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PAIN NEWS

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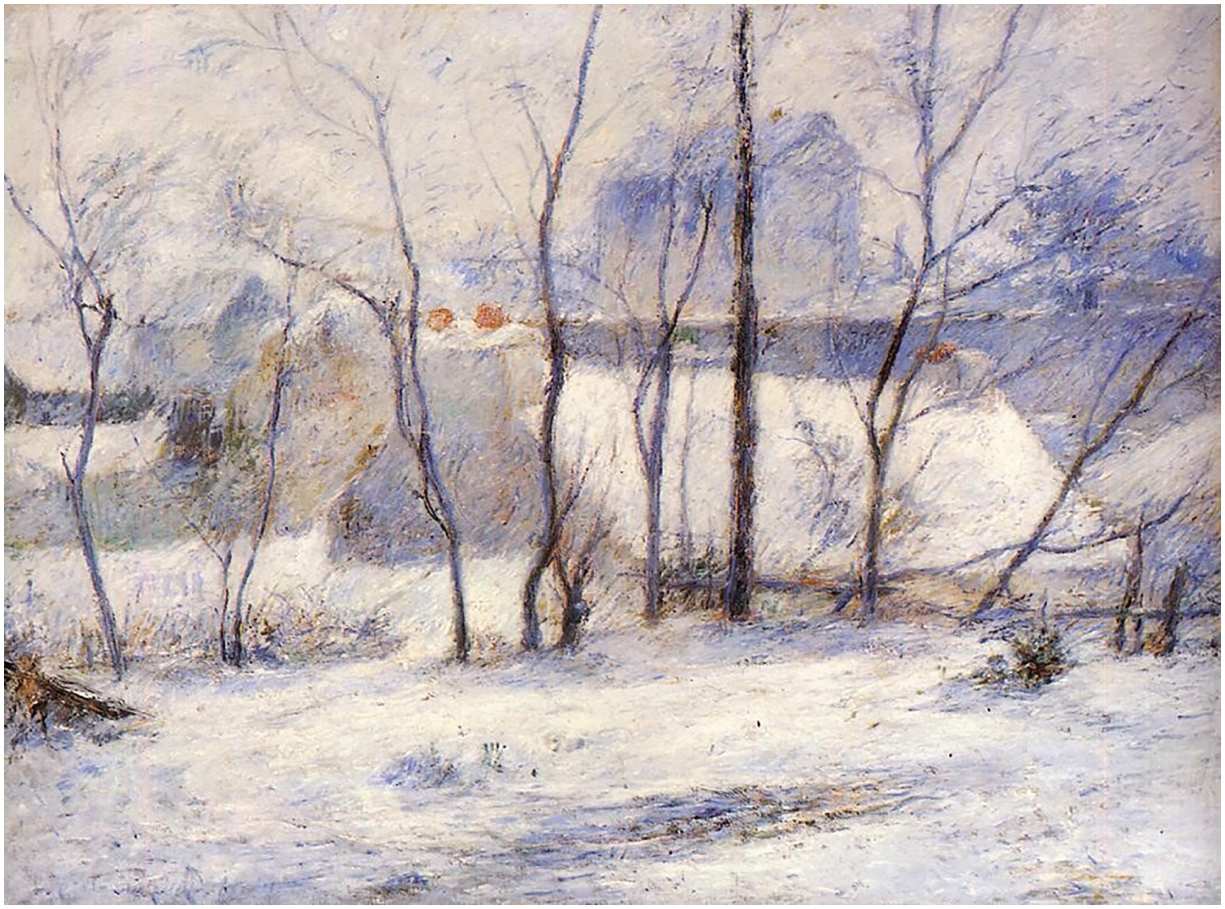

Winter Landscape Paul Gauguin 1879

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THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Advertorial

Empowering Patients with Drug-Free Pain Relief through Nevro's HFX™ Spinal Cord Stimulation Therapy

NO DAY OFF. NO RESPITE. JUST CONSTANT, UNREMITTING PAIN.

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Chronic pain is a silent epidemic affecting millions in the UK, with significant economic and personal costs. It also has broader societal and economic implications, often leading to absenteeism, lower productivity, and increased healthcare costs. If your patient has been suffering with persistent spinal pain syndrome (formerly known as failed back surgery syndrome (FBSS)) for six months or more[1] treating them with Nevro's HFX Spinal Cord Stimulation (SCS) therapy could be the answer they have been waiting for.

Is HFX Spinal Cord Stimulation the answer for your patient?
Unlike traditional low-frequency SCS, HFX powered by high-frequency 10 kHz SCS technology, goes beyond merely masking pain. HFX is a drug-free, minimally invasive, and reversible treatment targeting the root cause of chronic pain by calming hyperactive neurons in the spinal cord.

The effectiveness of HFX SCS is backed by impressive results, with a treatment response rate of over 70% sustained for up to 10 years post-implantation[2]. This innovative therapy has even been recommended by the National Institute for Health and Care Excellence (NICE) for treating chronic neuropathic back and leg pain persisting after back surgery[3].

PAIN PATIENT TESTIMONIAL

"I'm not in day-to-day pain and I can get a good night's sleep. I'm not doing steroid injections. I got my medical back. I was able to start flying again. I go snowboarding. I do hovercraft racing… all the stuff that I used to be able to do."

Robert, HFX SCS Patient

More than just pain relief
But HFX SCS isn't just about pain relief. It's about improving your patient's overall quality of life. Studies have shown that patients receiving 10 kHz Therapy™ experience a significant reduction in disability, with 70% moving to a lower disability category[4]. Moreover, 66% report better sleep[5] and 72% of patients eliminated or reduced opioid usage[6].

Furthermore, the latest regulatory approvals have expanded the scope of HFX SCS, highlighting the clinical benefits, including quality of life enhancements, improved sleep, better function, and reduced opioid dependence as part of expanded CE marking[7].

Here's what you need to know:

1. **Non-Drug Treatment Option:** HFX SCS is a non-drug treatment option, reducing the risks associated with long-term drug use.
2. **Centrally Funded by NHS England:** This treatment option is accessible to a wide range of patients, ensuring equitable care.
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Identifying the right patients for Spinal Cord Stimulation Surgery is crucial for successful pain management outcomes. With expanded clinical benefits beyond pain relief, referring patients for a minimally invasive trial procedure with Nevro's HFX Spinal Cord Stimulation therapy could be the turning point they've been waiting for. Let's work together to empower patients and offer them a future free from constant pain.

Learn more at: www.scs4chronicpain.co.uk

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contents

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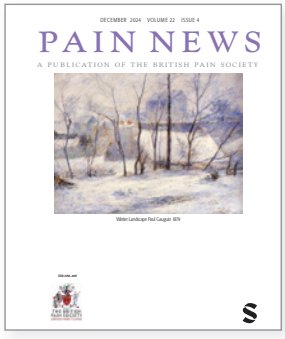

The Editor welcomes contributions including letters, short clinical reports and news of interest to members.

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President's message

Editorial

Articles

https://www.britishpainsociety.org/for-members/pain-news/

President's message

Winter 2025

Professor Roger Knaggs

Pain News
2024, Vol 22(4) 114–115

Sage

Welcome to the final issue of *Pain News* for 2024.

First, thank you for your ongoing support for the British Pain Society over the last year. I have written on numerous occasions over the last couple of years about it being 'your' Society. I am grateful to the support and dedication from fellow Executives, Council, the numerous Committee and SIG Chairs and members, who give their time to support the work of the Society. There are still opportunities to become involved in our mission, 'Together, we will do more for pain'. We will continue to advertise vacancies in our monthly electronic newsletter, BPS Connections.

As I have learnt over the last few years, there is much that goes on behind the scenes that most people do not see. We are lucky to have such a dedicated and committed secretariat; Ester and Jo work tirelessly to ensure the day-to-day running of such a complex organisation. At the last Council meeting in September, we spent some time discussing the direction and strategy for the Society over the next few years. Once this has developed a little further, we intend to share with members for your opinions and comments.

Over the course of the last year, there has been a large number of educational events, including a regular webinar programme. Thanks to everybody who has contributed to these webinars and made them such a success. Such a diverse range of topics has been covered including music therapy, pain in children, facial pain and ensuring quality in pain research. Recordings of previous webinars are now available on the BPS YouTube channel, so if you missed them the first time there is always the opportunity to catch up at a time convenient to you. We are interested to hear topics or potential speakers that you would like to see included in the programme for 2025.

There has been a substantial increase in the number of media requests that the BPS has received. This can only be positive to keep pain in the news. We do try and respond to as many as possible but often timescales are very short. The Chair of the Communications Committee, Alan Fayaz, has made several TV and radio appearances over the last few months and has been promoting the work of the BPS and the wide range of treatment approaches for managing pain. To stay up to date with our media coverage, our social media are updated regularly.

The Annual Scientific Meeting (ASM) held in Nottingham was a great success, with many positive comments about the programme and quality of speakers. However, time does not stand still and preparations are now taking shape for the ASM next year. I am thrilled that we will be holding the ASM in Wales for the first time in over 20 years. We have been collaborating with friends and colleagues from the Welsh Pain Society to ensure that there are opportunities to highlight national priorities and successes, and to experience some local culture.

The Scientific Programme Committee began with a list of over 50 suggestions to be considered as plenary speakers and has selected a varied programme that will be of interest to all. By the time this issue of *Pain News* lands on your doorstep, the call for workshops and other topical sessions will have closed. However, there are still opportunities to contribute to the programme by submitting your work as an abstract. Remember all abstracts are published in a special issue of the *British Journal of Pain*.

In order for the Society to grow and develop, we need to nurture the next generation of professionals and researchers

interested in pain management. After much discussion, a new membership category for students and early career professionals and researchers has been created with a membership fee of only £25/year. Please do promote this within your locality and in your networks. More information about eligibility is available on the BPS website. If you or potential members have questions, please do not hesitate to contact the Secretariat who will be able to help answer them.

A change in government inevitably means a change in policy. A few weeks ago, there was the publication of a report on the state of the NHS by Lord Darzi. Although there was little mention of pain specifically, it is clear that further change is inevitable. However, government priorities remain rather vague at present. There has been mention of increased focus on prevention, better use of digital technologies and support for primary care and community services.

This may seem challenging and unsettling, but we must see this as an opportunity to make a difference for the people we see in clinic. Over the last few months, together with the Faculty of Pain Medicine, the BPS has been engaging positively with policy officials to ensure that effective pain management is seen as a priority that needs addressing. We will continue to work with the Patient Voice Committee to ensure that lived experience is at the centre of our activities.

This is your Society. My door remains open for BPS members to contact me about any issue related to the Society or pain management in general. It is always interesting to hear about your successes. I hope that we can continue to celebrate more of them through BPS Connections over the coming months.

I trust you and your families enjoy a break over the festive period, and that the New Year is both prosperous and healthy for you all.

With best wishes,

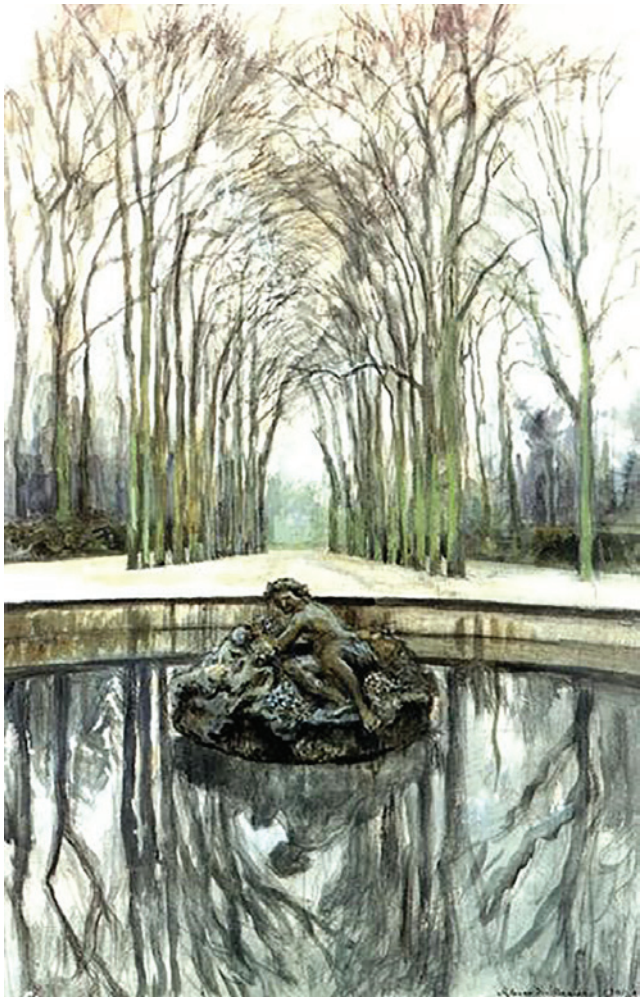
Roger.knaggs@nottingham.ac.uk

Editorial

Pain News: Winter 2024

Professor Margaret Dunham *Associate Editor Pain News*

Pain News
2024, Vol 22(4) 116–117



Versailles. Fountain of Bacchus in the winter. Alexandre Benois.

Does anyone else think that time accelerates away from you the older you get? As I write this for the Christmas edition of Pain News this is only the end of October; imminently approaches Halloween with all the ghoulish references – ghosts, blood, guts, pumpkins contrasting with splendid autumn leaves, pretty sunsets, and beckoning frosts.

It is also the day before the budget announcement so we wait hopefully and slightly fearful of how the new funding strategy will affect our National Health Service (NHS). The journalists seem to have a magical crystal ball on what the future holds, so much speculation over the last few weeks, so many mixed messages . . . and that's the point really, so many mixed messages about the NHS and on what the NHS is for. I don't think Aneurin Bevan ever anticipated his concept of an NHS would be focused on acute hospitals and expensive equipment. We have moved so far from a health and well-being focus to one that is effectively firefighting all the ills of an ageing population. And therein lies the issue: we have an ageing population where we do not have sufficient births to replace the population we have and the ageing population that we have is not as fit as a generation before. So few people walk or even go outside, we are effectively a majority nation of screen watchers.

We do not have enough General Practitioners, yet many GPs in training are unable to get jobs[1] as GPs because apparently the funding is not there. We are not training enough of any of the health professional groups to compensate for normal attrition rates, let alone future-proof health care provision. The RCN has recently published data[2] on the diminishing numbers of student nurses attracted to our UK universities; alarmingly this is 21% down, in stark contrast with the surge in 2021 following the outbreak of COVID-19. So, if we cannot recruit enough students and we are not training enough for the post-graduate specialisms, what does the future hold for pain services?

These may well be extraordinary data, and I am sure that every generation is living through unprecedented circumstances. There are also some unfortunate and extraordinary conversations, related to palliative care v ending life and new or developing roles in health care. Because of social media these heated discussions are being aired very publicly and may be damaging to many, both reputationally and in terms of future service provision. However, we cannot allow the current noise of the politicking around roles and responsibilities to obscure the need to provide pain services that keep a significant proportion of our population out of acute care, living independently and promoting good-quality lives.

Thankfully, optimistic colleagues continue to bolster our enthusiasm with their curiosity to explore new approaches to

managing chronic pain and its associated co-morbidities. A team led from the University of East London's School of Psychology has conducted a trial of a novel intervention for major depressive disorder.[3] Some 174 adult participants were recruited to a randomised controlled study of home-based delivery of "transcranial direct current stimulation tDCS." The depressive symptoms in participants showed significant improvement. However, no differences in reported pain were noted. Given the strong association between chronic pain and depression, having a non-drug approach which can be administered at home is worthy of further exploration and cost–benefit analysis.

You the reader will understand that chronic pain is not one homogeneous experience, and within the life span, most adults and some children will experience chronic pain. Hence pain services need to reflect the heterogeneity of society as well as providing access to the requisite expertise and specialist services. Sadly, children experience cancer, thankfully less frequently than adults, but as the treatments become more effective for the cancers, increasing awareness of the sequelae of side effects is acknowledged. Researchers at Nottingham Trent University[4] are investigating the relationship between chemotherapy and mitochondria that can lead to neuropathy and pain perception.

Women's health is also an area of concern, when women represent 70% of the people who experience chronic pain.[5] Women experiencing painful chronic conditions alongside other silent, or minority, communities need specialist support and robust research too. Lack of access to chronic pain services may contribute to people's ability to work as well as directly affect their quality of life, with a massive hit to the exchequer in terms of lost tax revenue.[6] Where are the workforce researchers, all the data about how our excellent pain services have got people back into work and helped people regain the dignity of being in gainful employment? Following the impending budget, perhaps the new government will commission some formal data gathering to substantiate its revised approaches to the health of the nation.

So, I will end on a hopeful note that by the time you get this, you will be enjoying the festive season with less "bah humbug" and a glowing future for the population's health and, to quote Charles Dickens,

> *I will honour Christmas in my heart, and try to keep it all the year. I will live in the Past, the Present, and the Future. The Spirits of all Three shall strive within me. I will not shut out the lessons that they teach.*

Have a great Christmas and a healthy 2025
Dr Margaret Dunham, RN, BA (hons) MSc, PhD

Associate Professor in Nursing & Pain Management, Edinburgh Napier University m.dunham@napier.ac.uk X @ margaretmdunham

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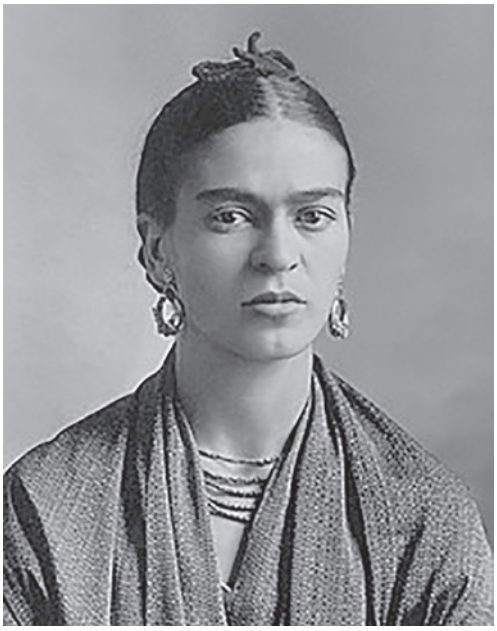
Article

Chronic pain: a self-portrait

Beth Evans *Senior Editor Pain Concern*

Pain News
2024, Vol 22(4) 118–119



Frida Kahlo 1932.

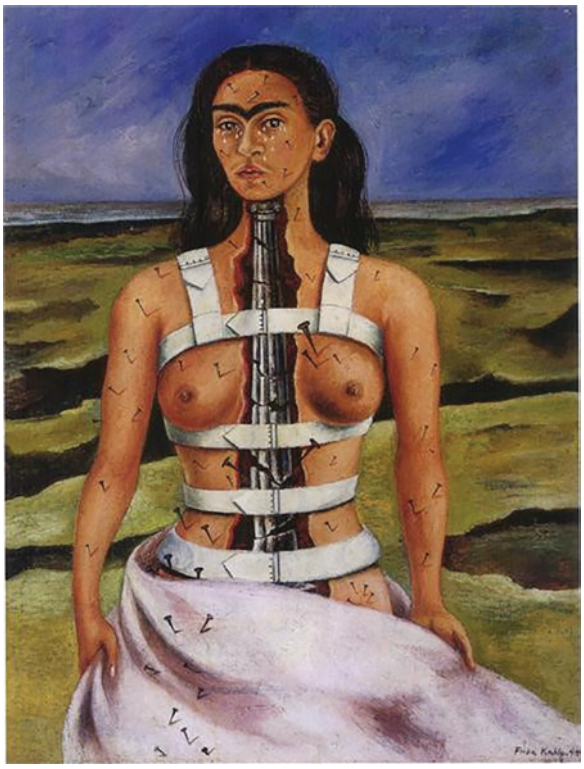
The images and image of Frida Kahlo are universal. Her striking dark features, prominent monobrow and hundreds of self-portraits hang in galleries, are stuck on John Lewis cushions and have become the symbol for much feminist discourse.

But did you know that Kahlo lived with chronic pain for most of her life?

After being hit by a bus at the age of 18, Kahlo was left with multiple injuries and persistent pain. She began painting, encapsulating her pain and the impact on her life.

The Broken Column (1944)

Kahlo painted *The Broken Column (1944)* following an unsuccessful surgery on her spine. Kahlo is centre frame, partially naked and covered in nails surrounded by blue skies and rugged landscape. Her body is wrapped in a white strappy corset, as if holding her together. There are striking white tears on her face contrasting with her dark features. Her body is ripped in two, split by a cracked column that stands jarringly inside her body as if to represent her pain. Her hair flows down her back, her breasts exposed and she holds a white cloth to cover her lower body.



Parallels can be drawn between Kahlo and *The Birth of Venus (1483)*. Botticelli imagines Venus with her hair flowing, breasts partially exposed and covering her 'modesty'. As the painter, Kahlo takes autonomy of her own body depicting it just as striking and beautiful as the divine female.

Look me in the eye

Kahlo looks straight ahead at the viewer, giving the painting an intense yet intimate feeling. She stands strong in the face of her physical restraints and pain. As we gaze and marvel at her body, she does the same to us despite the limits of her painted form. Her eyes follow you, daring you to stop and stare.

Kahlo depicts her physical pain with such raw and beauty, it is physically a part of her but it does not define or overshadow who she is.

She shows that she is as beautiful and important as a person living with chronic pain. She bares herself to us as she is and stands just as tall.

This is who she really is, and you better look.

Article

‘Nudging’ an improvement in the prescribing of modified-release opioids

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Pain News
2024, Vol 22(4) 120–123

Sage

M Wilcock, S Medlicott, B Booker and N Roberts *Royal Cornwall Hospitals NHS Trust, Truro, England*

Introduction

Opioids are effective and appropriate for acute nociceptive pain, particularly post-surgical pain, yet can cause harm if used or continued inappropriately. Such harms from opioids are well described in the literature. In the short term, opioids can cause nausea, vomiting, constipation and dizziness, while potential long-term harms include dependence, overdose and death.[1,2] However, confusing and somewhat contradictory guidance has led to uncertainty in prescribing opioids for pain. In the United Kingdom, guidance from the National Institute for Health and Care Excellence does not recommend the initiation of opioids to manage chronic pain in those aged 16 years and over.[3] Yet European clinical practice recommendations do allow the use of opioids for chronic non-cancer pain, particularly where non-opioid treatments have been ineffective, contraindicated or not tolerated.[4]

In the context of surgical practice, the introduction and increased use of the modified-release (MR) opioid preparations was driven by the beliefs of reducing nursing workload compared to the administration of immediate-release (IR) opioids, in addition to providing more sustained analgesic benefit.[5] However, increasing recognition that MR opioids showed lack of benefit and increased risk of harm compared with IR opioids has led to guidance that they should not be used for the management of acute post-operative pain in adults,[6] and more generally that MR opioids should only be used to treat severe and persistent pain in exceptional circumstances.[7]

Opioids remain commonly prescribed for acute pain management during hospital stays for surgical procedures and trauma but often are continued post-discharge. There is growing evidence that overprescribing opioids at hospital discharge adds to the increased risk of persistent opioid use after discharge.[8,9] Evidence that such continuation also contributes to the increasing opioid epidemic[10,11] has led to increasing requirement of opioid stewardship. Enacting opioid stewardship activities within a hospital setting should optimise the benefits for patients from opioid therapy while minimising these risks.[12]

A prior audit within our hospital identified 50% of new MR prescriptions were continued or had been increased at 3 months post-discharge, prompting an education session for medical staff.[13] This generated interest within some clinical teams around identifying safe prescribing practices to reduce high-risk opioid prescribing.

Nudge theory is an aspect of behavioural theory which recognises the complexity and influence environment and experience have on decision-making, and within health care, there is much interest in the use of nudge to improve decision-making to increase guideline concordant care.[14–16] In relation to opioid prescribing, multiple nudge strategies have been used, and many of the effective strategies are not used in isolation.[17] Although there are increasing opportunities to use nudge techniques to influence clinical practice, investment of resources to support their construction and maintenance is required.[18]

We sought to evaluate changes to opioid prescribing following an email sent by the Inpatient Pain Team (Box 1) to doctors who prescribed a new MR opioid (including opioid patch), copying in the consultant in charge of the patients’ care, with the aim of breaking habits and embedding new ones grounded in evidence.

Methods

A prospective analysis of MR opioid prescribing for inpatients who commenced such treatment in a 750-bed hospital in England, serving a population of 430,000 people.

A daily live web feed generated by pharmacy identified these patients, and a patient-specific email was sent from the Pain Team to the relevant prescriber and Consultant. The email (Box 1) explained there is a trust-wide review of MR opioid prescribing and asked the prescriber to ensure this is the most appropriate analgesia. If so, the rationale has to be clearly documented in the medical notes with an indication and review date specified, and ensuring the general practitioner (GP) is informed of a plan regarding this medication.

Box 1.

The inpatient pain service with support from our pharmacy colleagues is conducting a trust-wide review of modified-release (MR) opioid prescribing. This follows a recent RCHT audit, which identified 50% of new MR prescriptions were continued or had been increased at 3 months post-discharge from hospital. We now receive a daily report of new prescriptions of MR opioids and patches within the trust to help us identify patients newly prescribed or who have received dose increases.

We have noted that you have recently prescribed an MR opioid to patient XXXXX. Could we please request that you ensure this is the most appropriate analgesia. If, in your considered opinion, it is indicated, could you please ensure that the rationale is clearly documented in the medical notes, and an indication and review date are specified and ensure the GP is informed of your plan regarding this medication.

We are contacting all prescribers and consultants of the prescriber to ensure that the MR opioid prescription has been considered on a risk and benefit basis to ensure it has been appropriately and safely prescribed. Part of this stewardship is to ensure that there is robust documentation supporting the commencement of the MR opioids, and there is an identified review date and an expectation of use. If patients are expected to be discharged from hospital with this new prescription, it is important that the expectation of use and weaning advice is communicated with the GP via the discharge summary.

MR opioids (including patches) are difficult to titrate, difficult to stop, lead to tolerance, dependence and addition. While we appreciate in some exceptional circumstances they may be indicated, there should be a clear rationale documented regarding this. We would like to know how much improvement in function that the commencement of MR opioids has achieved. The faculty of pain medicine also do not recommend commencing MR opioids in acute pain; therefore, prescribing MR opioids without a clear indication will be against local and national guidance.

NICE has recently released new guidelines about the prescribing of MR opioids to ensure safe prescribing: https://www.nice.org.awal-symptoms-safe-prescribing-and-withdrawal-management-for-adults-pdf-6614377uk/guidance/ng215/resources/medicines-associated-with-dependence-or-withdr6880581.

If you have any concerns or wish to discuss this with us further, please contact the inpatient pain team B3233.

The email also detailed risks with MR opioids and that the Faculty of Pain Medicine does not recommend commencing MR opioids in acute pain, therefore prescribing MR opioids without a clear indication is against local and national guidance.

Health Research Authority criteria about research and service evaluation were considered. This was a prospective assessment involving no changes to the service delivered to patients, and we used the National Health Service (NHS) Health research authority tool (http://www.hra-decisiontools.org.uk/research/index.html) which helped confirm that no ethical approval was required for this project. Patient data were used in accordance with local NHS hospital policy, and this assessment was recorded on the trust's clinical effectiveness database.

Patient characteristics and relevant data were identified from the hospital electronic prescribing system (Careflow Medicines Management) and electronic notes. Extracted data included dose of opioid prescribed at admission and discharge, the indication for the opioid, and other opioid-specific messaging to the GP as described in the discharge summary.

Results

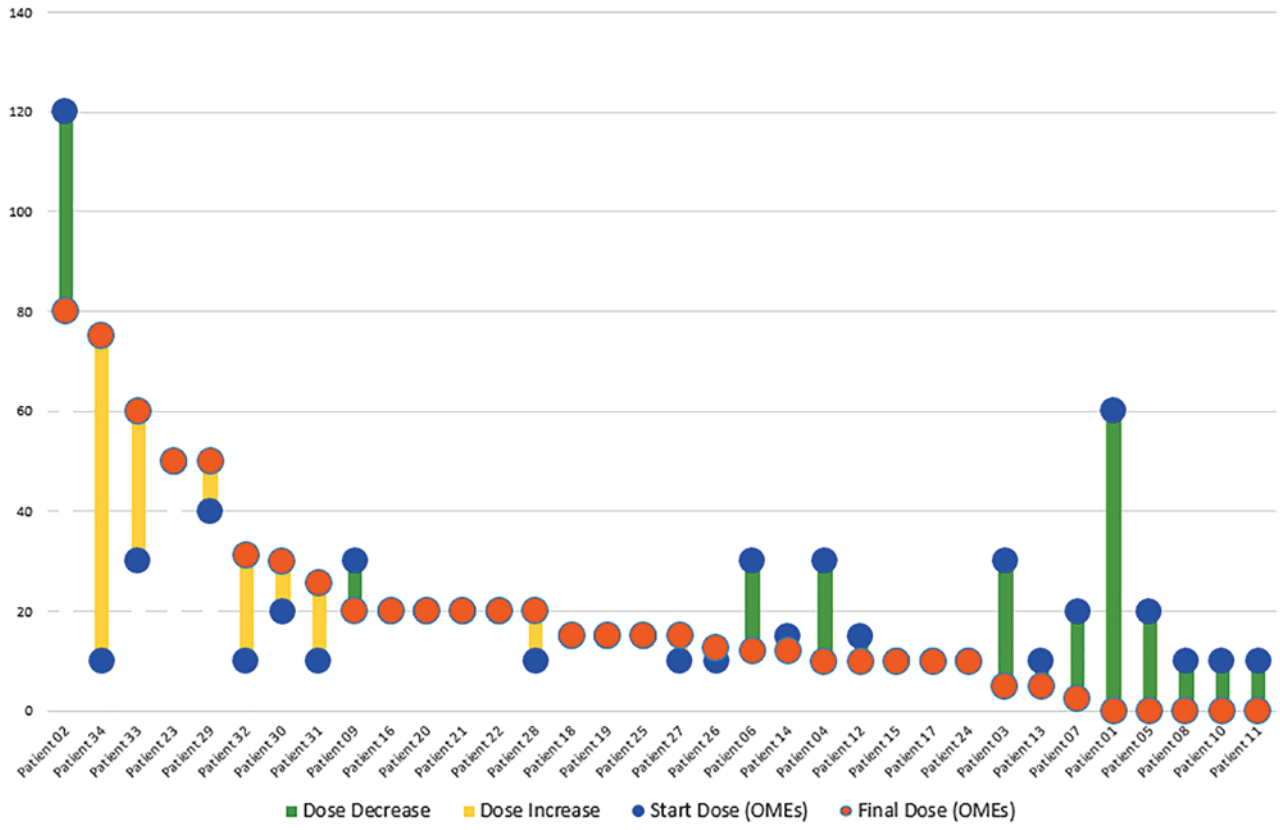
A total of 47 emails were sent from the Pain Team over 3 months starting December 2023. Data for 34 patients (mean age = 75 years, 65% female) were analysed in early summer 2024 after excluding 12 palliative care patients and one patient who remained in hospital at the time of analysis.

Regular MR opioids were used for a variety of indications (pain associated with fracture 14, with surgery 7, other 13), and at commencement were MR versions of morphine (14), buprenorphine (10) and oxycodone (10).

At discharge, five patients (14%) were on a regular or as required weak opioid, and three (9%) were discharged without any opioid prescribed. Eight (24%) patients had their MR opioid converted to a standard-release strong opioid, while the remaining 18 (53%) continued on an MR opioid.

The total daily oral morphine equivalents (OMEs) from commencement to the dose on the discharge prescription (including any PRN opioid) reduced from 765 to 680.8 OMEs (an 11% decrease). Fourteen patients (including the three

Chart 1. Reduction in oral morphine equivalents from opioid commencement to discharge.



without any opioid at discharge) had the daily OMEs decreased from commencement.

There was a note in the discharge letter about opioid commencement in hospital for 20/31 (65%) patients discharged on an opioid and a note about review/weaning in 14/31 (45%) instances.

Discussion

Implementing this nudge in our hospital was associated with an overall decrease in OMEs between when the email was sent to discharge and that 47% (16) of the identified patients had a reduction in overall OMEs or a switch to an IR preparation. There was also an improvement in discharge summary documentation. A prior audit showed 25% of patients discharged on MR opioid had a weaning plan,[9] compared to 45% in this current study. In line with the evidence,[16–18] our nudge had followed on from other strategies (targeted education sessions for junior doctors, senior doctors, nurses and non-medical prescribers) implemented after the prior audit. One study concluded that feedback on clinicians prescribing using both individual feedback and peer comparison positively influenced opioid prescribing with a decrease in pills per prescription.[19]

Having previously provided education sessions on this topic, we cannot say which nudge elements were most important, given the time-consuming nature of the case identification. Further research is needed plus enabling, if possible, our electronic prescribing system to automate appropriate messages. Future work could also consider following up patients discharged on an opioid to ascertain if continuing prescribing occurred.

We acknowledge that our study involved a small subset of patients prescribed MR opioids during hospitalisation from just

one hospital, and hence, we do not know to what extent it reflects overall current practice in the United Kingdom. This study used routinely collected data from health records and therefore has numerous limitations. It is able only to identify correlations and patterns. The study involved a review of clinical records not specifically designed for the purpose of data collection.

Conclusion

Clinical practice is a complex behaviour and should be considered as such when attempting to change it. Behavioural change interventions should attempt to address change holistically. Various models are available to shape this, rather than simply focusing on a single aspect of behaviour that may not bring about the desired effect. Nudges like this feedback email can be useful, as they address capability (through education), motivation (through education and feedback) and opportunity (through asking prescribers to evaluate their specific prescribing decision). The improvement shown needs to be weighed up against how time-consuming an intervention is. Automation of this patient identification process via electronic prescribing systems is an example of how future technology could make this more efficient. In an ideal world, tools like this nudge email would be built into the system, creating a decision environment for the prescriber that consistently gives a nudge towards thoughtful and safe opioid stewardship.

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Article

Drugs, addiction and pain

Tim Atkinson

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Sage

Rydal 2024: The British Pain Society Summer Retreat, Cumbria

Hosted by the Philosophy and Ethics Special Interest Group (SIG), Rydal Hall, Cumbria, 23–26 June 2024.

Rydal Hall credit Charlie Atkinson.

Bill Clinton famously quipped that the Hay Festival was the 'Woodstock of the Mind'. And after a packed 3 days including hypnosis, wild swimming, *Tai Chi*, varied and stimulating lectures, good food, great conversation and ending with live music, maybe we should start calling the Philosophy and Ethics SIG's annual retreat the 'Woodstock of Pain'?

Once again, this eclectic mix of BPS members and guest speakers came together to produce an event that is always more than the sum of its parts. And what parts! Beginning, on Monday morning, with the entertaining and erudite Professor David Nutt and followed by the BPS president, Professor Roger Knaggs, the programme got off to a flier. But that's only part of the story. For some, Monday morning had begun bright and early with a bracing dip in Rydal Water; for many, it then continued with 30 minutes of *Tai Chi* in the morning sun, expertly guided by Betsan Corkhill. And, after the morning sessions, there was time for walking round the lake, more swimming, cycling or strolling or even 'just doing nothing' as it said in the programme. Never have holistic principles been so intimately integrated into a day's professional development activities.

David Nutt might be familiar to some as the government's first (and last?) Drugs Tsar (more accurately, chair of the Advisory Council on the Misuse of Drugs). He was appointed by Tony Blair to bring some common sense as well as academic rigour to the realm of government drugs policy. And he certainly provided it, being sacked (or rather, 'asked to resign'!) in 2009 after claiming that ecstasy and LSD were no more dangerous than alcohol. Speaking truth to power is never straightforward, and his statistical claims (such as his assertion that ecstasy was no more dangerous than horse-riding[i]) sometimes made for uncomfortable reading, especially at the Home Office. As Voltaire said, 'It is dangerous to be right when the government is wrong'.

But these are precisely the conversations we should be having, Nutt argued, if we are ever to arrive at a coherent and effective drugs policy. There is an urgency to his claims, too, given that so much more harm than good has transpired from *50 Years of Failed Drugs Policy* (which was the subtitle of Professor Nutt's presentation). His main title – *More deaths, more pain* – took no prisoners either. Which is a good job, as Nutt also revealed that – thanks in part to policies like making cannabis arrests a measure of police efficiency – it is largely as a result of drug convictions that the UK's prisons are now full to capacity. And the irony of this is that those very prisons are themselves incapable of stemming the tide of substance misuse, either within or without their high walls. Current drug laws fail both to reduce harm and permit research into the untapped medical potential currently illegal substances might have. But then bans (like the Roman Catholic Church's 1616 ban of the telescope!) are almost always borne of ignorance and fear.

Professor Roger Knaggs delivering his talk on the opioid crisis.

Next, it was Roger Knaggs' turn to give his view on the opioid problem. We might think we know all there is to know about the opioid epidemic, but – as Professor Knaggs showed – the reality is inevitably more complex. And in a nod to the previous speaker, Knaggs also made it clear that statistics relating to opioid deaths apply both to prescription doses and to street drugs, another under-appreciated fact. That, together with the geographical and social variations in opioid use, should add a much-needed note of caution to the headline-grabbing cries of politicians. Because the problem isn't (just) opioids; it's poverty, comorbidity, lack of economic opportunity, poor education and inadequate access to primary care. *Plus ça change, plus c'est la même chose* as Jean-Baptiste Alphonse Karr had it in 1849. Mind you, in 1849 opioids were being dispensed liberally from the local pharmacy, could be bought legally and even went into the ingredients of infant cough medicines. So perhaps we *are* making progress. Slowly.

Rydal Water.

The weather is notoriously changeable in the Lakes. (They're not called *The Lakes* for nothing; parts of Cumbria have some of the highest annual rainfall totals in the UK!) In June 2023, the SIG assembled at Rydal Hall on what proved to be the last day of that month's wonderful heatwave. This year, our timing was better. The sun shone (almost) every day, and it was mercifully dry. So strolls in the gardens, walks by the lake, hikes up the hills and more could be enjoyed to the full. And that fresh air proves delightfully addictive. Which is appropriate, perhaps, given that Dame Clare Gerada was presenting a paper (via Zoom) on gambling addiction that had almost everyone reaching for their phones and checking just how many gambling ads routinely pop up on our social media channels. The ease by which people can be lured into online gambling and the frightening speed by which habits can deteriorate to addiction and lead to ruin were all too apparent. It brought to mind questions raised at the start of the day about the need to understand precisely the causes of harm and take action accordingly – not be led by media scares and political point-scoring into reaching for apparently popular (but often counterproductive) solutions.

On Day 7, after a convivial evening spent at *The Badger Inn* – with lively (and ale-fuelled) conversation inspired by Monday's sessions – the 7 am alarm for an early-morning swim might not seem quite as appealing as it did the day before. But persevere! The water certainly wakes you up, and then half-an-hour's *Tai Chi* with Betsan completes the nature cure. And what if you could, somehow, tap into this natural well of feel-good

Evening discussion at The Badger.

emotions and keep it flowing? Perhaps you can, and Sarah Partridge's inspiring presentation on the value of clinical hypnosis certainly raised that possibility, as well as detailing its use and efficacy in pain management. Dr Partridge is Consultant Clinical Oncologist at Imperial Healthcare NHS Trust, specialising in head and neck cancers. It was her efforts to deal with the resistance and fear felt by many cancer patients to some of the more alarming treatment options that first led her to investigate the use of clinical hypnotherapy, a practice she initially explored in 2002 as part of a Research Fellowship. She has since completed a Diploma in Clinical Hypnotherapy and founded (with Dr Rumi Peynovska) the hypnotherapy service at Charing Cross hospital. Evidence of the power of suggestion is widely accepted;[ii] it is a short step from there to the idea of hypnosis as a valuable way of deepening this power. But, rather like trying to explain a love story to someone who has never, themselves, been in love, personal experience is vital, and we (those of us who were willing) were offered a short, 10-minute hypnotherapy 'taster' session at the end of Dr Partridge's presentation. All I can say is, it works for me!

Niki Jones is an energetic patient advocate with lived experience of debilitating pain – and the personal triumph of a significant recovery. In the day's second session, she provided ample personal evidence of the devastating effects of traditional treatments for chronic pain. For her, the drug regimes she was on and the surgeries she underwent led at times to greater problems than the original causes of her pain. In the end, as she said, 'I realised I was part of my own solution' and with determination, support and education she managed to turn her life around. Niki's story is as inspiring and moving as it is shocking. But then, 'Illness makes storytellers of us all', as Polly Atkins writes, 'whether we want it or not'. Award-winning Lakeland poet and author Polly has written a wonderful memoir – *Some of Us Just Fall: On Nature and Not Getting Better* – recounting her own illness story. She was in conversation with SIG chairman Dr Tim Johnson for the final session of the day on Tuesday. And we were immediately plunged back into the realm of nature cure when she read a brief extract from her book about her daily swim in neighbouring Grasmere. Atkins' prose is expertly-crafted with a beguiling, poetic turn of phrase (as you would expect of a poet) and she rises to the challenge of describing her illness – and her lifelong search for a diagnosis – in terms that make for compelling reading. But this gently probing conversation ultimately brought us face-to-face with a stark truth. 'All conversations about illness', Atkins says, 'seem to be about either recovery, or death: but most of us are stuck in the middle with chronic conditions we have to live with'.

Some conversations, of course, have added therapeutic purpose and dimension. Mary Smeeth is a Family and Systemic Psychotherapist working in East Anglia. And her session on Wednesday morning – *Motivational Interviewing* – stressed the importance of understanding the process of change and choosing the right words in therapeutic conversations. Subtle verbal clues need recognising, and neat conversational formulations used gently to challenge inherent, negative thinking. Such linguistic focus seemed to confirm what had become something of an inadvertent theme for the entire retreat. Words are powerful tools, from the *nocebo* of 'this is going to hurt' to the *placebo* of 'you won't feel a thing'. Getting it right can mean the difference between success and failure; getting it wrong can be a disaster. Words can unlock a powerful natural state of healing, as Sarah Partridge demonstrated in her session on the value of hypnosis. Words can soothe and heal, as Polly Atkins demonstrated. They can be cathartic, as Niki's powerful poem, *Broke* showed only too well. But it's as part of a therapeutic conversation, as Mary Smeeth explained, that the importance of words can be linked most directly to positive change. Choosing the correct word or

the right turn of phrase is just as important as understanding what lies both on and under the surface of those words spoken by both patient and practitioner.

Finally, 'Where words fail, music speaks' as Hans Christian Andersen once said. After the closing business of the SIG and discussion of next year's agenda, it was time for some entertainment. Specifically Andreas Erdmann playing Johann Sebastian Bach's *Prelude in C major* from Book 1 of *The Well-Tempered Clavier* (1722), Gillian Dickson singing the *Coconut Song* (in character!), Peter Wemyss-Gordon with the beautiful *Foggy, Foggy Dew*, yours truly with *Brigg Fair* after which SIG secretary Maureen Tilford led the ensemble with *Always Look on the Bright Side of Life* from Monty Python's *Life of Brian*. The intellectual and therapeutic value of music is, of course, beyond doubt. I might justifiably demur as far as my own meagre contribution goes, for mere modesty's sake. But for the rest, as the saying goes, play on!

Any requests for next year?

Notes

i. https://www.researchgate.net/publication/23806800_Equasy_-_An_overlooked_addiction_with_implications_for_the_current_debate_on_drug_harms.
ii. http://www.mnhypnotherapyassociates.com/index.php/brain-activity-during-hypnotic-pain-relief.

Article

With. Draw. All

Nikki Jones

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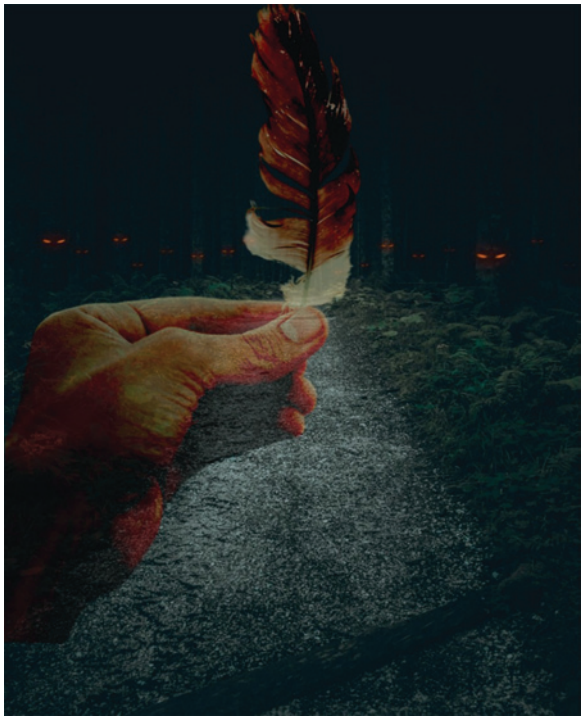

I broke.

Pieces of Me scattered, shattered on the ocean.
Drifting. Floating. Speeding away.
Jetsam not flotsam.

Negligent not mistaken.

Waves thrust Me ever higher,
further afield,
losing connection,
bleeding apart.
Calling desperation,
shuddering rage.
Fear overwhelming,
ungrounded and screaming.

Lost from the land, the sense of who.
Lost from the others, no longer holding hands.
Lost from resilience of love in this world.
The ink deep abeyance of care, of hope.

I am lost.
I am impotence, unimportant.
I am hiraeth.
When the worlds hurts, joys, cares and pleasures fold around you, inside you, without you. Overwhelm with the feelings,

All the feelings.

I wonder,
Is death running away or running toward?
Is it in accepting the stillness that you learn to breathe?
Sometimes I lust for you,
for the energy of you, for the oblivion and surrender.
When I've been fighting in a battle with no honour, no reason, no right.
Did I lose my shell? It was chemical, ripped away, exposed, raw, nerve ends screaming hate hate hate . . .

I'm just tangled in my own mind, my own spiral of receptors
screaming,
dying,
violent spite.

My body suddenly alien, discomforted.
A relentless buzz, of action in pieces of perpetual, pointless merry go round,
swirling,
nauseating,
maelstrom internal,
confined.
A flow chart of destruction,
A hulk above me, grave, remote, inexorable menace and might.

You won't kill me they say

– they in their offices, their rooms of misunderstanding.
Castles of judgement,
the rubbled battlements a mass of denial, resistance,
and the righteous smog of superiority.

You climb on the shoulders of the men before you, the evidence base
that crumbles and trips beneath you.

I say it loud, ringing clear – you hurt me.
You hurt me soul deep.
A murk of betrayal;
mine body, mine mind,
thine care, care less.

No apology no justice no right to reply.
All my fault, all, all, all all mine.
~
Oh, Hello again. Again. Predictable, my choice, my sabotage, my determined blight.
Stick it out. Bored with you, within me, with you, with me, with this, again yet again.
Tell me why I do?
I'd give up, I wish I could I would. I would.

With. Draw. All

But.
The only way out is through and
Through,
And Through.

I'll get there, bloody, bowed and determined. But oh it hurts and it's a justiceless fight I did not choose.

So turn and turn again and the future will come,

This is keeping going, this is the why.

Just one step more, in time-
and so much small in that step – how much we can fit in,
where large cannot.

Living is the small thing,
the small courage,
the tiny might.
Small is not insignificant,
is not dismissed.
Living is the reason of a million whirling moments,
of delight,
despair,
contentment,
rage,
watching,
waiting,
love and thought.

Stay.

https://soundcloud.com/niki-jones-778049061/poem-opioid-withdrawal

Nikki Jones: ‘Battleground; the harms of opioid prescription, dependency and withdrawal’.

Presented at Philosophy and Ethics Special Interest Group, Rydal Hall, Cumbria, 23–26 June 2024.

Abstract: A personal insight into the challenges of the ‘journey’ from high doses of used as prescribed opioids, through reduction to cessation – against a backdrop of systemic, political, ideological, societal and individual entanglements. Reflection and discussions on how to upstream to mitigate the harms and start to turn the battleground into an oasis.

Niki Jones recovered from 17 years of highly disabling facial pain and headaches in 2018 using the Curable App. However, she then found significant challenges arose when attempting to come off the very high doses of opioids that she had been taking for years. Prior to recovery, her life had become very small and dark – unable to work, have much of a social life or even walk a mile without pain and exhaustion. She had multiple surgeries including Motor Cortex Stimulator. Prior to being struck down with Trigeminal Neuralgia, TACs and migraines, she was Research Executive at the British Horseracing Board (now Authority) in London, has a first degree in Environmental Science and did 2 years of a PhD in Atmospheric Chemistry. She also ran a small livery yard and has worked with all kinds of horses from racehorses to trekking ponies. Now she works closely with the Flippin Pain™ campaign who aim to bring modern pain science to the public. She is Chair of the Footsteps Festival – a co-production of people with lived experience of persistent pain with health care professionals (HCPs) and academics formed during COVID-19, which aims to provide support and information on living well with pain. She co-hosts an online monthly Journal Club which successfully brings diverse groups together to discuss the latest in pain science. She also works as an expert by experience/patient partner with various academic groups, including Prof. Lormier Moseley (as part of PETAL), Prof. Cormac Ryan, Dr Chris Penlington and Dr Jackie Walumbe.

Now qualified with Animas as a transformative Life Coach, she is starting to build a coaching business with a focus on those with pain and chronic conditions and those tapering dependence-forming medications. She runs group coaching sessions for those working with the Curable app or similar. Outside of the pain world, she works part time as Assistant Manager at her successful local community shop and café – a project she has been involved with since its inception 3 years ago. She still keeps horses and trains them with positive reinforcement, reads and writes for enjoyment, walks 15k steps most days, enjoys yoga, hikes in the Welsh Mountains and has an active and varied social life. She has joined two Flippin Pain™ Outreach tours (cycling and public speaking) and cycled the English C2C last year with friend Lee Vaughan, raising £2k for Pain Concern.

Article

Identification of domestic abuse in people with ongoing pain

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

Pain News
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Sage

Dr Anna Sydor *SFHEA Senior lecturer – Midwifery, Cardiff University*

Chronic pain has been defined as pain that continues even when beyond normal tissue healing time.[1] Treating and caring for those experiencing chronic pain has long been a complex issue; its ongoing nature and variety of factors impacting the experience of pain make it difficult to offer straightforward treatment options. This article examines the importance of considering domestic abuse and coercive control when undertaking a pain assessment or offering treatment input for those experiencing chronic pain. It should be noted that these factors may also be present in cases of acute pain, but the nature and difficulty of considering domestic abuse may make assessment difficult in an acute phase of illness. Some of the key factors within domestic abuse and coercive and controlling behaviour are discussed to illustrate the intransigence and victim-specific nature of the crime, as well as demonstrating how difficult assessment could be. Following this discussion of the key factors and issues pertinent to providing good quality care, assessment and support to those who may be experiencing abuse are outlined.

The incidence of chronic pain is estimated to be around 40% of the population of the United States[2] and between 30% and 50% in the United Kingdom.[3] It is a phenomenon experienced at different stages of life and in different ways, causing impacts throughout the sufferer's life.[4] Chronic pain has an impact on and is impacted by a person's relationships and wider social situation.

Domestic abuse

There are a number of terms used to describe the phenomenon of abuse that happens within the home; see Table 1.

Abuse is not always visible from the outside, physical injury may be present, but the victim may also react to the abuse violently and seem angry or violent themselves, limiting opportunities for seeking help.[10] It can be difficult for an outsider to ascertain what is happening. Economic abuse is also not always obvious, a victim may believe money has been removed for their own benefit, they may have been coached and agree that they would mismanage the money, make poor decisions or are just too unwell or stupid to manage. Economic abuse can include removing access to goods or services;[5] a perpetrator limiting the victim's access to healthcare, or removing the opportunity to make their own decisions about money or property, could also be abusive.

The prevalence of domestic abuse is difficult to estimate exactly. It is thought that in the past year prevalence is up to 4.5%. Difficulties in measurements and different tools used to measure the phenomenon compound the difficulty of estimating this Ali et al.[11] but there are some factors that are known. Women are more likely to experience domestic abuse or intimate partner violence than men [11,12] and disclosure is known to be difficult even in cases where violence is apparent.[13,14] Even if disclosure takes place victims may decide to remain in an abusive relationship for many reasons, including not wishing to separate the family or feeling financially entrapped.[15]

In Wales, government guidance requires front line practitioners to 'Ask and Act'[16] about abuse – this is targeted enquiry to provide support and enable disclosure, but some victims may choose not to disclose. Victims may also be unaware that their experiences constitute abuse, meaning that they find enquiry irrelevant or cannot voice their experiences.

Coercive and controlling behaviour

Coercive and controlling behaviour has been a crime in England and Wales since 2015;[7] this is relatively recent and prosecutions have been few to date.[17]

Coercive control is present in most cases of domestic abuse;[18] it is a tool an abuser can use to assume control. Many other forms of abuse often ensue but are built upon this control and a victim's feeling that they, and not their abuser, are the problem.[19] Isolation is achieved by limiting a victim's access to other relationships with family and friends, meaning the victim is

Table 1. Terms used to describe violence and abuse at home.

Domestic Abuse	Covers both violence and other forms of abuse that do not present physical signs. Covers abuse when the perpetrator is not an intimate partner or former intimate partner. Defined as an act or pattern of acts perpetrated by someone personally connected to the victim.[5] Personal connection refers to a partner, former partner or family member but the definition is broad, ensuring that different types of relationships are included.
Domestic violence Intimate partner violence	Used in literature, definitions are not always precise, this term seems to refer to violent acts. Includes physical violence, sexual violence, psychological abuse (and coercion or control) as well as stalking. Perpetrated by current or former intimate partner.[6]
Coercive control, coercive and controlling behaviour	The object of the controlling behaviour is to control, harm, punish or frighten the victim.[7,8] The victim experiences entrapment[9] often including isolation and inability to make decisions about their own lives. Control can include emotional abuse, economic abuse, punishment and threats, although these may not be apparent to onlookers.

left without external checks on their abuser's language and behaviour. Other activities of everyday life are curtailed or managed for the victim. These can include (but are not limited to) clothing, activities outside the home, management of the home, employment, sleep, food and access to healthcare. It is important to note, though, that coercive and controlling behaviour is victim-specific[9] meaning that definitive lists of how it will appear are impossible to create. Fear and entrapment are experienced, physical violence or threats of physical violence may be present, but these may not be made explicit. Other forms of punishment may be sufficient to exert control, for example sulking or ignoring the victim, shouting and blaming the victim, threats to others (including children and pets) or accusations that the victim is an unfit parent. All of these behaviours leave a victim not only willing to acquiesce to their abuser but also convinced that the situation is of their own making.

Coercive and controlling behaviours are usually present in cases of intimate partner homicide,[20] even if violence has never been noted in the relationship previously. The experience of a relationship of this nature has long-term implications for the victim, and any children who are recognised in Wales as victims in their own right.[21,22] The impacts of experiencing coercive and controlling behaviour are far reaching for victims and include suicide and self-harm,[23] long-term physical consequences such as increased risk of diabetes, worsening of CD4+ cell depletion in HIV and development of chronic diseases and pain.[24] The mental health of victims is also impacted, who experienced increased incidence of post-traumatic stress disorder (PTSD) and depression.[25]

The presence of coercive control in healthcare interactions may not appear in the way that healthcare professionals anticipate. For example, a controlling partner might be expected to control the healthcare contact and monopolise the conversation, but disinterest and distance was a tactic of control identified by some pregnant women.[26] This illustrates the differing nature of the presentation of abuse and shows how easily it could be missed by a healthcare professional.

Chronic pain and abuse

There is a complex interaction between chronic pain and domestic abuse. Pain may be caused by physical injury sustained during abuse.[27–29] The impact of ongoing abuse may also exacerbate pain being experienced for a different cause. Hegarty et al.[30] found that victims of abuse were likely to present with symptoms such as diarrhoea, chest pain and tiredness; atopic disease has also been linked to experience of abuse;[31] generalised pain was found to be a presenting symptom of victims of abuse[32] and disease activity was exacerbated in patients with lupus who also experienced IPV.[33] The experience of abuse results in physiological changes leading to health conditions;[31,34,35] victims of abuse are likely to experience health conditions to a greater extent than other people. For example, the severity of symptoms and experience of chronic pain has been linked to other conditions associated with experiences of abuse such as PTSD,[29] where the experience of one condition exacerbated the other. Chronic pain exists in tandem with abuse in many instances.[34,36,37]

Healthcare professionals should consider the possibility of underlying abuse in all their patients and have a high index of suspicion in patients who present frequently with different conditions. A victim's experience of managing the healthcare system may also be impacted by the abuse that they have or are continuing to experience. This may mean that the abuser attends appointments, refusing to or making it difficult for the victim to attend.

Identification

It would be easy to assume that disclosure of abuse could allow the victim to leave a relationship or living situation with resultant benefits to their health and life more generally. This is rarely a straightforward process; leaving an abusive relationship presents challenges and is a period of increased danger for the victim;[38] homicide risk is increased following separation;[39] and post-separation abuse is experienced as a consequence of leaving.[40] This abuse has been described as a never-ending cycle, perhaps worse than the abuse present in the relationship.[41] Healthcare professionals must be aware of this increased physical risk and the prospect of ongoing and increasing abuse, when talking to a victim. Identification of abuse may require referral, safety planning and ongoing support for the victim.

The efficacy of screening interventions in prevention of sequalae of domestic abuse is not clear, although it may increase identification of abuse.[42] Screening or discussion of abuse could put a victim at risk, although there is no clear indication that this is the case[42] and careful and sensitive approaches by healthcare professionals are necessary to support and protect victims.

Guidelines are provided to support healthcare professionals responding to domestic abuse[43] setting out responsibilities and the need to identify abuse to reduce long-term consequences. Some areas of healthcare use a universal screening approach, all women are asked about domestic abuse by a health visitor or midwife, during pregnancy and when they have a young child.[44–46] In Wales, 'Ask and Act'[16] requires healthcare professionals to be trained to identify signs of domestic abuse in patients, ask about it and then act to offer support, referrals or other assistance. It is acknowledged that the wider working environment promotes good practice in identification of abuse; if the norm is to enquire and allow opportunity for disclosure it is easier for individual practitioners to enact this. Healthcare professionals need to be trained in domestic abuse and its recognition[43] in order that they are aware of the indicators of domestic abuse and understand how to respond.

How to discuss domestic abuse

- Create an environment that gives permission to disclose – visible posters including details of organisations that can offer support are part of this.[47,48]
- Provide a confidential space for discussion, create rapport, listen to your patient. If abuse is happening the victim may be reluctant to disclose if they feel that a healthcare professional identifies with their abuser. Try to be neutral and open, try not to rush discussion.
- Domestic abuse and coercive control may present subtly, and victims might not fit a stereotype held. Indicators may include frequent presentations or an inconsistent relationship with the health service, not arriving for appointments or repeated attendance with injuries, pain, headaches, genitourinary symptoms and psychological symptoms.[43]
- A victim may not want to disclose or may not know what is happening. It might help to remind them that they can talk to you at future appointments or discuss their life more widely if they wish to.
- Questioning about abuse should be sensitive but also direct, giving a potential victim opportunity to disclose if desired; always ask in a private and confidential space.
- Ask the victim when they are alone. An accompanying person may not be the abuser but may report back to the abuser.
- If needed a professional, trained interpreter should be used.[43,49]
- If a victim does disclose offer support, make sure that you know protocol for referrals and explain to the victim what can be done. A victim who has had agency removed by their abuser should not feel that professionals will also make choices on their behalf.
- If there is not a safeguarding or public interest concern and a victim refuses referrals then confidentiality should not be breached.[16] Refer to local policy about safeguarding referrals.
- Make sure that records are kept accurately.
- If abuse is not disclosed it does not mean it is not happening; support the patient and build the ongoing relationship if possible.

- Coercive control is particularly difficult to identify: methods of addressing this in healthcare are currently being investigated.[50]
- Dealing with difficult circumstances can be distressing. Professionals should be provided with the opportunity to be supported and discuss moral dilemmas to avoid moral distress.[51]

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Article

A review of barriers to optimal pain management in prehospital care

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Sage

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Background

Pain is a phenomenon encountered in every field of medicine. It is an 'unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage'.[1] Pain serves an essential survival role, yet there is inter-individual variability in the severity and character of pain following similar stimuli.[2] It is a complex, subjective experience that remains poorly understood.

Early studies of pain management in emergency settings indicated that approximately 54% of all patients seen by UK ambulance services experienced pain[3,4] with Entonox (nitrous oxide and oxygen) being the only analgesic carried by ambulance services. Despite increasing focus on pain syndromes, and pain relief being acknowledged as a human right in 2004,[5,6] there has been limited improvement since. Globally, 20%–50% of patients seen in prehospital care are in pain[7–9] increasing to 70% of trauma patients.[10] There is a 50%–90% prevalence of pain of any kind in patients presenting to emergency departments (EDs).[7,9,11,12] Perhaps more concerningly, 74% of patients who present with pain continue to experience moderate to severe pain at discharge.[13] The variation in these figures reflects the different countries represented and demonstrates the challenge of accurately assessing and recording pain in emergency healthcare.

Much research in prehospital pain management has focused on acute pain, particularly of traumatic origin. Acute pain is typically experienced for a limited time following a specific insult.[14,15] However, prehospital clinicians frequently encounter other types of pain. This review aims to outline the benefits of prehospital analgesia and the barriers to its administration, and compare pharmacological agents. The structure of prehospital care provision varies globally, but the focus here is on UK systems consisting of ambulance services staffed by paramedics with limited prescribing and administering capabilities and critical care services, mainly formed of doctor–paramedic teams, who carry a wider range of pharmacological agents.

Causes and prevalence of oligoanalgesia

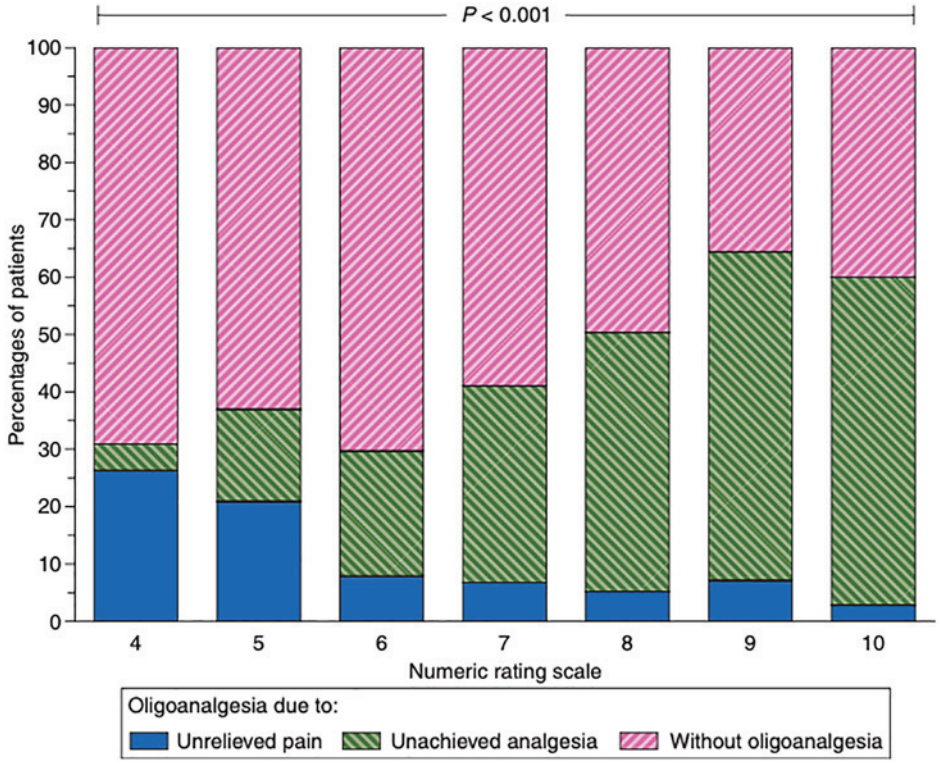
To treat pain in any setting, it must be accurately assessed, managed with appropriate pharmacological and non-pharmacological interventions, and reassessed regularly.[16] Oligoanalgesia is the undertreatment of pain, either caused by a complete lack of (unrelieved), or inadequate (unachieved) analgesia (Figure 1). In up to half of cases, pain is not assessed at all,[7] but when it is, oligoanalgesia occurs in 43% of adult and 85% of paediatric patients.[14,17] Elderly patients are another group more likely to experience oligoanalgesia.[3,18,19]

Prehospitally, the aim of analgesia is to reduce physiological and psychological distress and aid extrication, packaging and transport. Moreover, appropriate and timely analgesia can prevent the development of longer-term complications such as chronic pain, prolonged hospital admissions, poorer quality of life and psychological harm following illness or injury.[17] Managing acute pain does not always mean that patients are pain free but that their pain is reduced 'with minimal adverse effects while allowing them to maintain function' and this facilitates further assessment and management.[15]

Transport intervals and analgesia

One of the conflicts of prehospital care is that pain does not kill patients and so there is, and should be, a prioritisation of resuscitation and life-saving interventions. This often necessitates rapid transfer to hospital. However, patients experiencing non-traumatic pain or not requiring rapid transfer to hospital represent a significant proportion of encounters and yet are understudied and underserved. Many patients in pain, who would benefit from analgesia, are not in imminent danger

Figure 1. Causes of oligoanalgesia. The proportion of patients experiencing oligoanalgesia due to unrelieved pain (complete lack of analgesia) or unachieved (inadequate) analgesia by numeric rating scale (subjective pain rating) in a 10-year retrospective study of adult trauma patients. The burden due to unachieved analgesia increases with pain severity indicating that pain relief is administered but not sufficient to prevent oligoanalgesia.[17]



of dying. This is seen in data from one physician-led critical care service showing significantly higher rates of analgesia administration,[20] indicating that screening prior to dispatch and a higher threshold for attending predisposes a mind-set that patients will be unwell and thus in need of analgesia. For patients where rapid transport is a consideration, the belief that leaving as soon as possible will limit suffering is misplaced as transfer times are often longer than the time taken to initiate analgesia. One researcher argues that 'sometimes a few minutes' delay is a reasonable price to pay for earlier analgesia'.[20] A study of patients with lower extremity fractures found that when analgesia was initiated prehospitally, patients received pain relief a mean of 2 hours earlier than those treated in ED.[18] Among patients presenting directly to ED, there is an average time of 90 minutes from triage to administration of analgesia.[13] Administering prehospital analgesia increases the perceived acuity of patients by ED teams and increases the likelihood of analgesia being given once in hospital.[20]

The physiological effects of prehospital analgesia

Aside from suffering, pain induces changes in immune function, coagulation and haemodynamic stability which can worsen short- and long-term outcomes.[15,20,21] Adequate opioid pain relief following myocardial infarction reduces the incidence of arrhythmias.[4] Maintaining oxygenation and ventilation are a priority in prehospital care. Particularly for patients with abdominal or thoracic pathologies, pain can cause hypoventilation and in the subacute setting increases the risk of respiratory infections.[4,15] Analgesia in these cases facilitates respiration and improves oxygenation.[20] In traumatic brain injury (TBI), adequate analgesia can facilitate the prevention of

secondary brain injury by stabilising cardiorespiratory function, associated with improved outcomes.[22] The risks of analgesia must be weighed against the risks of non-treatment and consideration given to the effects of analgesia choice on physiology.[4] As with many things, the solution is not a 'one-size-fits-all' approach. One paper argues that 'not all head injuries are equal' and withholding analgesia from all patients with head injuries regardless of severity or other injuries has potentially damaging consequences.[20] These physiological benefits of pain relief are enhanced by early initiation in the prehospital setting but require care and clinical judgement.

The long-term psychological effects of prehospital analgesia

Long-term psychological effects often follow physical injury. Undertreated acute pain leads to pathological neural pathway formation which may develop into chronic pain disorders. Memories of painful events are more easily retrievable and shared neurobiological pathways, including central and peripheral sensitisation, and neuroendocrine and neuroplasticity circuits, exist between the experiencing of acute pain and encoding memories of a trauma.[6,21,23] These relationships are thought to impact the development of post-traumatic stress disorder (PTSD). Mechanisms which predispose individuals to reporting higher pain scores may also underlie an increased risk of PTSD.[24] Pain, trauma severity, tachycardia and acute stress disorder are peritraumatic risk factors with a significant influence on the likelihood of PTSD. Furthermore, experiencing pain lowers the threshold of subsequent painful experiences.[25] One study reported an increase of 0.5 standard deviations from the mean in self-reported pain within 48 hours of injury increased the odds of PTSD by a factor of five at 4 months and almost seven times at 8 months.[24] A single-point pain score following trauma offers an opportunity for early detection of those at risk of PTSD without psychological assessment or repeated monitoring.

In an observational study looking at the use of morphine in preventing the development of PTSD among military personnel following major trauma, morphine was associated with a reduced risk of PTSD (odds ratio 0.47; 95% confidence interval (CI): 0.34–0.66; $p < 0.001$). This effect remained significant after adjusting for injury severity, age, mechanism of injury, and other variables. The authors considered that optimal pain control and limitation of anxiety is not restricted to morphine.[26] These results suggest that adequate, appropriate, and swift analgesia following trauma impedes memory consolidation and reduces a conditioned response to fear helping prevent PTSD and other psychological complications.

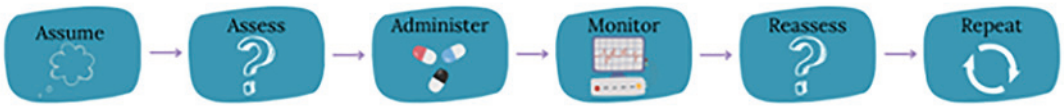
Barriers to prehospital analgesia

Patient, clinician, and environmental factors all influence whether analgesia is given, which agents are chosen and at what doses. It is often a combination of these which contributes to oligoanalgesia. The effect of environmental factors is not discussed here. Patient characteristics which increase the risk of oligoanalgesia include a higher initial pain rating, increased respiratory rate and a greater burden of injury. This may reflect clinicians prioritising critical interventions over pain relief and more severe pain being susceptible to attempted but unachieved analgesia (Figure 1).[17] Males tend to be at higher risk of oligoanalgesia following acute injury while females have a higher prevalence of undertreated chronic pain.[2,3,17] Other patient factors include: complex backgrounds, particularly relating to multimorbidity and age, lack of cooperation,[19] and decreased consciousness.[16]

Many patients are not aware that prehospital analgesia is available and even among those who do, 90% do not request analgesia.[20] This can be due to unfamiliar surroundings, confusion, vulnerability, and power dynamics.[3,17] Patients failing to request analgesia does not mean they are not in pain and should not be a factor in whether pain relief is given.[20] Cases of patients refusing analgesia are seldom recorded but may contribute to oligoanalgesia.[14] On the contrary, patients who do request analgesia also present challenges. Despite the risk of addiction following the administration of analgesics, particularly opioids, in acute settings being repeatedly disproven, clinician concerns about dependence persist. A 1973 study demonstrated physician concerns about addiction and misinformation about effective dosages and duration of action led to undertreatment, resulting in 32% of inpatients studied continuing to experience severe pain.[27] Attributing requests for pain relief to 'drug-seeking behaviour' contributes to oligoanalgesia but often stems from firsthand experience of individuals with drug misuse problems.[3,14] Discrepancies between patients' description of their pain and clinicians' assessment can provoke a sense of defensiveness and harm the therapeutic relationship. Individual responses to analgesia vary widely and clinicians frequently underestimate the doses required to alleviate pain.[17] Titrating to effect rather than administering standardised doses is associated with improved relief.[28]

Less-experienced clinicians are less likely to administer any analgesics at all and more likely to give lower doses if they do. They tend to overestimate the risk of analgesia and underestimate the harm of being in pain.[17,29] They are also less likely to have the capacity to reassess pain regularly as they focus on other tasks, are more uncertain and may be less accurate in assessing pain.[17,19] The other end of the experience scale is also at risk; prehospital clinicians witness

Figure 2. Visual representation of actions required to overcome barriers to pain assessment and management in the prehospital setting. Information from.[19]



pain regularly which can lead to desensitisation and a reduced ability to accurately estimate pain. Clinicians will almost always have 'seen worse'. Guidelines in the United States and Europe indicate that all patients with acute traumatic pain should be considered eligible for analgesia, regardless of transport interval.[15,16] Despite this, fostering a mind-set that assumes trauma patients will be in pain of sufficient severity to warrant medication is challenging, for the reasons outlined above.[20] Pain can be viewed as an inevitable feature of injury and disease, a view compounded by a lack of education about pain assessment and management in medical training. In one study, 48% of physicians and 24% of nurses deemed pain to be tolerable, and this was associated with the significance they placed on analgesia protocols.[30] Moreover, the transient nature of acute pain can itself be a barrier to treatment as clinicians believe that it will resolve with treatment of the underlying cause.[3,15] Medical training is centred around finding a diagnosis and initiating diagnosis-specific treatments, and this can neglect managing symptoms in the interim.[14] The development of safer, more effective analgesia will contribute to pain being viewed as reducible if not entirely avoidable. Using feedback to create environments where oligoanalgesia is taken as seriously as the overuse of pain relief, and clinicians are encouraged to learn rather than being reprimanded, will improve care.[17] Figure 2 provides a schematic of elements required to reduce oligoanalgesia in prehospital care.

It is a widely held view among both clinicians and the public that giving analgesia can compromise clinical assessment. One study found the main reason for withholding analgesia was the belief that localised pain assists in diagnosis.[30] In most cases, this has been disproved; patients with abdominal pain commonly have globalised guarding, and the administration of analgesics can relax patients and make eliciting specific signs more accurate.[20] In a study of surgical patients, the administration of analgesia had no significant impact on patients' ability to give informed consent. Furthermore, 36% of patients stated they would have asked more or different questions had they not been in pain.[31] This suggests that being in pain may have as much or more of an effect on the ability to give informed consent as analgesia.

The effect of analgesia on neurological assessment is one area which remains contentious. Discriminating components are vital even with the increased use of imaging. Opioids in particular can affect consciousness and pupillary responses.[4] However, there are no good quality data which indicate that short-acting, easily reversible agents utilised wisely results in missed diagnoses or that the administration of analgesia has a greater effect on clinical assessment than pain itself.[20] Concerns about consent, autonomy and accurate assessment are amplified when administering sedation, whether for the induction of anaesthesia or for the management of behavioural sequelae of illness and injury.[3]

In prehospital care, traumatic pain is more frequently addressed than pain of medical origin, particularly in severe pain. One study found that traumatic pain was treated in 25.3% of cases versus 17.7% of medical pain.[19] This may be because clinicians are more confident of the cause, and there are often other indicators of pain including bleeding and obvious fractures, whereas other types of pain rely more heavily on patient reporting.[2]

Methods of evaluating pain

A standard measure for evaluating and reassessing pain is needed to determine the requirements for, efficacy of, and adverse effects of interventions.[32,33]

Documenting pain scores improves the proportion of patients who receive pain relief. Patients should have their pain assessed using a reliable scale 'suitable for the patient's age, developmental stage and cognitive function' which responds sensitively to changes in pain following treatment.[20] The same assessment tool should continue to be used in the hospital setting.[34] Comparisons between validated assessment tools have been extensively studied elsewhere.[35] The Numeric Rating Scale (NRS) and Visual Analogue Scale (VAS) are commonly used for adults.[36] In children, the Wong-Baker FACES pain scale[37] and Face, Legs, Activity, Cry, Consolability Scale[38] can be used, depending on age and development.

Current guidelines and future directions

The prehospital environment is unpredictable, and every patient and every situation presents unique challenges. UK guidelines for major trauma indicate that following the assessment and stabilisation of respiratory, circulatory and neurological emergencies, pain management can be addressed.[34] Based on this stepwise approach, analgesia is rarely considered before circulation is assessed and intravenous access is established. One study estimates 10–20 minutes from the beginning of a clinical encounter, for paramedics to administer analgesia, to be feasible. Frequent reassessment (every 5 minutes) is recommended after the first dose of an analgesic agent.[16] In practice, this is difficult, and reassessment is only recorded in 24% of cases.[19]

Optimal analgesia is a spectrum encompassing 'physical, psychological and physiological' approaches.[33] This spans from minimising or removing the cause of pain when possible, and using non-pharmacological strategies such as heat/cold, good communication, reassurance and immobilisation, to pharmacological agents, and on to sedation and anaesthesia.[14] A combination is often required, and clinicians should be prepared to upscale and downscale their management in response to pain assessment and analgesic availability. Extensive research has been done into drugs which have potential as alternatives to, or in combination with, morphine. A full analysis is not performed here but some of the most commonly used are summarised in Table 1. The structure of prehospital care provision influences

Table 1. A summary of selected pharmacological analgesics available to UK ambulance or critical care services.

Pharmacological analgesic	Benefits	Limitations	References
Methoxyflurane	Patient controlled encouraging feelings of autonomy. Easy to administer. More rapid onset (4 mins) than intranasal fentanyl (11 mins) and intravenous morphine (5 mins). Statistically significant difference in pain relief versus placebo.	Adverse effects (mainly headache and dizziness). Dose-related nephrotoxicity. Additive depressant effect when used with other CNS depressants.	39,40–42
Fentanyl	Recommended for use in children. Multiple routes of administration.	May have more adverse effects than morphine. Slower onset of action than morphine.	32,41,43
Regional analgesia	Opioid sparing. Potential for increased use with prehospital ultrasound guidance. No impact on consciousness.	Contraindicated if repeated neurological assessment required or risk of compartment syndrome. Limited use for patients with polytrauma. Increase in on-scene time of 9.4 minutes for FICB versus standard care (P = 0.006). Training and skill maintenance can limit usefulness.	21,44
Ketamine	Limited adverse effects on cardiorespiratory function. Patient maintained airway and preservation of upper airway reflexes. Rapid onset of pain relief. Greater pain relief effect than morphine in some studies. May be more effective when used in combination with opioids than opioids alone.	Lack of high-quality data demonstrating benefit over morphine. Emergence phenomena.	32,43,45–47
Morphine	Widely used by UK ambulance services. Similar efficacy to ketamine.	Potential for cardiorespiratory depression.	43,45

which agents are recommended for different pain intensities.[19,20,32]

Unfortunately, no perfect agent exists, and options are particularly limited for prehospital teams. Medications should be effective, safe, free of serious side effects and any monitoring required must be available out of hospital.[33] Intravenous morphine is the strongest analgesic routinely available to UK paramedics. It is associated with adverse effects including nausea, respiratory depression, arrhythmia and excessive sedation, although the frequency of adverse effects may be disproportionate to the reluctance to administer.[45] Unavailability of intravenous/intraosseous (IV/IO) access is a contraindication and intranasal ketamine or diamorphine are alternatives; however, these are not available to paramedics, frequently resulting in oligoanalgesia.[16,34]

Conclusion

Prehospital medicine is an inherently demanding field with unique challenges. Decisions are frequently made under time pressure, with limited information and fewer opportunities to speak to colleagues. Despite the development of advanced emergency service vehicles and clinicians, adequate pain recognition and relief is not yet universal for a variety of reasons, some easier to address than others.

There are several limitations to this review. While the causes of pain in prehospital care are varied, this review has focused on traumatic pain. This has been more widely researched but may not reflect challenges around pain of other causes. Managing pain in children also requires a different approach: some of the articles included have incorporated paediatric populations but a separate analysis is not provided here.

In prehospital care and medicine more widely, striking a balance between doing no harm and preventing unnecessary suffering is challenging. The prevalence and variety of pain provides an opportunity for improved analgesia to have a substantial impact across patient populations, regardless of demographics and disease course. Prehospital analgesia not only offers symptomatic relief but reduces physiological and psychological complications. Tackling barriers and biases combined with the availability of safe and effective drugs will foster progress towards care where no patient is in pain. While this is by no means a comprehensive review of existing literature on the safety and efficacy of analgesic agents available, it is evident that pain relief should be a routine and fundamental part of excellent prehospital care.

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Article

The development of pain medicine as a sub-specialty of anaesthesia: a personal perspective

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

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Sage

Tim Nash *Retired Consultant, Liverpool and Trustee Pain Relief Foundation*

I had suffered from intermittent sciatica over the years, starting in my pre-registration house jobs in 1969. I had been offered surgery, which I declined, so it came as a surprise to find myself doing epidural steroid injections for patients with sciatica 3 months into my first Senior House Officer (SHO) post in anaesthesia in Basingstoke in 1972. I would have leapt at the chance to have one when first afflicted! After obtaining Primary FFARCS, I did an ITU job in Derby. My ears pricked up with interest one day when I heard my boss Brian Kay discussing Pain Clinics with the Senior Registrar.

My next post was back at my alma mater, UCH (University College Hospital London), starting as SHO then becoming a registrar. I was able to occasionally attend the Pain Multidisciplinary Meetings, with Professor Pat Wall, a neurologist, and an anaesthetist, Dr Peter Verrill. Dr Verrill asked me to perform barbotage on one patient discussed in the meeting. This involved withdrawing 20 mL of cerebrospinal fluid via lumbar puncture then re-injecting it forcibly and repeating this several times.

On my East Anglia Senior Registrar Rotation, starting in Bury St. Edmunds and Newmarket, Brian Stead in Newmarket realised my interest in Pain Medicine and suggested I should arrange to visit Mark Mehta at the Norfolk and Norwich Hospital on a day release basis to get some Pain Medicine experience. He told me to present this to my supervisors as a 'fait accompli'. So Friday afternoons I drove up to the Norfolk and Norwich. This was disallowed during my neurosurgical anaesthetic rotation at Addenbrookes – there was a definite view among a number of colleagues that anaesthetists should give anaesthetics, and should not be doing pain work. My first attendance at the annual meeting of the Intractable Pain Society (IPS) was in 1975.

I was fortunate to be appointed to Basingstoke District Hospital in 1976 as a Consultant Anaesthetist with an interest in ITU, obstetric anaesthesia, and Pain, initially half a session per week of Pain, rapidly increasing over the years to four and a half sessions. My first 3 months I was allowed to complete my own pre-arranged programme, 2 months at Alder Hey for paediatric anaesthetic experience, with day release for further Pain Experience to Sam Lipton at The Walton Centre, Mark Swerdlow at Salford and Dinge Riding at Liverpool Royal. The final month included visits to St Christopher's Hospice, London and Robert Twycross at Michael Sobell House for Hospice Care, John Lloyd at Abingdon and James Burn in Southampton for further Pain experience. That was my training in Pain Medicine, all of which was obtained by my own initiative and persuasiveness. I was fortunate that the first Senior Registrar in my time in Basingstoke, Jill Hurley, developed an interest in Pain Medicine, so within a couple of years she joined the Anaesthetic Department as a colleague, and promptly took on one, then two sessions in Pain alongside me. Other Senior

Registrars included Peter Rogers (Portsmouth) and Hamish Hutchinson (Pembury).

IPS reached a membership of 100 when I joined in 1976, and the elders of the Society saw me as the first consultant to be appointed with a recognised designated session in pain treatment. At that time IPS was effectively the only source of further education in Pain Medicine, with its annual meetings. Being relatively small, and priding itself on being a friendly society, it was easy to discuss clinical and organisational problems with other members. Most were fitting in nerve blocks around theatre lists. I avidly signed up to any pain meeting organised in the country at that time, and slowly developed my own pain library. I became the Assistant Secretary of IPS in 1982, with Gordon Taylor as Secretary, and John Lloyd as President, followed by Hugh Raftery. I became Secretary in 1985, with Keith Budd following Hugh Raftery. As Assistant Secretary my primary remit was to start a newsletter. Keith Budd, the Secretary who preceded Gordon, introduced me to Mike Ridley of Reckitt and Colman, developers and producers of Temgesic (buprenorphine), and together we developed IPS Forum, funded by Reckitt and Colman. The first issue was published in 1983 and Mark Swerdlow gave a very fine account of the Society's early years, published in the first three copies of IPS Forum. Andrew Diamond followed me as Assistant Secretary and editor of IPS Forum, changing its format to IPS Forum – the Journal of the Intractable Pain Society. It has since developed into both the *British Journal of Pain* and *Pain News*, serving the needs of an academic journal and a separate lower key platform for news and discussion. I later edited *Pain Bulletin*, a drug-funded newsletter-style review of recent Pain Science publications, and also was the Assistant Editor of the *Pain Clinic Journal*, handling the European and Asian submissions. I served on Council for 15 of the 16 years between 1982 and 1998 as Assistant Secretary, Secretary, council member, President Elect, President and Immediate Past President. The Presidents I served under were John Lloyd, Hugh Raftery, Keith Budd, Ken Hardy, Andrew Diamond, myself and Ed Charlton.

On my appointment to Basingstoke, I was made the Tutor of the Faculty of Anaesthetists of the Royal College of Surgeons. I actively gave anaesthetic tutorials throughout my time. Years later, as the Mersey Regional Advisor for Pain Medicine of the Royal College of Anaesthetists, I was enormously gratified to meet many of my former Basingstoke trainees at the Annual Assembly of Royal College Tutors, thanking me for my teaching. One, Debbie Nolan, who had become a Vice President of the College, reminded me that I had 'kicked arse' when she was having difficulty getting the exams and was close to giving up, and my breakfast tutorials helped her get the exams at the next sitting. I also initiated the Wessex Pain Group, and tried to set up a funded Senior Registrar position in Pain Medicine, obtaining over half the money for this. John Norman, Professor of Anaesthetics, Southampton, intervened and started a regular rotation of Senior Registrars to be with me, specifically in the Pain Clinic. After I had resigned, before moving to Liverpool, I was invited to the inaugural meeting of the Faculty of the Wessex School of Anaesthesia.

In 1984, I presented a paper based on the then IPS' Committee discussions on the training requirements for specialising in Pain Medicine to the annual Assembly of Tutors of the Faculty of Anaesthetists of the Royal College of Surgeons. While Secretary of IPS I was involved in discussions with the last Dean of the Faculty, Aileen Adams (my old boss at Addenbrooke's). The Faculty of Anaesthetists were at the cusp of founding their own college, now the Royal College of Anaesthetists. Intensive Care had posed problems for the new College, who had to collaborate with the Royal College of Physicians, so the College progressed the idea slowly, fearful of similar complications, but eventually in 1993, they recognised Pain Medicine as a specialty within Anaesthesia, and 1996 saw us granted our own accreditation, and eventually the Faculty of Pain Medicine came into being. Doug Justins had worked hard on the Board of the College to enable this, and he rightfully became the first Dean of the Faculty of Pain Medicine of the Royal College of Anaesthetists. It was a very proud moment to join the first meeting of the Founding Fellows of the Faculty of Pain Medicine of the Royal College of Anaesthetists, and then to find myself the first Mersey Regional Adviser for Pain Medicine. While secretary, with Keith Budd as President, we approved three national courses on Pain Medicine, that run by the Pain and Nociception Group course in London on basic science, the Oxford Course on Clinical Science, and the Liverpool Course with clinical teaching in a clinical setting. While on the Council of IPS, I was made Audit Lead; this led to a survey of workloads in clinics throughout the United Kingdom, and also being Chairman of the Pain Medicine Working Group of the Read Codes, ensuring all the Taxonomy of the International Association for the Study of Pain (IASP) was coded into the Read Codes Lexicon. This was work with the NHS Information Management and Technology Strategy. Through this I was given a funded research Registrar, Cathy Stannard, who became a Consultant at Frenchay, joined me from Cambridge to do all the hard work collating the codes. She also later became editor of *Pain News*, and prominent on Council of the Society.

During my time on Council, it became clear that there was much to be gained by broadening our membership. Our constitution was changed in 1988 to include other health disciplines, and we were then able to merge with IASP, and

then changed our name to become the Pain Society, depicting that we had been the first such group, and then the British Pain Society. We also developed our Coat of Arms, designed by Charles Gaucci. It was my honour to go to the College of Arms and receive our Arms from the Norroy and Ulster King of Arms. We also strove to be recognised by the Department of Health. John Hangartner of the Department visited the Officers of the Society to discuss this issue. He was keen to obtain an idea of Pain Clinic activity. I had been collecting data in my clinic, so was able to send him regular monthly updates of my own activity. I learnt that the best information he had on Pain Clinic activity came from my returns from Basingstoke, and in 1988 we had a code that the coding department in the hospitals could use to record activity. This progressed to us receiving our own Korner Specialty code in 1997, my last presidential year, with mandated information collected for central returns to the Department of Health on inpatient activity. At this time, the Working Party of the Clinical Standards Advisory Group submitted a report on pain services, and the Audit Commission started looking at Anaesthetic Services in toto, including Pain Medicine. During my Presidential term, the Standing Medical Advisory Committee, who directly advise the Chief Medical Officer, selected our submission relating to changes in medical practice, *increasing spread of proven chronic pain management techniques to acute hospitals from specialist centres, necessitating resources to train clinicians and set up and run services* in its short list for detailed investigation. We also began to influence the NHS Research and Development assessment with regular submissions appearing in calls from them for research applications on our submitted topics.

I performed an international questionnaire survey of chapters of the IASP to see how other countries' training measured up to the Standards for Training of IASP, which led to me chairing the Working Party on Education and Standards of the European Federation of Chapters of IASP.

When I moved to Liverpool, in the middle of all this activity and having just taken on the presidency, I became Honorary Director of Pain Studies and Honorary Senior Lecturer within the Department of Neuroscience of the Medical School. I added aspects of pain and its management into the clinical scenarios of the new Liverpool problem-based learning course while editing the first study guide for their second clinical phase. I also encouraged and facilitated the development of special study modules in Pain Medicine around the Mersey Region. I became a member of the Admissions Group for the Medical School.

I sought out the Palliative Care Physician, Ged Corcoran, at the University Hospital, Aintree and we started a weekly joint ward round of his patients with pain from Cancer. He supported my application to Macmillan Cancer Support for funding of a Clinical Fellow in Pain Medicine. This was successful, and was one of the first year-long out of rotation training fellowships fully recognised by the College for Anaesthetic Senior Registrar training. I met the College Regional Advisor for Anaesthetic training, Raymond Ahearn, and was invited to join the regular meetings of the Mersey Anaesthetic Tutors, and later the Liverpool School of Anaesthesia. Training in the Pain Unit was very disjointed, but I soon found the School was placing registrars with us on a regular basis. We also had a number of visiting doctors, particularly from abroad. This needed regularising for them to get maximum benefit from their visit. Short-term honorary observer contracts were easy to arrange, but to maximise benefit from longer stays, I set up honorary clinical fellowships, requiring them to pass the Professional and Linguistics Assessment Board test and obtain General Medical Council registration prior to their visit. I was also deeply involved in the Liverpool Clinical Management of Chronic Pain Course, and lectured to the Liverpool Medical Students and on the Liverpool Anaesthetic Course, and participated as an examiner for MBBCh finals, and mock vivas and OSCEs on the Liverpool Anaesthetic Course.

This involvement in the development of Pain Medicine as a recognised specialty within Anaesthesia, and in education, meant it was quite natural to think to the future and how medical students might be influenced to take an interest in Pain Medicine. I therefore requested the Pain Relief Foundation (PRF) to fund an annual medical student essay competition.

PRF Student Essay Prize

At my s, the PRF started an annual medical student essay competition, in the late 1990s, I think. My hope was to increase the profile of Pain Medicine within the profession, and to stimulate interest as early as possible in people's careers.

The annual essay competition was originally advertised in all the Medical Schools in the United Kingdom, with the winner being invited to Liverpool, expenses paid, to present their essay to one of our weekly educational meetings, and to be presented with their monetary prize. The essays were judged by a panel of Consultants from The Walton Centre for Neurology and Neurosurgery Pain Service. After I retired in 2006, it became clear that there was a need to expand the competition to include other health groups, and the running of the competition was taken over by the chair of the PRF Education Committee.

The competition is for an essay on an aspect of chronic pain of up to 3,000 words and is now open to Medical, Physiotherapy, Nursing, Occupational Therapy and Clinical Psychology Students. There are three first prizes of £500, and three second prizes of £100. The winning essays are all presented at one of the PRF and The Walton Centre Clinical Pain Multidisciplinary Team education meetings, and put up on the PRF website. The competition is advertised in all UK medical schools, Universities and hospital intranets, on the PRF website, and on social media. The students initially submit an abstract of their essay, which is assessed by three judges from the Education Committee, and if successful they are invited to submit their full essay. The essays are distributed again between the judges, who select their top choices, and the chair of the committee then makes the final selection.

We have become impressed by the standard of submissions and especially the winners, and last year's winning entries are published below.

Article

Chronicles from family medicine: 2009 Brian the pothead

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Dr Steve Johnson

I know some general practitioners (GPs) who have a black and white view of their role (and other aspects of their life) but, in my experience, most are pragmatists and comfortable living with a bit of moral uncertainty. And if we take our role as patient advocates seriously, then we are going to have to be prepared to swim in some murky moral waters.

'*Brian Saunders*'. I called over the tannoy. A gaunt, pale man with greasy hair entered the room. He was in his early forties and wore an unironed T-shirt, which had once been white. He had a round-shouldered stoop and a small pot-belly. He smiled a friendly smile which revealed heavily nicotine-stained teeth.

'*I wonder if you would be prepared to write a note for me, Doctor? Explaining I use cannabis for . . . medicinal reasons.*'

I nodded, trying to appear receptive, but noncommittal.

Brian was polite and genial. I knew he was unmarried, and I had been providing him with sick notes for the DSS for years. He owned a three-bedroomed semi on a small estate in one of the nicer parts of Canterford. He moved stiffly as a result of the ankylosing spondylitis he suffered from, for which we prescribed a hefty dose of daily Indometacin.

'*You see, Doctor, I've been charged with possession and intent to supply; my solicitor thinks a letter from you will help.*'

'*Help to . . .?*'

'*Help to reduce the charge to possession for personal use.*'

'*You mean you were caught with a large amount?*'

He nodded; a slow, noncommittal nod.

I started to write the letter, dictating as I wrote so that he knew what I was saying. Over the years I have found that by agreeing to help and starting the process I am more likely to get to the truth.

'Mr Saunders suffers from Ankylosing Spondylitis, a lifelong incurable condition affecting the joints in the spine and limbs'. I wrote. 'In middle age the joints begin to seize and the sufferer becomes progressively more immobile; this in addition to the constant pain they experience. Mr Saunders has been unable to work for many years and has been prescribed daily doses of strong painkillers which have proved insufficient to control his pain. He has found that by supplementing his prescribed pain killers with cannabis he can improve the pain relief'. I looked up. He was smiling and nodding approvingly.

'In order to achieve a tolerable level of pain relief he needs to use . . .' I looked up. '*So, how much do you use?*'

'*About 100 g per month.*'

I did the sums.

'. . . about 3-4 g per day of cannabis.' I wrote.

'*And how much were you in possession of when the police arrested you?*'

'*A hundred and twenty plants. They raided my house.*'

'*Oh! . . . So you were growing them?*'

He nodded.

I added no more to the letter, other than the usual formalities, pressed print and then handed it to him.

'*Thanks, Dr J. How much do I owe you?*'

'*Nothing. I am not going to charge you for this.*'

Dear reader, GPs vary widely on how they respond to requests such as this. Some will beat the moral drum and refuse point blank, while others are prepared to try and tread a path through the shifting sands of morality. I'll leave you to guess why I did not charge him, and it has nothing to do with altruism or generosity.

One of the receptionists, Hilary, who regularly scans the Canterford Chronicle for gossip and tidbits on Factory Lane Surgery patients, handed me an article a few months later.

'*Isn't Mr Saunders one of our patients? Turns out he's a bit of a pothead.*'

I took the article from her. 'Canterford man charged with Cannabis possession receives hefty fine'.

'*Five hundred pounds. That's a lot of money.*' Hilary said, '*He doesn't work, does he? He's going to struggle to afford that.*'

I nodded noncommittally. *

The average plant yields 600–700 g of cannabis. A 'heavy' cannabis user will smoke more than 3.5 g daily. Possession of cannabis carries a maximum sentence of 5 years imprisonment. If there is a medical reason for use, the sentences can be much less severe, ranging from a caution to a fine (the size dependent on income). Possession with intent to supply is much more likely to result in a custodial sentence, as is being charged with cultivating cannabis plants.

Article

Chronicles from Family Medicine: a most unnatural death

THE BRITISH PAIN SOCIETY
EXPERTISE WHERE IT MATTERS

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Sage

Dr Steve Johnson

On the TV, the coroner is often depicted walking around the scene of an unnatural or suspicious death, peering at the body and directing the gathering of evidence. Or they are seen impatiently drumming their fingers, waiting for the body to be delivered to the mortuary, itching to get started on the post-mortem. Is this what their working life is really like? Or is the coroner just another overworked professional, trying their best to do their job while juggling conflicting demands and scant resources? I don't know, but I assume the latter. Two memorable experiences support my view.

During a morning surgery approximately 20 years ago, I received a panicked call by neighbours of a reclusive elderly lady, Edith Whitehall. The neighbours had called round to her house to hand over some misdelivered post and got no answer – peering through the murky window, they could see her on the floor near the fireplace. I sped up to her house. She lived in a development of prefabricated bungalows on the North Downs. Although the development was just off a major trunk road and consisted of over 100 houses, it managed to feel remote as the access roads were unmade and there were no shops or amenities nearby (other than a petrol station on the trunk road). The original prefab bungalows had been erected just after World War 2. They were on large plots, and most had been knocked down and replaced with bigger, more modern and more substantial dwellings of wildly varying design. Edith's small bungalow was original. The drive was grass; the single garage was wooden and collapsing. The garden was overgrown, and the outside of the house looked as if it had not been painted or received any maintenance for decades. I met the neighbours outside. They hadn't gone inside, as they were afraid of what they might find. The back door was unlocked, so I ventured in. Edith's sole means of heating the house was a fire in the living room. The metal structure surrounding the fire grate had a decorative spike at each of the corners. Edith was lying on her side with one of the spikes of the grate-surround impaling her skull from temple to temple, and a large pool of dark congealed blood had spread out onto the surrounding hearth rug. I quickly backed out, told the neighbours not to enter or touch anything and called the police. The police arrived and took over. I was asked to pronounce death and left shortly after, assuming that would be the end of my involvement. A few days later, one of the receptionists handed me a message from the coroner's officer asking if I would like to issue a death certificate for the lady. Surely not? I was straight back on the phone.

'The police at the scene found that there were no suspicious circumstances, Doctor', said the polite female coroners officer.

'*The door was unlocked. Anyone could have entered and . . . I don't know; pushed her over?*'

'*There was no sign of a struggle, Doctor. And no indication that anything was stolen.*'

'*No struggle! She was 89 years old and about 5 stone. A puff of wind could have done it.*' My brain ticked over slowly and the penny dropped. '*So, do you mean there hasn't been a post-mortem?*' I said incredulously

'*No, Doctor. No PM. The coroner deemed it unnecessary. He has asked that, as she was your patient, perhaps you could venture a cause of death and issue a certificate? Please let us know what you intend to say before you issue and, if the coroner agrees, we'll proceed*'.

I went back to Edith's notes. Neither I nor any other health professional had seen the lady for years, and she had no recorded health problems other than a hysterectomy 40 years ago, so whatever cause of death I came up with was going to be pure conjecture. I rang the coroner's office again. I could hear my wife's voice in my head, '*Easy with the sarcasm, Steve*'. It was no good.

'*What about 'Impaled by spike?*'

The coroner's officer was unfazed. '*No, Doctor. The coroner wouldn't accept that.*'

'*Brain injury following fall?*'

'*Umm*,' The hesitation told me that was also a no.

'*OK then . . . Give me a clue.*'

'*I can't do that, Doctor.*' She made me feel like she was humouring a silly child, but this time I didn't reply and let the

silence hang for a while. She folded first. '*The coroner was thinking that maybe there was some natural event that caused her to collapse and fall onto the spike?*'

'*Stroke?*' I ventured. I could feel the '*Finally, he gets it*' vibes down the phone.

'*Yes, I am sure the coroner would be happy with that. Could you say "Cerebrovascular Accident" instead of stroke, as that is the preferred term?*'

And so the certificate was issued. I guess other doctors might have dug their heels in and refused to issue a certificate on the basis that, if the case was reopened in the future and the lady found not to have died of natural causes, the doctor issuing the certificate would be in a sticky position professionally. But I'm a pragmatist and believe we all have to compromise to get the job done.

Fast forward to summer 2020. In the middle of the COVID pandemic, I got a polite message from the coroner's officer inviting me to issue a death certificate for a widower in his 70s whose dead body had been discovered that morning by his daughter when she called to check on him. She had spoken to him the night before on the phone, and he had said he was going to bed early because he had a bit of a cough. Neither I, nor any health professional, had seen or spoken to him for over 12 months. I was on the phone to the coroner's officer straight away. We got through the preliminaries, no suspicious circumstances and no, there was not going to be a post-mortem.

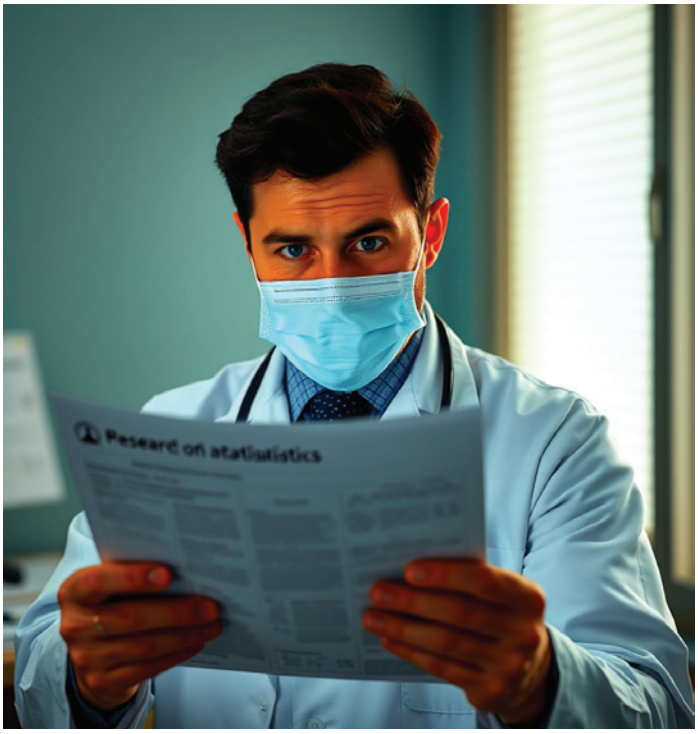
'*What does the coroner propose I declare as the cause of death?*' You have grasped by now that the game is that I come with something suitably apt and the coroner endorses it, but this time, I felt less inclined to dance to that tune.

'*The coroner respectfully suggests you might state "Coronavirus infection" as the cause of death.*'

At the time, the Office for National Statistics was producing figures for deaths by COVID broken down by age, sex, region and place of death. The criteria for inclusion in the statistics were mentioned of COVID on the death certificate.

Of course, I issued the certificate; it would have been churlish not to. These experiences have left me with two lasting impressions:

1. I never assume to know what another medical colleague's job is really like.
2. I don't trust statistics.



Article

Chronicles from Family Medicine: A Doctor's letter

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EXPERTISE WHERE IT MATTERS

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Sage

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Never underestimate the power of a Doctor's letter. Over the years, I have learned that a concise, factual, carefully worded letter that makes a clear point can achieve surprising results.

Finn and Carl Stewart were brothers, 2 years apart in age. Both had left school with no qualifications at 16, having grown up on a council estate in Canterford. They were the sons of Frank and Barbara. Frank was a hopeless alcoholic, signed off sick since his 30s and miraculously still alive at 60, and Barbara was a hard-working, no-nonsense dynamo of a woman who worked 50+ hours a week in two jobs and kept the family above water and the house spick and span. Finn and Carl were both in their early 30s and both married with no children and both had council houses on the same estate as their parents, but other than that they could not have been more different. While Finn got up at 4 a.m. to start the first of his three cleaning jobs, Carl would be in bed until midday, unable to rise earlier because of the migraines that prevented him from working or from doing any household chores. Or, at least, this is what he told me when he came every 3 months for his certificate and a top-up of the three different anti-migraine drugs he took daily along with the codeine-based pain-killers that 'just took the edge off' the headaches.

At the surgery we employed a cleaner who would come in as the surgery was closing at 6 p.m. and clean the building. The cleaner was employed for 3 hours daily and would lock up and set the alarm after finishing. Over the years we employed various people; generally they would start in a blaze of glory and then gradually the thoroughness and attention to detail would slip and the time they finished would get earlier, and eventually we would give them notice and look for someone else. The current cleaner was a middle-aged lady who lived on one of the council estates in Canterford. Early on she asked if her husband could occasionally help her – we agreed, and for a while they came as a pair. Then he started coming without her and we only saw her occasionally. They did a good job so we didn't question the unusual arrangement.

I was surprised one day to receive a letter from the benefits agency telling me that Carl Stewart had been interviewed and examined by their independent assessors and found to be fit for work. His benefits had been stopped and I no longer needed to provide a certificate. The next day, in an emergency appointment, he stood before me, agitated and upset:

'It was my neighbour what shopped me to the DSS. She took photographs of me from her upstairs back window'.

'Photographs of what?'

'My back fence blew down in the winds. I had to repair it so the dog can't get out'.

'Sounds reasonable', I said. *'Why would the DSS be interested in that?'*

'I had to dig out the old fence posts and concrete in the new ones. She took photos of me mixing cement and wheelbarrowing it across the garden'.

'Ahh', I said. *'What will you do?'*

'I want you to write to the DSS and tell them I'm not fit to work. Damn near killed me doing all that'.

'But they've assessed you as fit to work. Their decision is final'. I gave a sympathetic smile but inside I was privately smirking, thinking he'd finally got his comeuppance.

'My neighbour. The one what shopped me. She's your fucking cleaner, Dr J. How did she know I was on the sick and what was wrong with me?'

Old Man with a Stick Vincent van Gogh 1882.

Luckily for us, Carl was more upset about his money being stopped than angry that his confidentiality had been breached. I told him that this was a wrong that was on the surgery and that it was my responsibility to put it right. He accepted that and left.

The practice manager phoned the cleaner and requested that both she and her husband be there at 6p.m., and when they arrived, we confronted them. In the early noughties, we were still mainly using paper notes and it was surgery policy that all patient details were kept under lock and key at all times that they were not in use. All staff, including the cleaners, sign a confidentiality agreement which states that breaching patient confidentiality could lead to summary dismissal. But the cleaner had clearly worked out where
the key to the filing cabinets containing the patient notes was kept. To be honest, that would not have been difficult for her.

I had never sacked anyone before and so I was very nervous. The practice manager and I explained to the cleaner and her husband that we knew that they had looked at Carl's notes and that this was a breach of the confidentiality agreement they had signed. The cleaner flatly denied everything.

'Anyroads, 'e's a lazy, sponging piece of shit 'an' 'e's never done a day's work in 'is life. I see 'im creeping up the road in the afternoon to take 'is mutt for its walk, letting it do its business wherever it wants an' not cleaning up after it.' There was spittle at the corner of her mouth. *'I found its business in my front garden. It's disgusting'.* She looked me in the eye and said, teasingly. '*An' I never looked in 'is records. If you don't believe me, prove it'.* Her husband sat silently through all of this but I could tell from his increasingly worried expression that he did not share his wife's certainty of her innocence.

'We don't need to prove anything because we know you did it'. I said evenly, now confident that we were on firm ground. '*The only course of action available to us is to terminate your employment'.* I stopped to give that time to sink in and the cleaner echoed back my words in a mocking, sing-song voice.

'*Terminate my employment . . . Only course of action available. Oh, what big words he uses*'.

I ploughed on regardless. *'And you need to give us all of your sets of keys, take anything that is yours and leave the building. We'll send you a cheque for the balance of your wages, including tonight's hours, in the post'.*

They left with her shouting threats about suing us and seeing us in court. We never heard from them again.

Then I set about writing a letter to the DSS stating that Carl's neighbour was an unreliable witness who had shopped him out of maliciousness after using her position as our employee to deceptively gain sight of his medical notes. I was surprised and greatly relieved when the DSS reinstated Carl's benefits with back pay and we returned to the three-monthly consultations where I provided a sick note and anti-migraine medication. At these consultations, I would be showered with compliments and praise because, in Carl's eyes, I was now England's top GP and possibly his best friend because I had gone to such lengths to get his sick pay reinstated. Outwardly I smiled, while inwardly I squirmed.