the owner), with interpretation of the findings by a person with knowledge and experience of pain assessment (i.e. a vet). Currently, there are still only a small number of validated scales available

based on pain-specific behaviours. But as the life expectancy of companion animals such as dogs, cats and horses increases, the challenge of assessing pain associated with the co-morbidities that these animals suffer from becomes ever more urgent.

The tools devised for assessment of chronic pain are heavily dependent on owner assessment with interpretation and decision-making done in conjunction with the veterinary surgeon. Interestingly, a recent study showed little correlation between the owner assessment and force plate gait analysis when evaluating response to treatment in osteoarthritic dogs.⁶ This is not to suggest other tools are not useful but this study emphasised that treatment efficacy in the eyes of the owners is determined by factors other than lameness alone.⁷ A number of tools have been developed for the measurement of chronic pain and quality of life (QoL) in dogs.^{8,9} These have been designed to some extent from existing human QoL instruments. Dogs are living longer and are increasingly succumbing to painful and chronic diseases associated with the ageing process. It is





important to capture and measure the impact from the disease itself and its treatment on QoL. These assessments aid in decision-making with respect to treatment interventions including euthanasia.^{10,11} QoL is an abstract construct that is widely used in human medicine, but it seems appropriate to adopt the definitions (but apply them somewhat differently to animals) with the intention of improving the welfare of animals.¹² The veterinary surgeon needs to consider whether the chosen tool is valid, reliable and responsive. These tools are species specific, and their development is complex and hugely time-consuming but aid decision-making.¹³ Since we currently do not have a 'gold standard' of chronic pain assessment with which to compare these QoL scales to, the question of criterion validity remains. For the vet, it is important to have information about the psychometric testing of these scales and how they compare with each other, so they can choose the most appropriate tool for their patient. A study comparing the Liverpool Osteoarthritis in Dogs (LOAD) scale, Helsinki Chronic Pain Index (HCPI) and the Canine Brief Pain Inventory (CBPI) was undertaken in 222 dogs with osteoarthritis.⁶ There were moderate correlations between all instruments, implying construct validity for all instruments. Significant but weak correlations were found between LOAD scores and 'symmetry index' (calculated from force-platform analysis for peak vertical force) and between CBPI scores and symmetry index. The CBPI is a

multifactorial tool composed of a Pain Severity Score, Interference Score and an Overall Quality of Life Score. Interestingly, when a visual analogue scale (VAS) and a similar chronic pain index were compared through owner evaluation of pain in arthritic dogs, the conclusion was that a VAS was a poor tool for untrained owners because of poor face validity (i.e. owners could not identify their dogs' behaviours as signs of pain). It was only after the owners had seen pain diminish and then return (after completing a course of nonsteroidal anti-inflammatory drugs (NSAIDs)) did the VAS have face validity.

For feline patients suffering from degenerative joint disease (DJD), a similar client-based metrology tool has been devised. The Feline Musculoskeletal Pain Index (FMPI) is a client questionnaire designed following item generation and questionnaire testing.¹⁴ This tool has showed good readability, internal consistency, reliability and repeatability,¹⁵ but the FMPI did not demonstrate responsiveness nor criterion validity in subsequent testing.¹⁶ Responsiveness describes whether the tool can detect a change in a parameter following treatment, ideally in a blinded placebo-controlled design. A novel study by Gruen et al.¹⁷ used the FMPI and client-specific outcome measures (CSOM) and were able to circumvent the placebo effect by demonstrating recurrence of clinical signs after withdrawal of treatment compared to placebo. Further testing such as criterion validity describes whether the results the tool generates correlate to another validated measure. The FMPI did not show criterion validity; however, this was correlating the FMPI against activity measured through the use of accelerometry.¹⁵ This lack of correlation challenges the common assumption that DJD changes lead to decreased activity and that cats receiving NSAIDs are motivated to increase their activity levels. Furthermore, some owners seem unconcerned about the activity levels per se in their elderly cats and are

concerned about other potential indicators of pain. These findings highlight the need to include active and non-active terms to fully assess the patient, the pain and quality of life, and as yet there is still no 'gold standard' tool to assess chronic pain, and we still have a way to go! Devising a validated scale is a time-consuming process. There is a well-described process to constructing subjective rating scales in human studies.¹⁸ First, the items to be assessed must be collected and refined for inclusion in the questionnaire. Second, the assessment forms must be scrutinised (face and content validity). Finally, the scale must undergo test-retest reliability and validity testing.^{19,20}

The performance of these subjective pain scoring systems for assessment of pain varies according to the pain being assessed (e.g. acute or chronic pain), the scale chosen, the behaviours chosen to be evaluated (dynamic or interactive) and the personnel involved in observing the animal.²¹ One study evaluating pain in horses found that grooms distinguished post-surgery horses from controls more successfully than veterinarians.²² The grooms awarded higher pain scores to these horses affirming the well-held belief that the owner/caregiver is best placed to perform the pain assessment as they detect more subtle signs and deviations from normal behaviour. Clinical experience also undoubtedly contributes to the reliability of the assessment. Web-based versions of some of these tools are freely available, facilitating easy and accessible recording for owners. Multidimensional scales do not exist for all species and may not be appropriate in some cases. Unidirectional scales can in some cases be used successfully to assess chronic pain. For example, Welsh et al.²³ used the VAS and SDS to successfully assess lameness in sheep with chronic pain from foot rot.

Pain faces and grimace scales are becoming more widely recognised in the clinical veterinary practice. As far back as Darwin and Ekman,²⁴ it was recognised

The art of assessment of chronic pain in animals



that pain behaviours could be expressed by the face. Facial expression is used as one measure of pain in infants and other non-verbal or cognitively impaired humans. It is believed that there is benefit to humans and some animals by displaying specific facial expressions as signals for assistance or to serve as a warning signal. However, for some species, this overt signalling may indicate weakness and vulnerability and so is an evolutionary disadvantage. Therefore, it is possible that some species may adaptively hide or diminish their 'pain faces'.²⁵⁻²⁷ Facial expression of pain have been identified in horses. One study involved the kinematic analysis of facial movements of horses during a brief painful stimulus.²⁸ Facial expressions in horses that have undergone castration have been described.²⁹ It is hoped that studies of 'pain faces' will differentiate changes due to pain from different stimuli and intensities. This potentially would improve owners' and caregivers' ability to recognise pain.³⁰

Focusing on the face, particularly the eyes, is demonstrated to be a common trait in humans when assessing pain in others. Eye contact is hugely important, and many emotions are read from the face and eyes.³¹ Leach et al.³² used eye-tracking equipment to confirm the suspicion that observers irrespective of gender or experience spend most time focused on the animal's face when assessing pain. The technology involved in automated eye-tracking is used to assess where people focus their attention in many activities including

observing attractiveness of other humans, driving and using a computer or evaluating websites. Therefore, automated eye-tracking could easily and effectively be applied to the assessment of where and how people attend when observing an animal's behaviour. The study by Leach et al.³² identified the bias towards focusing on the face which may lead observers to neglect other parts of the animal's body which display important clues about pain. Rabbits that have undergone ovariectomy exhibit behaviours and postures that are mainly limited to the back and abdomen³³ (e.g. belly pressing, back arching, skin twitching along the back), and bias towards focusing on the face may result in pain behaviours being overlooked by observers. Castrated calves exhibited abnormal posture, abnormal walking and licking associated with the surgical site.³⁴ Furthermore, the signs waxed and waned, stressing the necessity for the observer to spend adequate time observing the animal and awareness of all possible behaviours associated with pain. Castrated or tail-docked lambs also showed behaviours predominately associated with the area of pain or associated with posture and movement.³⁵ This brings us back to the necessity to devise composite pain assessment tools that include as many behaviours and other objective assessments as possible for the species of interest. The development of pain face tools will only serve to improve the pain assessment, and as long as appropriate weighting and emphasis is afforded, these tools will continue to improve the art of clinical pain assessment.

In conjunction with the development and validation of pain tools, emphasis on appropriate training and audit of the use of pain assessment tools is also pivotally important. There is the assumption that all people working with animals automatically have the ability to assess pain and its severity. A survey of current

practices in recognising pain, suffering and distress noted that the majority of research establishments use subjective assessment methods or scoring systems that are not validated despite being confident that their pain assessment was adequate.³⁶ This demonstrates that not only must objective behavioural scales be developed and validated but necessary training must also accompany their introduction. Functional measurements including force-platform gait analysis and pressure-sensitive platforms are used to assess lameness in horses, dogs, cats and sheep. These methods may also assist in clinical decision-making, for example, during the healing of bone fractures. Cats are more difficult to assess using these types of tools,^{37,38} as it is more challenging to get the cat to walk on the plate, but limb function following onychectomy has been assessed with this technology.³⁹ The use of devices such as activity monitors or accelerometers may be more appropriate in cats.⁴⁰ Activity assessment as a quality of life construct is potentially useful in dogs and cats using these devices. These electronic gadgets are attached to a collar or harness, and the device indicates levels of activity particularly when the animal is unobserved. Careful placement is necessary to avoid erroneous activity recordings, for example, eating and grooming which might cause movement. The information gives the vet further information to assist in decision-making and interventions. Comparing the results to other behavioural indices of chronic pain that manifest as lack of mobility or activity still needs elucidation.⁴¹

There is still a current need for animal models of pain for the understanding of nociception and development of new analgesic compounds for humans and animals. The development of advanced neuroimaging modalities allows the in vivo study of the central nervous system (CNS) activity concurrent with pain reporting; couple that with the huge advances in the understanding of the



neurobiology of pain and it highlights the considerable advances that have been made in last few decades. But, as yet, these cannot replace the need for animal models of pain. Pain in animals is usually studied using either responses to brief noxious stimuli in naive animals or by delivery of a tonic, sustained noxious stimulus that induces sensitisation, often termed a 'pain model'. These models are used worldwide in the search for new therapeutic strategies for pain relief. For most diseases and pain states, the aetiology is multifactorial, making the development of a fully translatable animal model very difficult. However, in addition to the models, there is a small but growing interest in using companion animals with naturally occurring disease conditions that cause pain (e.g. osteoarthritis in dogs) to study both pain mechanisms and evaluate analgesic drug efficacy for both humans and animals.

Conclusion

This article has brought together existing information on the subjective and objective behavioural assessment of chronic pain in companion and laboratory animals. Attempts to rank and score behaviours to assess the severity of the pain have been undertaken by many workers with some very promising results being published. Behaviours specific to different types of pain have been observed, quantified and validated by a range of assessment and treatment approaches. The accurate and localised detection of pain in animals remains

notoriously difficult; furthermore, recognition of pain in some species is complicated because of the subtlety of changes that can occur, for example, prey species have evolved to minimise or mask signs of pain to reduce the chance of predation. Furthermore, specific behaviours or obvious postural alteration and subtle changes in time budget activities may be more representative of pain type and severity. The recognition of chronic pain in animals has further challenged us to address the quality of life experienced by our animals and so further adapt tools to capture behaviours associated with this type of pain.

The treatment of chronic pain in animals will be covered in a second article in spring edition of *Pain News*.

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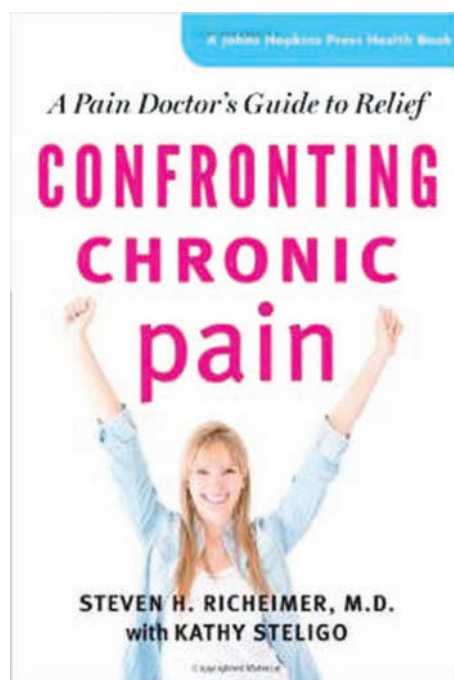


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A Pain Doctor's Guide to Relief: Confronting Chronic Pain by Steven Richeimer, Kathy Steligo, Johns Hopkins University Press, 2014, ISBN 9781421412535

Reviewed by Dr Thanthullu Vasu
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University Hospitals of Leicester
NHS Trust

Confronting Chronic Pain is a Johns Hopkins Press Health Book designed to help everyone with chronic pain. Dr Richeimer is the chief of pain medicine at

the University of Southern California, and Ms Steligo is a freelance writer. Not only do the authors promise patients that they can learn how to manage pain but also how to manage the physicians caring for their pain. So, amidst the sea of so many chronic pain books for patients, what does this book offer that is different?

In the first two chapters, the authors describe the science of pain and explain various persistent painful conditions. This is followed by a chapter on medications. The last seven chapters are related to looking at pain as a whole and how to control emotions, complimentary therapies, spiritual pain and about the family in pain. The authors stress that the aim of the book is to help the patient to be in control:

*"There is nothing we can do
You just have to live with it."*

These are repeatedly heard by chronic pain sufferers, but authors look at various other ways to deal with the pain. It is heart-sinking when the authors point out that the yearly cost in treatments and lost productivity due to pain is estimated at US\$635b, or nearly US\$2000 for every person living in the United States! No one can argue that the economic toll of chronic pain is monumental, but the personal suffering is also immeasurable.

The authors look at spiritual resources that patients can use to help manage their pain effectively. The seventh chapter of 'Spirit over Pain' discusses this in great detail; this might be the difference

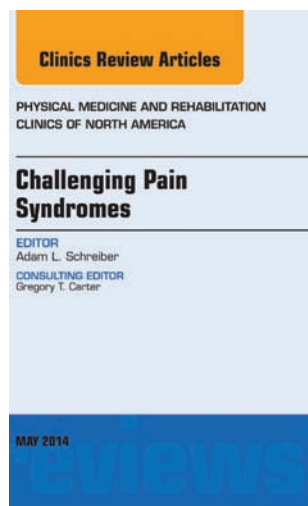
of this book compared to other similar patient-help books. The authors stress and point out to patients that although there are many healthcare professionals acting as partners, the patients themselves are the captains of their spiritual ship. The authors describe the need to shift the perception of pain by spiritual coping strategies.

I like the words when the authors state, *"Never give up and never lose hope. Although life with unrelenting pain can be difficult, with the right tools you can hope and thrive, even when pain remains a part of your life"*. This clearly summarises the objective of this book.

One of the key pitfalls of this book is the presentation. Although there is a lot of information, there could have been more illustrations. Even the limited pictures and illustrations are in black and white and not very attractive. Although this book is aimed at chronic pain sufferers, in particular, the second chapter about medical conditions can be tiring to read for a chronic pain patient!

The authors do also mention recent advances in the pain medicine, but few are complex. For example, they mention genetic testing to look at medications' effectiveness (p. 63) – rather than aiming at self-management strategies, this could give false hope and unnecessary expectations to patients.

In summary, this is a very useful informative book for patients suffering with chronic pain; but in my National Health Service (NHS) clinical practice, I will tend to refer these patients first to free self-help websites like Pain Toolkit!



**Challenging Pain Syndromes.
Clinical Review Articles:
Physical Medicine and
Rehabilitation Clinics of North
America by Schreiber AL, Carter
GT, Philadelphia, PA: Elsevier
Inc., 2014**

**Reviewed by Paul Cameron,
National Chronic Pain Coordinator,
Scottish Government & Clinical
Lead Physiotherapist, NHS Fife**

Whenever I am asked to review a book, I am always both honoured and delighted, although I am also struck with a sense of responsibility to ensure that readers of my review are left with a succinct, balanced sense of the contents and worth of the book. While I try to present this balanced view, I always remind readers that this is one person's opinion among many, and for this particular book, I feel this is an important point to make.

Largely, American authors write this book, and some aspects strike a particularly resonant tone of being for an American readership, with numerous references throughout to American guidelines, and US Food and Drug Administration (FDA) approved medications.

Part of a series of books whereby attempts are made to compile themed volumes on various topics, this book attempts to discuss up-to-date evidence and treatment application of physical medicine approaches to treating pain syndromes that, by their very nature, can be challenging to treat.

A decent range of conditions including Failed Back Surgery Syndrome, Myofascial Pain Syndrome, Complex Regional Pain Syndrome (CRPS) and Parsonage–Turner Syndrome are covered. Although some of the more obvious challenging pain syndromes, for example, Phantom Limb Pain, are not mentioned. My general sense is that the book has no real focus and is trying to cover too much with too little. With the added inclusion of chapters for Cancer Pain, Spinal Cord Injury Pain and side effects of Pain Analgesics (is this a syndrome I ask myself?), and ending with a special article on a systematic review of epidural steroid injections (again, not a syndrome).

The chapters themselves are well written and informative, with what appears to be well referenced pieces of work, although the chapter on Carpal Tunnel Syndrome set off some alarm bells when I noted the reference list was largely compiled of references from the authors of the chapter. This may of course be a positive sign that the author is experienced and justified in contributing to this chapter, but it is difficult to believe that many more references from researchers and clinicians not connected to the book could not be found. Having said that, the chapter was detailed and informative with clear explanations of signs and symptoms, and additional detail around differential diagnosis. Aetiology was covered, along with an explanation around optimal use of ultrasound as a diagnostic tool, with helpful photographs and sonographic images. Overall, an excellent chapter in the book.

Each chapter follows a pattern of discussion through diagnosis in terms of up-to-date criteria, and where relevant includes additional difficulties with diagnosis, and then follows up with suggestions and discussions of conservative treatments ranging from physical therapies, to medicines management and injections.

With some chapters offering more than others, I found the Greater Trochanteric Pain chapter to be less than fascinating and failing to offer anything particularly new to my knowledge of the field of treatment (although, admittedly the differential diagnosis table serves as a useful reminder to us all). The chapter on Opioid Syndrome proved to be an interesting read, with some useful insights into spotting this problem early, and addressing it appropriately (or indeed, preventing it from happening in the first place). While this is not yet the same scale of problem in the United Kingdom as in America due to some other medico-legal and administrative transatlantic issues, it would be prudent to be mindful of the risk of its development, and have some idea as to how to tackle it.

Therefore, the question remains, 'would I recommend this book for specialists or non-specialists in pain management?' I would have to say that I am undecided. There are a number of better and more comprehensive books available for specialists, and most specialists will already be familiar with large amounts of this text. However, for non-specialists who may come across some of these conditions, this book may be a useful addition to their reference shelf as a starting point for these challenging conditions. I would suggest that for pain specialists, this book might not offer enough in terms of scope, while for non-specialists, this may prove to be value for money when presented with a patient with one of the challenging pain conditions included in this book.



Spotlight: Dr Emma Briggs



The width and breadth of British Pain Society (BPS) membership is testimony to the diversity within the organisation and in the pain world. The Editorial Board would like to acknowledge this richness by shining a spotlight on some of our members. In this edition, we speak to Dr Emma Briggs, Chair of the Pain Education SIG.



Dr Emma Briggs
King's College,
London

1. What first brought you in contact with the BPS?

As an enthusiastic and excited PhD student, I attended my first ASM in 1999. It was

a particularly memorable conference because, distracted at one point, I accidentally crashed into Patrick Wall (profuse apologies followed). My networking techniques have become a little more refined since!

2. What is your role in the BPS? What excites you about this role?

I have the privilege of chairing the Pain Education Special Interest Group (SIG) working, and I love working with a fantastic interprofessional group who are passionate about education for learners and patients. The SIG work hard to move pain education forward and are working on and have completed some exciting projects. I also link in with the European Pain Federation (EFIC) and International

Association for the Study of Pain (IASP) through specific projects and working groups.

3. What do you feel is the role of the Pain Education SIG within the BPS?

The Pain Education SIG has a developed short description of our role:

The Pain Education SIG is a dynamic, interprofessional network of people passionate about improving pain education for healthcare professionals for the benefit of patients. The SIG members are involved in educational research and development, influencing change in undergraduate and postgraduate education at local, national and international levels.

And specific objectives:

1. Improve pain education for patients, the public and healthcare professionals;
2. Create opportunities to enhance the skills of those delivering pain education;
3. Promote educational methods and technologies that are available to deliver pain education;
4. Provide an interprofessional forum for debate and collaborative

research and development around pain education;

5. Organise meetings, seminars and workshops on pain education.

4. If you were President of the BPS for a day, what would you do?

Oh gosh, what a dilemma. I'm guessing that after giving the Secretariat staff the day off, I'd be incredibly busy front of house.

5. What are you known for professionally?

Ah the day job? Based in the Florence Nightingale Faculty of Nursing & Midwifery at King's College London, my role includes research, teaching and practice revolving around pain education and research. I work part-time and also co-chair an Athena Scientific Women's Academic Network (SWAN) panel (<http://www.ecu.ac.uk/equality-charter-marks/athena-swan/>) in the faculty; this is a charter mark by the Equality Challenge Unit for the advancement of women in science. I am also the immediate Past Chair of the Royal College of Nursing London Pain Interest Group, an active network of specialists in the region.

6. What are you most passionate about professionally?

Our Interprofessional Pain Management Learning Unit at King's. It was the first of its kind in a university in the United Kingdom, and every year, we work with 1,300 undergraduate students from six disciplines (dentistry, medicine, midwifery, nursing, pharmacy and physiotherapy), so they can learn to work collaboratively in the context of pain management. The students love it, and we felt like it had been all worthwhile when one feedback sheet read

"Working collaboratively means a more holistic approach and better pain management."

and

"I now understand the importance of communication and trust in providing effective pain management as part of a multidisciplinary team."

7. What do you have a knack for?

If I ever win the lottery, I am going to work on my creative side more – love photography, ceramics, painting or any messy arts. A qualification in reflexology would be great too.

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

Being a kid or playing with some (the latter helps you get away with

the former); my daughter when asked to describe her mum, simply replies 'crazy' – I take it as a compliment. The other place you may find us is digging the allotment!

9. Any other volunteer activities apart from the BPS that you are passionate about?

Outside of work, I am passionate about primary school education – I have been an infant school governor for 5 years, and I never cease to be inspired by the children and teachers who work tirelessly. To be part of the strategic team and see the impact on the children is very rewarding.

10. Any favourite non-profit organisations that you support and why?

Children in Need and National Society for the Prevention of Cruelty to Children (NSPCC) are two children's charity we support. Each year, we bake cakes and create handmade chocolates and raised £580 last year – heck of a target to beat this year. Cancer Research, because like many families we have been affected by the disease, and local wildlife charities and the Royal Society for the Protection of Birds (RSPB), because the environment and its future are important to us.

11. What would be impossible for you to give up?

Chocolate. I tried once.

12. How do you want to be remembered?

I suppose as someone who was kind, generous and enjoyed a giggle. Also as being supportive, engaging and enabling, someone who made a difference, however small.

13. Any life achievements you are particularly proud of?

Having a family is the most rewarding and challenging thing I have done, and I am proud of their achievements, good nature, generous spirit and wicked sense of humour.

Professionally, obtaining a PhD is always a huge milestone, and more recently, I was awarded a fellowship of King's College London in recognition of my outstanding contribution to pain education at a local and national level.

14. Anything else you would like to tell people about yourself?

I need to be kept away from any type of dream analyst – they would have enough material for several PhDs. Maybe I am crazy after all!

Thank you Emma for your time.

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