MARCH 2016 VOLUME 14 ISSUE 1

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

Social media for professionals in Pain Medicine

Impact of dysmenorrhea

The diagnosis – shades of grey

The tyranny of hidden waiting list

ISSN 2050–4497

THE BRITISH PAIN SOCIETY

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

Third Floor Churchill House
35 Red Lion Square
London WC1R 4SG United Kingdom
Tel: +44 (0)20 7269 7840
Fax: +44 (0)20 7831 0859
Email info@britishpainsociety.org
www.britishpainsociety.org

A company registered in England and Wales and limited by guarantee. Registered No. 5021381. Registered Charity No. 1103260. A charity registered in Scotland No. SC039583.

contents

Regulars

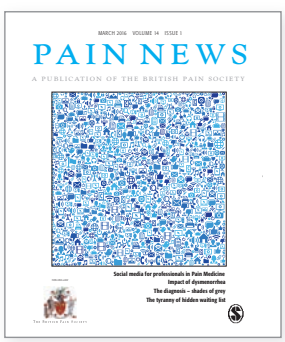
News

Professional perspectives - Margaret Dunham, Associate Editor

Informing practice - Christina Liossi, Associate Editor

End stuff - Ethel Hili, Associate Editor

PAIN NEWS is published quarterly. Circulation 1600. For information on advertising please contact
Neil Chesher, SAGE Publications,
1 Oliver's Yard, 55 City Road,
London EC1Y 1SP, UK.
Tel: +44 (0)20 7324 8601;
Email: advertising@sagepub.co.uk



The Editor welcomes contributions including letters, short clinical reports and news of interest to members, including notice of meetings.
Next submission deadline : 31 March 2016

Material should be sent to:

Dr Arasu Rayen
PAIN NEWS Editor
The British Pain Society
Third Floor Churchill House
35 Red Lion Square
London WC1R 4SG United Kingdom
Email pns.rayen@gmail.com

ISSN 2050-4497 (Print)
ISSN 2050-4500 (Online)
Printed by Page Bros., Norwich, UK

At SAGE we take sustainability seriously. We print most of our products in the UK. These are produced using FSC papers and boards. We undertake an annual audit on materials used to ensure that we monitor our sustainability in what we are doing. When we print overseas, we ensure that sustainable papers are used, as measured by the Egmont grading system.

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

British Pain Society Calendar of Events

To attend any of the below events, simply book online at:
www.britishpainsociety.org/mediacentre/events/

THE BRITISH PAIN SOCIETY

2016

Annual Scientific Meeting
Tuesday 10th – Thursday 12th May 2016
Harrogate

The multidisciplinary nature of the Society's is pivotal to the continuing success of its Annual Scientific Meeting, which has attracted an average of over 600 healthcare professionals to its previous five Meetings. This multidisciplinary nature is reflected throughout the scientific programme, with lecture, workshop and seminar topics chosen specifically to be of interest to all participants, whatever their specialty. Further information can be found on: **https://www.britishpainsociety.org/2016-asm/**

The Power of the Mind in Pain
Philosophy & Ethics SIG Annual Meeting
27th to 30th June 2016
Rydall Hall, Cumbria

This meeting promises to be a most stimulating conference considering the power of the human mind in pain. There will be a number of speakers looking at a wide range of subjects including spirituality, hypnosis, healing, the placebo effect and other mind-body connections.
It will be held at Rydal Hall near Ambleside in the Lake District and during the conference there will be time to explore the gardens and grounds of the hall as well as the beautiful surrounding lakes and hills.

Pain in Children Study Day
13th July 2016
Churchill House, London

Interventional Pain Medicine SIG Annual Meeting
16th September 2016
Manchester Airport

Patient Liaison Committee Annual Seminar
3rd November 2016
Churchill House, London

Headache SIG Annual Meeting
16th November 2016
Churchill House, London

Further details for all our meetings can be found on our events listing page:
www.britishpainsociety.org/mediacentre/events/

Editorial

The British Pain Society

Pain News
2016, Vol 14(1) 5

SAGE

Dr Arasu Rayen *Editor*
pns.rayen@gmail.com

Recently, after my consultation, myself and one of my patients were discussing about advancement in technology and how much the technology has changed the world, especially in the field of communication. He told me that in 1970s, if he wanted to talk to family members abroad, he had to book a long distance call at the Post Office at a particular time. Fast-forward 30 years, you can Skype or Facetime from anywhere in the world to anyone of your nearest and dearest. So many VOIP (Voice over Internet Protocol) apps, instant messaging, social media and video chat apps are available at our disposal on our smartphones. These not only help us to keep in touch with our nearest and dearest but they are also great for anyone to propagate ideas, news, information and so on instantaneously across the world. This unique property is so useful in our professional life. In this issue of *Pain News*, Damien Smith, Stephen Humble and Arun Bhaskar are elaborating for us professionals in Pain Medicine, on the importance of keeping up with the explosion of the social media phenomenon. They provide us with a simple introduction to social media and Twitter. Please read this interesting article. They are planning to write at least two more articles in future on this subject, so watch this space.

As ever, this edition of *Pain News* is packed with lot of news items, articles on professional perspectives and informing practice. There are three articles on Paediatric Pain Management – a news item on the Paediatric Pain Symposium, an article by Thanthullu Vasu on their Paediatric Pain Service and another article by Matthew Jay on the Paediatric Chronic Pain Network (Informing Practice). They are not only useful for everyone who deals with paediatric pain, but also for anyone of us. There are three articles on tyranny of diagnosis in the Professional Perspectives section (which are transcripts of the talk given at the Philosophy & Ethics Special Interest Group (SIG) meeting). They are interesting and thought provoking.

Although I am writing this editorial in January, by the time you read this, we must be very close to the change of season. Winter is fading away (hopefully!). Spring is on the horizon and the time to move your clocks forward is just a few weeks away. Similar to the seasons, we are having change in the British Pain Society (BPS) as well. In May, William Campbell, who has been our President for the past 3 years, will be stepping down, and Andrew Baranowski will be taking over the helm of BPS. The President's message in this issue of *Pain News* will be William's last one. He has been steering the BPS through difficult times. He was always very supportive of *Pain News*, the editorial board and its autonomy. I thank him wholeheartedly for this and wish him well.

Professional perspectives

Social media for professionals in Pain Medicine – an introduction and Twitter

Damien Smith *Consultant, Pain Medicine & Anaesthesia, Hillingdon NHS Foundation Trust, Middlesex; @thepaindoctoruk*

Stephen Humble *Consultant, Pain Medicine & Anaesthesia, Charing Cross Hospital, Imperial College Healthcare NHS Trust, London; @kafkesque787*

Arun Bhaskar *Consultant, Pain Medicine & Anaesthesia; Chair, Communications Committee; Elected Council Member, British Pain Society; @DrArunBhaskar*

The British Pain Society

Pain News
2016, Vol 14(1) 24–27

SAGE

Social media, noun:

Websites and applications that enable users to create and share content or to participate in social networking.

Social networking, noun:

The use of dedicated websites and applications to interact with other users, or to find people with similar interests to one's own. (*Google* definitions)

Introduction

When we see or hear phrases like social media or social networking, applications such as Twitter, Facebook and Instagram might come to mind for most of us. But for millennia, we have found effective ways to interact with others who have similar interests to our own across vast distances. Therefore, social media in one form or another has been around for a very long time. Indeed, there are claims that the first postal service originated in Persia between 1700 BC and 500 BC. However, the first well-documented state-run service was the *Cursus Publicus*, which was set up by Emperor Augustus (64 BC–AD 14), which enabled communication across the Roman Empire. The need to form social networks is not a new phenomenon, but the tools used for this process have changed over time.

Telegraph	1792
First successful telephone transmission	1876
Marconi patented radio	1896
Email	1966
Wikipedia	2001
Facebook	2004
YouTube	2005
Twitter	2006[1]

Reaching 50 million users

Telephone took 75 years to reach 50 million users compared to Internet which took only 4 years. Compare these to the reach of angry birds which took only 35 days to reach 50 million users.[2]

Radio, telephone and television required raw materials, construction and labour to have the infrastructure and then

distribution and sales to reach the 50 million mark. In contrast, once the infrastructure of the Internet was in place, interactive websites such as Google, Facebook and Twitter could harness the Cambrian Explosion of technology and applications that constitute a significant part of the global community. 'The strengths of social media are the interactivity, connectedness, participation, openness, conversation and sense of community that it fosters'.[3]

Over the coming issues of *Pain News*, we will introduce social media and some of its current applications and discuss how it can be utilised to further communication and knowledge relevant to Pain Medicine.

Twitter

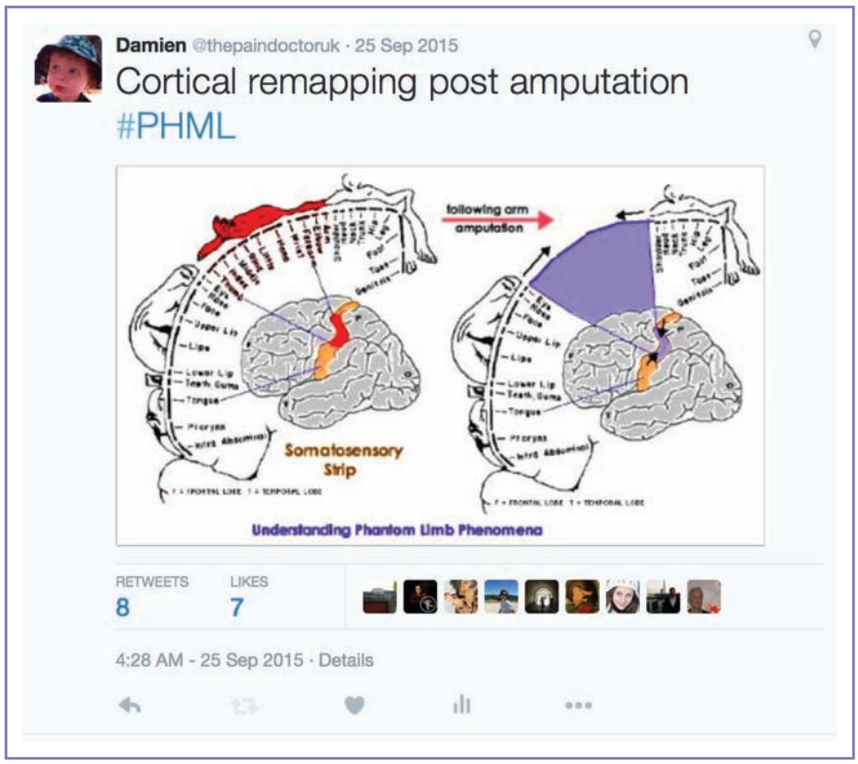
What is it?

Twitter was founded in March 2006 and was launched in July 2006 by Evan Williams, Noah Glass, Jack Dorsey and Biz Stone. Many use it to share news, jokes or message whatever is on their mind. Users are limited to using a maximum of 140 characters to convey their message. Every second there are (on average) 6,000 tweets (messages) that correspond to 360,000 tweets per minute, 500 million tweets per day and a whopping 200 billion tweets per year!

Looking at those numbers, you would be right to think 'how can I be heard among all that Twitter noise?' The power of Twitter may be illustrated as follows: one of the authors (D.S.) attended the Peterhouse Medicolegal conference in Cambridge, United Kingdom, on September 2015. In one of the afternoon lectures, there was an excellent slide on cortical remapping post amputation (Figure 1). The slide was tweeted by one of the authors to 150 followers. It was retweeted by a follower in the United Kingdom who has 7,000 followers and then retweeted by them and so on. Within 45 minutes, it was read and retweeted by people in Athens, Amsterdam, Utrecht, Izmir and London. It was then seen and 'liked' by people in Buenos Aires and Melbourne. Within a very short period of time, within an hour, the tweet had gone around the world and was seen over 1,500 times.

The rapid mode of communication and dissemination of information is also the reason that Twitter has been involved in controversy and censorship. It has been used as a mode of communication during political and civil unrests, used in protests and revolutions including the 'Arab Spring'. Currently, it is completely blocked and unusable in Iran, China and North Korea and has been previously banned in Turkey, Iraq and Egypt. Most people all over the world, young and old alike, are using smart phones and are familiar with smart-phone technology.

Due to its instant networking, it is now increasingly being used in emergencies and during major incidents. In March 2012, the UK Government produced a document giving tips on how to use social media in emergencies. During the recent flooding in the United Kingdom, the environment agency was sending regular updates with flood warnings and alerts, this was then mirrored by the Twitter traffic in the corresponding areas using hashtags (#) mentioning the word #flood (Figure 2).[4]

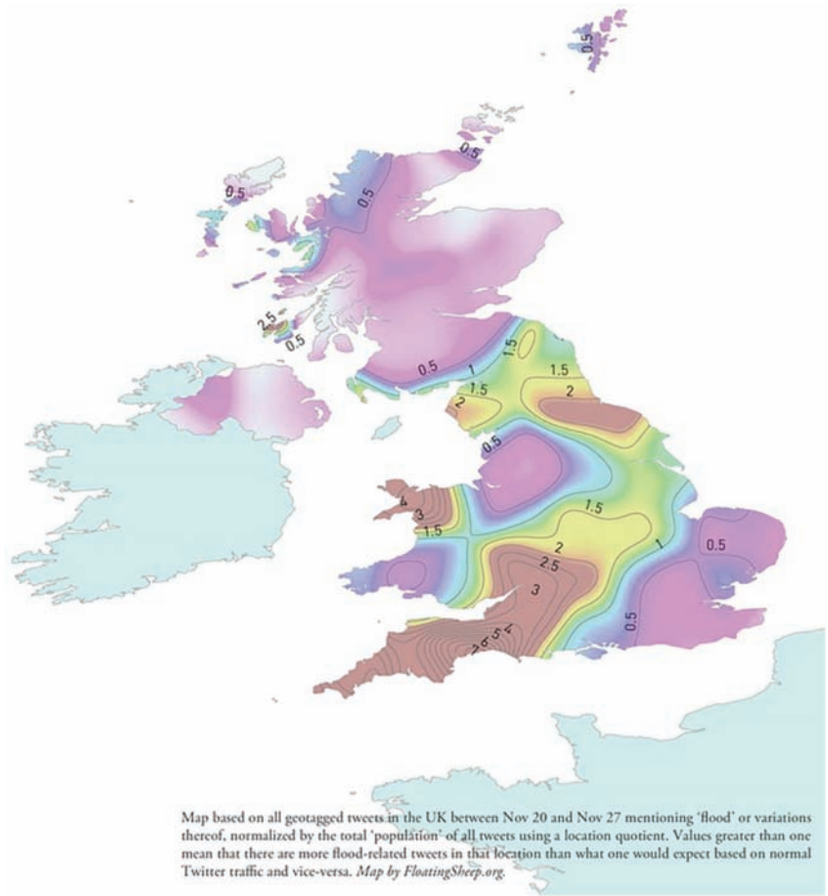


How do I use Twitter?

Once you sign up using an email address, you can create your own Twitter profile or persona. Search for someone who you know or anyone who you may find interesting. You then 'follow' these people or organisations. You can look at who your friends and colleagues follow to get some ideas. You will then receive a constantly updated 24-hour Twitter feed onto your homepage from everyone you follow and things they have tweeted, retweeted or liked. If you do not like what someone is saying or they Tweet too much, then you can politely mute them from your homepage (temporarily or permanently) without having to 'Unfollow' them. Twitter could be described as a very noisy party with many of people talking at the same time, but you can control whom you listen to or interact with.

Twitter definitions

Twitter	The brand name of a social media service and website where user can post messages which are 140 characters long
Tweet	A message sent on Twitter up to 140 characters
Retweet	The act of sharing another user's tweet to your following
Twitterati	Keen or frequent users of Twitter
Liked	Liking a tweet indicates that you appreciate it and also save it on your homepage so that you can access it quickly later on
Follower	Another Twitter user who has followed you to receive your tweets in their homeline
#	Denotes something that is happening and you can see what everyone is saying about it (e.g. #BritishPainASM2015, #Flood, #FOAM)
@	denotes a person or organisation that you can follow (e.g. @ BritishPainSoc)
Trending	A topic or hashtag that is popular on twitter at that moment
Troll	Internet slang for an unpleasant person who starts arguments or upsets people with inflammatory or offensive comments



When can I use it?

Twitter is a great tool to use at conferences. It is possible to see what is happening in satellite sessions and to share pictures and links of papers being discussed and feel that sense of participation, conversation and community. Before the conference, the organisers can create a # related to the meeting, for example, #BritishpainASM2015 and #IASPCongress2016. Delegates can use this #name during the conference to share information from the lectures:

Pictures from the lecture;

Links to papers that have been quoted;

Take notes;

Share comments with others;

Send questions to speakers;

Information from the exhibition hall.

Delegates may tweet the contents of the lecture, workshop or poster, and this is a positive way of sharing and summarising the salient educational messages. In this way, Tweets can even be accepted during the appraisal and revalidation process as proof of attending the meeting and of reflective practice.

How can I get my voice heard?

Pain Medicine may not be the largest specialty in the United Kingdom, but with simple measures, it is possible to communicate its message effectively to patients and the general population. With approximately 200 pain clinics in the United Kingdom, we should make our voices heard. This can be illustrated by looking at some analytics from Twitter. The number of people that organisations follow and the number of tweets sent may be considered to reflect how large an audience or population can be reached and also the potential impact on that audience (Table 1).

Table 1. Twitter analytics using Twitonomy Metrics for pain, anaesthetic and medical organisations (figures used from 9 January 2016)

	@ BritishPainSoc	@ EFIC_org	@ IASPPAIN	@ rcoanews	@ aagbi	@ TheBMA	@ FOAM_ Highlights	#FOAMed
Followers	1,227	451	3,301	7,737	6,726	64,972	14,903	
Following	168	329	75	26	4,039	2,200	105	
Tweets/day	0.17	0.7	0.1	0.5	3.7	13.8	2.8	~1,000
User Mentions	98 (0.5)	108 (0.3)	40 (0.1)	99 (0.1)	1,275 (0.4)	1,373 (0.4)	578 (0.1)	
Retweets	26%	38%	4%	11%	43%	29%	15%	

Table 2. Twitter analytics using Twitonomy Metrics for individuals (data from 9 January 2016)

	@EricTopol	@pascalmeier74	@traumagasdoc	@ButNHS
Followers	78.3K	45.6K	9,446	51.6K
Following	347	50K	1,650	4.5K
Tweets/day	6.1	16.8	14.7	25
User Mentions	4,216 (1.3)	2,576 (0.8)	3,456 (1.08)	376 (0.1)
Retweets	94.8%	33%	26.5%	13%

The International Association for the Study of Pain (IASP), European Federation of IASP Chapters (EFIC), British Pain Society and Royal College of Anaesthetists (RCoA) all send less than one tweet per day. This means that the number of people reached will be severely limited. The British Medical Association (BMA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) send more than one tweet per day and follow over 2,000 people giving them a larger audience and therefore significant impact. Indeed, there are approximately 15 million people on Twitter in the United Kingdom alone,[5] and it is very popular among journalists.

But you do not have to be a large organisation to be heard (see Table 2).

When we compare these figures with the ones mentioned previously, it is clear to see that pain organisations have plenty of scope to improve their presence on Twitter and on Social Media in general, which will lead to an enhanced impact. Social media such as Twitter and Facebook may be used in a highly effective manner specifically for clinical education and continuing professional development. An excellent example of this is #FOAMed (Free Open Access Meducation). This will be explored further in the next article on Social Media to be published in the next edition of *Pain News*.

Conclusion

Social media may be considered as a natural evolution of our desire to interact with each other. News is disseminated as it happens often by people involved or around where it is happening using social media; there is no delay in getting the information out unlike conventional printed press, radio or TV. There is an untapped opportunity for professionals working in pain clinics to become interconnected with each other and the outside world. This may lead to an advancement of knowledge through greater sharing which has the potential to enhance patient care. At the same time, there is also a chance to raise the profile for Pain as a specialty and ultimately improve public awareness, and perhaps even help to safeguard the specialty through the current (and future) climate of financial austerity.

References

1. http://avalaunchmedia.com/infographics/the-complete-history-of-social-media/
2. http://visual.ly/reaching-50-million-users
3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85946/Using-social-media-in-emergencies-smart-tips.pdf
4. http://www.theguardian.com/news/datablog/2012/nov/28/data-shadows-twitter-uk-floods-mapped
5. http://www.rosemcgrory.co.uk/2014/01/06/uk-social-media-statistics-for-2014/

The British Pain Society

Pain News
2016, Vol 14(1) 28–30

SAGE

The diagnosis: shades of grey – healing the disease or the diseased?

Suan Khoo *Professor in Oral Pathology & Oral Medicine, University of Malaysia*

This article is the transcript of the lecture given by the author at 2015 Philosophy and Ethics SIG meeting at Launde Abbey

I am in a privileged situation. I do something, oral pathology, very objectively: I look down a microscope and it is 'yes' or 'no' with no shades of grey. I see patients in the clinic with lumps and bumps which is again very objective. But, a large part of what I deal with is orofacial pain and I spend a lot of time talking with patients – perhaps not more than three in a 4-hour clinic.

Temporomandibular joint disorders

This is a very non-homogenous group including myofascial pain, arthrogenic pain from a true joint disorder such as disc displacement, or from degenerative osteoarthritis. I also see neuropathic pain such as trigeminal neuralgia, or secondary to interventions such as extractions or root canal treatment, and what is known as burning mouth syndrome, and a few neurovascular disorders such as facial migraine which we do not treat, but diagnose and refer.

I did my PhD in biopsychosocial aspects of temporomandibular disorders (TMD). Quite a lot of the patients do have depressive or anxiety disorders together with TMD, which makes it complicated when you treat them. I always tell the general practitioners (GPs) or the students that it is a thing I cannot deal with quickly because by the time the patients reach me they have acquired many layers that I have to undo. Incidentally, I am also a sufferer myself, I have temporomandibular joint disorder.

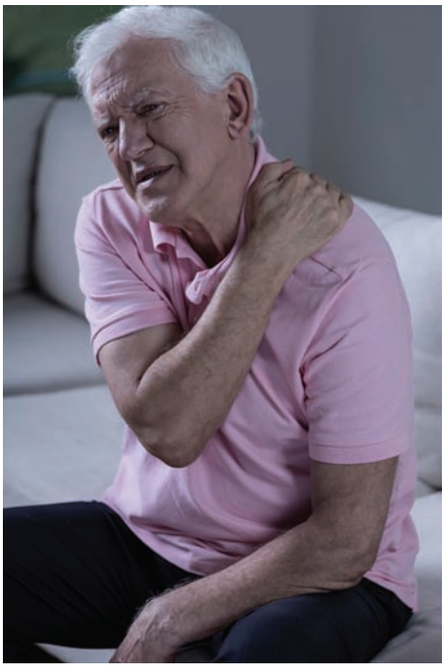
We tell students and trainees that their first priority is to make the diagnosis and make sure they are not missing any serious pathology and decide if they want to treat or refer. But, we have to be careful to avoid just putting people in compartments, thinking we have got it right and dishing out the prescriptions. When it becomes apparent that you have no effective treatment for them, you realise that you will have to spend time with them. Time is a very expensive commodity, but there is no other way. Students find this difficult to grasp.

Most of my patients come because of pain; anxiety is usually only a secondary issue. It is difficult to get Asian patients to talk about their pain. They just want something done. They will tell you where the pain is, but will only talk *about* it if you ask them. The patients I now see in the private hospital are more able to verbalise their problems than the ones I used to see in the public hospital, but also seem to spend more time ruminating about it than the latter who tend to be more stoic.

I have suffered from TMD since my dental school days, more than 30 years ago. I treated it initially with diazepam with some success; but, I came to recognise that that I was taking more and more and more of it, especially at times of stress. I tried splints and everything else. But for the last 20 years, I have hardly used anything. I am not desperate and am not in pain every day, but I have learnt to regard it as a warning signal that I should slow down. I can relate to many of the stressors involved in combining career and family that my patients tell me about, and this helps me

a lot in managing them; but I have learnt not to intrude. At the beginning, I thought I was doing them a favour by giving them a year of appointments and encouraging them to pour things out. But then I realised that they might not want to see me again because they are very embarrassed because they have told me so much. But sometimes they do break down – maybe what I have said triggers something – and they unload everything on me.

The old approach to TMD was very biomedical, trying to find out what was wrong with the patient's muscles or joints and trying to fix it. For instance with occlusal rehabilitation (correction of bite abnormality by dentistry or jaw surgery) which is irreversible and we do not advocate any more. Now, we have Dworkin's dual axis classification with physical characteristics on Axis 1 and psychological factors on Axis 2, and I find that the kind of descriptive diagnosis this provides is more useful than a label. I do not now even believe TMD is often much to do with the dental apparatus at all. But I have to be careful what I teach trainees about this, or they may tell patients 'it's just



stress' – the most overstated diagnosis – don't we all have stress? So, I take pains to make trainees and patients understand that it is not just stress alone, but at the same time help them to recognise the stressors, which may be quite minor everyday things bugging them, which tend to aggravate their problems.

I still have to assess the physical disabilities of the jaw from which I can get an Axis I diagnosis and classify them as suffering from a muscle disorder, a disc displacement or a joint condition. Whereas 10 or 15 years ago it was all lumped together simply as TMD disorder we have come to realise that every patient is different. Assessment of pain is no longer on a simple 0–10 VAS; we assess functional limitation due to pain. With regard to psychological distress, we are not trying to diagnose depression or anxiety, but rather getting a feel that something is going on. We may want to refer them, but most of the patients I see do not want to see a psychiatrist. But about 2% of the patients I see are suicidal, and those I have to refer.

I use a simple questionnaire to assess psychosocial functioning. I try to show trainees how to use the biopsychosocial model to see that the ways in which patients manifest and appraise their pain are individual. As society is becoming more affluent, I am seeing more people who want to talk, but in our medical culture, we are not used to listening which can be regarded as wasting time in a busy clinic or GP surgery.

Neuropathic pain

I see a group of patients with burning or shooting pain which can be trigeminal neuralgia, but it is very often related to trauma. Some have had implants. The damage is done, and the brain pathways have changed and very often the management is only supportive. Occasionally, I can pick up from the cone beam computerised tomography (CT) scan that there has been damage to the alveolar nerve either from local injections. This is always a danger when you take out a wisdom tooth or place an implant, and sometimes, the CT scan shows that the canal is breached proving trauma. This is avoidable and the question of litigation arises. What should I tell the patient? Should they sue? This is a growing problem as more people are trained in physical interventions. Patients come with a mouthful of root canal treatments which may not have been done properly. There are already plastic changes in the brain and once again treatment is mainly supportive.

Patients, mainly peri-menopausal women, with burning mouth syndrome (a controversial and poorly understood problem) tell you that their whole mouth is on fire. This kind of expression is something that we have learned from the West and is not Asian at all. English words to describe pain that we learn from textbooks such as lancinating and pricking may mean little to Asian patients. This, and trying to use numerical pain scores, illustrates the difficulty of getting into numbers, words and symbols that you are familiar with but may mean little, or something different, to us.

Illness, suffering and culture

In Asia, to be ill means really ill, in bed or in hospital. Anything less such as chronic pain is little expressed and people carry on, they may have to work, stoically and do not talk about suffering unless it is very severe. But our society is changing. I probably suffer like a Westerner: I cannot stand pain; my tolerance is very low. Illness is only one of many possible forms in which suffering can appear in any culture. Suffering induces an individual to try to understand what is happening, by seeking the help of a doctor to legitimise it as the result of disease.

How do we read people's suffering? Just because someone does not verbalise it does not mean they are not in pain. Of our three main ethnic groups in Malaysia, Indians are much more verbal and expressive when in pain and are regarded as having low-pain thresholds, but this is really just a matter of culture.

There is a lot of respect for doctors among Asians and people do not like to question them even though they may disagree with them. The problem then arises when the doctor cannot pinpoint what is wrong and they do not have a diagnosis to legitimise their problems and their suffering.

Buddhism, mindfulness and meditation

I come from a Buddhist background. I have been brought up thinking about questions about me, the I and the ego, such as who is experiencing pain?

What is the *me* that is suffering? When relieving pain of the other, who is 'the other'?

When pain is 'relieved', who finds relief? These are very philosophical concepts to bring into a scientific culture, but Western society has begun to embrace Buddhism. I sometimes try to detach myself from pain through my practice of mindfulness, which stems from Buddhism. I try to use my own experience to help patients, for instance,

encouraging them to think of activities (other than work) which will distract them from their pain, and to try to introduce them to mindfulness and meditation. I tend not to use these words as people are very conservative in matters of religion, so I suggest that at times of stress, they just have to sit in a quiet corner and concentrate on their breathing, if only for 1 minute, and if they can do this, they can begin to detach themselves from their pain and spend less time ruminating about it.

My patients have taught me a lot. In their quest for healing, patients are engaged in a continuous search for new doctors and new information, looking for something to give them some hope of the possibility of healing. Trainees tend to learn everything in black and white and like labels such as psychogenic pain, but I have been trying to get them to try to understand what patients are searching for. Some may go too far and respond with empathic distress, and I have to remind them that they have to remain professional or they may add to the patients' problems. I encourage them to look at themselves and what is going on in their own minds and examine their own actions.

Listening

The physician healer creates a safe environment for patients to reveal their stories by encouraging storytelling. He must belay intentions to heal and suspend personal views and values so he can enter the patient's world without bias. He can help them to ascribe meaning to their illnesses and to move on to a new narrative that increases the ability to respond to the changes wrought by the illness. I have to keep reminding myself to listen properly. Sometimes we listen, just enough to make the diagnosis, trying to filter out the significant symptoms. We are so keen to get down quickly to when-why-exacerbating features and so on that we are continually interrupting. But instead of plaguing someone with pesky questions, we should be listening attentively and analytically as if he were a character in a play giving a soliloquy.

Objectivity and shades of grey

We use tools such as the Brief Pain Inventory and Beck's Depression Inventory in both research and in clinical practice to try to be as objective as possible, but I am not sure that something like the 'faces' (emoticons expressing severity of pain) in the Universal Pain Assessment Tool is very helpful in our culture. Nothing beats listening to the patient. Assessment and treatment of diseases and disorders are more or less universally accepted, but it is the cultural context that presents shades of grey. Our people are not very forthright with their opinions; in Asia, especially Korea, Japan and China, the ideas of harmony and balance of Yin and Yang and striving for the least disruption possible are prevalent. We try not to draw attention to our problems. My parents are in pain and are not happy about it, but do not talk about it.

Diagnosis and suffering

Whether or not the diagnosis is apparent, we are often tempted either to endorse someone's suffering or to alleviate their anxiety by giving them a minimal diagnosis. We are reluctant to mention death. This goes against the objectivity of my oral pathology training and again involves compartmentalisation. I tell them 'I do not really know but I do not think it is cancer but let us monitor you …' But this may not do the patient justice. The information you give depends on what the patient wants to know and why she wants to know it. We deal with so many shades of grey. We sometimes do not know who is playing the bigger role: the clinician or the patient. If you are dictated to by what the patient wants all the time, we who are supposed to be medically trained have no choice but to collaborate.

To receive a diagnosis that places one's suffering in a medical context can be both a confirmation and a disappointment for the patient. It does at least give them access to some treatments. But if these fail, then what …? The patient possibly acknowledges with gratitude the diagnosis she has received from the doctor, but this does not account for the fact that she never recovers. Diagnosis has elicited recognition from the medical establishment for her ailments and part, but not all, of her suffering. The remainder remains to be dealt with: she still has to live with it. Medical recognition of suffering involves acknowledging, and even sharing, patients' feelings of helplessness. When we do not have a diagnosis, or really know what we are treating, and at best are relieving only part of their distress, the patient needs to be aware that we do not know – but confident that we will continue supporting them.

Advances in medical technology infuse a hope that medicine is able to alleviate pain and suffering. In order to gain these benefits, patients as well as medical professionals, must interpret somatic or psychological suffering and disturbances in terms of medical diagnoses. The diagnosis becomes an emblem for hope while at the same time turning suffering into something medically and socially legitimate. Is it then our task to bring hope through diagnosis?

> *The change from expert-doer to servant-accompanier requires that physicians attend to how they are with patients as much as what they do for them.*
>
> HM Adler

> *The most powerful therapeutic tool you'll ever have is your own personality*.
>
> David Sackett

'THE POWER OF THE MIND IN PAIN'

The Philosophy & Ethics Special Interest Group of the British Pain Society

Annual Meeting 27th to 30th June 2016, Rydal Hall

You are invited to attend a most stimulating conference considering the power of the human mind in pain. There will be a number of speakers looking at a wide range of subjects including spirituality, hypnosis, healing, the placebo effect and other mind- body connections.

It will be held at Rydal Hall near Ambleside in the Lake District and during the conference there will be time to explore the gardens and grounds of the hall as well as the beautiful surrounding lakes and hills.

if you would like to receive further information about the Meeting, please contact us at: meetings@britishpainsociety.org

Would you like to read the full version of *Pain News*?
Then sign up to become a member of the British Pain Society today

Over 1,400 healthcare professionals are already enjoying the benefits of membership of The British Pain Society:

- ACCESS to original research and reviews on all major aspects of pain and pain management via your *FREE* quarterly copy of the *British Journal of Pain.*
- UP TO DATE information on new developments within the field of pain via your *FREE* quarterly newsletter *Pain News.*
- NETWORKING opportunities to meet with other professionals working in the field of pain management offering a multi-disciplinary viewpoint.
- REPRESENTATION at Department of Health and other associated professional bodies.
- ACCESS to join a wide range of Special Interest Groups.
- FREE SUBSCRIPTION to *European Journal of Pain* - the renowned international monthly journal
- SPECIAL RATES for our Annual Scientific Meetings
- SPECIAL RATES for Society events
- WEBSITE with up-to-date news and secure Members only areas
- OPPORTUNITIES for grants and awards

Please visit our website to find out more and apply for membership online:
https://www.britishpainsociety.org/become-a-member/

About the Society

Who are we?
We are an alliance of professionals advancing the understanding and management of pain for the benefit of people living with pain.

We welcome members from all healthcare professionals and scientists with an interest in or active engagement in diagnosis, management, education and research for the benefit of patients with pain.

THE BRITISH PAIN SOCIETY

What makes us so unique?
The British Pain Society is the largest multi-disciplinary organisation for pain in the UK as shown by the variety of disciplines comprising our membership. The British Pain Society is also the official British Chapter of the International Association for the Study of Pain (IASP), and as such is also a member of the European Federation of International Chapters (EFIC).

What do we do?
The British Pain Society aims to promote education, training, research and development in all fields of pain. It endeavours to increase both professional and public awareness of the prevalence of pain and the facilities that are available for its management.

JOIN US TODAY AND YOU'LL BE IN GOOD COMPANY