Airing Pain Programme 18: Growing old with pain

How to improve pain management for older people, and living with lower back pain.

Pain has often been seen as an inevitable part of getting older. ***Airing Pain*** *listened in to a panel of experts at a 'Growing Old with Pain: Innovation, Creativity and Development' conference in Edinburgh to hear how pain treatments can dramatically improve the quality of life of older patients. The importance of family and carers taking an active role in the management of elderly patient's pain is highlighted, along with the importance of raising awareness of the best treatments for pain in older people among health professionals. We also hear the inspirational story of Michael and Rosemary Morrison who together have rebuilt their lives around their chronic back pain and the benefits of using computers and computer games to access information and exercise.*

Paul Evans: Hello and welcome to ***Airing Pain***. A programme brought to you by Pain Concern, a UK charity that provides information and support for those of us living with pain. Pain Concern was awarded first prize in the 2009 NAPP Awards in Chronic Pain and with additional funding from Big Lottery awards funds for all programme and the Voluntary Action Fund Community Chest, this has enabled us to make these programmes.

Prof. Dennis Martin: Pain in older adults has been an unrecognised problem and we know that the number of people who have pain gets greater the older the age group you get. But it seems to get less in the very old age groups, and we're not sure whether that is due to people not reporting it because they think pain is a normal part of life and therefore just take it for granted.

Dr Beverly Collett: We've got an aging population, so we're all getting older – by 2020 we anticipate huge numbers of older people. And also, in that group, it's been suggested that often pain is *not* recognised and, in the worst case scenario neglected, because I think people assume, 'It's part of getting older so I have to live with it'.

Martin: And that's the kind of question we're wanting to answer because there's no reason why pain *should* be a normal part of life. It is at least as important, if not more important, in older adults where the effects are potentially more significant.

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Evans: Earlier this year, the Royal Pharmaceutical Society in Edinburgh and KT EQUAL – that's a group of UK researchers dedicated to extending quality life for older and disabled people – hosted an event focusing on 'Growing Older with Pain through Innovation, Creativity and Development'. I'm Paul Evans and in this edition of ***Airing Pain***, I'll be giving you a flavour of some of the issues raised.

Now, the focus of the evening was a question-and-answer session with a distinguished panel of experts. They were: Dr Beverly Collett who is the Head of Chronic Pain Coalition and Consultant in Pain Management at Nuffield Health Leicester Hospital; Prof. Dennis Martin, Director of the Centre for Rehabilitation Sciences at Teesside University; Prof. Peter Passmore, Professor of Aging and Geriatric Medicine at Queen's University Belfast; Dr Pat Schofield, Director of the Centre for Advanced Studies in Nursing and Centre of Academic Primary Care at the University of Aberdeen; and, finally, there was Dr Kevin Voles, who's a consultant clinical psychologist at Keele University. The event was chaired by the journalist, campaigner and former MSP Dorothy-Grace Elder:

Dorothy-Grace Elder: Katie Green of Arthritis Care in Scotland – her question, she says: 'In a recent survey by Arthritis Care, more than half – 52 per cent – of the respondents aged over 65 stated that they'd often or occasionally experienced depression as a result of their arthritis pain. Is the panel aware of other evidence about the psychological impact of pain and how pain management interventions can address this?'

Dr Kevin Voles: We all know depression is very prevalent when quality of life starts to get lower. The good treatments that are out there, the effective treatments that are out there, offer a combined approach that get people back on track. I think that's just as applicable to older adults who also tend to be more depressed for other reasons – of course there's a lot of depression and it's very treatable.

Elder: Dennis, do you want to comment?

Martin: Yeah, I think you can even expand on the context of the question: it's not just psychological, it's psychosocial as well. Social isolation is a very big thing for older people with chronic pain and that's something that *can* be addressed…

Elder: …in pain management.

Martin: All-around, yes.

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Schofield: Common causes of pain in the older population are things like osteoarthritis and osteoporosis and then the associated problems such as falls, injuries and so on and then they're left with ongoing problems, like chronic pain.

Evans: That's panel member Pat Schofield speaking prior to this event. She's Director for the Centers for Advanced Studies in Nursing and of Academic Primary Care at Aberdeen University. Now, her field of expertise is particularly relevant to the next question:

Elder: Jeanette Barrie from ex-Quality Improvement Scotland, who's done some marvellous reports and helped compile these and push them forward:

Jeanette Barrie: My concern really is for patients or residents of care homes. I think Peter mentioned that 50 per cent of care home residents report pain. In some of the papers I've read it says that it's *85 per cent* [others gasp]. A quick trawl of our own care homes reported that not many [people had] actually been assessed routinely, except in the Liverpool Care Pathway stage, in the last few days of life, which is extremely sad.

Schofield: A lot of the pain assessment tools that we use for measure pain in the general population are not necessarily appropriate for the older population, because they have difficulty in understanding the questions that we're asking. And then you add in things like confusion and so on, which makes it a little bit more complex. The first priority really is to actually talk to the family who live with that particular person, because they can observe any changes in behaviour that could be attributed to pain.

Similarly, I think, if you're talking about nursing home populations, the staff who work in those settings know the residents very well and also know if there are any changes in behaviour.

Pain assessment is not widely used in care home settings, it's not seen as one of their major priorities, I think. They have *so* many other things to deal with. And I think what we really need to do is to get those guidelines readily accepted in *all* care settings including nursing homes – they *can* help.

Elder: Onto the next question. From Ron Marsh, user member EOPIC, University of Aberdeen. What's EOPIC, again?

Ron Marsh: EOPIC is 'Epic'. EOPIC stands for engaging people in self-management of **c**hronic pain. Because I'm in it – I'm older, so they had to have an 'O'… [laughs all around]

Evans: Before we go on to Ron's question, let's find out a little bit more about EOPIC from Blair Smith. He's a GP and Professor of Primary Care Medicine at the University of Aberdeen.

Blair Smith: EOPIC is a study funded through the Lifelong Health and Wellbeing Initiative by the research councils, mainly the Medical Research Council. Its aim is to identify and begin to test self-management strategies for chronic pain experienced by older adults.

I think the important point about chronic pain, just like many other health questions, that a lot of research is being done not specifically in older adults, and in fact a lot of research actually *excludes* older adults and people with other illnesses. One of the important things is if you're looking at drug trials, for example, almost every drug trial has excluded older adults. And yet, many conditions... and most of the patients that come in to me at the surgery are older adults and therefore the evidence to support their treatment is not great.

Now that's just true when we look at the experience of chronic pain. Before we can identify and evaluate self-management strategies, we need to understand what the *experience* of chronic pain is and how people are managing it themselves already. We know a little bit about that in younger adults, but the research on older adults has not been done thoroughly, so we're looking at that just now.

We have a very active, enthusiastic and valuable group of service users, older adults who have experienced chronic pain themselves. Historically at Aberdeen, with my colleague Pat Scofield we've worked with older adults for a considerable time and we have a very active users group who've helped us to shape the research, to tell us what the research questions are and to help us identify what approaches to answering these questions might and might not be feasible. So then when we came to design this particular study, we had a smaller group of those inputted in to designing the protocol right from the beginning [who] continue to serve on the research team with regular meetings, input and reviews of materials. And we couldn't do without them.

Marsh: Hi, I'm Ron Marsh. I'm a patient that has pain through diabetes and lower back pain. We have a very wide remit: we can comment on any aspect of the study and we're welcomed in doing that. You know, it's not a case of 'them and us' at all; we're just a group of laypeople and medical researchers, medical people…

Evans: Can you give me and example of how you've helped, or what input you've had into their work?

Marsh: I think we've been able to give direct evidence of what it is like for an older person living with pain.

Evans: Explain to me, as somebody who feels he's very old – mid-fifties [laughs]– what I can look forward to as a person in pain, when I'm getting a little bit older.

Marsh: I have taken the view that pain is just something that comes with old age. Listening to discussions like this tonight, I shouldn't really be expecting pain...

Evans: You shouldn't lie down and just accept it.

Marsh: Correct.

Elder: Now, your question is: when will old age without pain arrive?

Prof. Passmore: If I may comment – I think it goes back to this sort of acceptance of pain as part of something that is just going to happen to you and I don't for a minute believe that! I suppose where I work from is: it depends on how far you go in terms of the root cause. So I will chase that.

The worry for me is that if people don't deal with the acute pain, the acute pain then becomes chronic, which just becomes an entity in itself. So at that stage it's not relevant what the root cause was, you're just in chronic pain with the physiology and the way it develops. So in that situation I think you're into psychology, explaining about the situation and what we can do in terms of alleviation. My comment to people who are in that situation 'Look, I might not get rid of all of this for you, but [I could] make it bearable', you know?

But to go back to your question – I think the question for people who are in pain is a simple 'Why?'. [And while] we do have a lot of investigational techniques, I think the question for *us* is 'When is it appropriate and when is it not appropriate?' – that is, you're into a cost effectiveness argument. And you're also putting the patient through a lot with some of these tests. So that would be the comment I would make.

Martin: Ron, I think a direct answer to your question, when will there be a cure for pain – I wouldn't put any money on it for the near future [laughs], but I think what Kevin talked about that is as important is the *effects* of pain. I think in terms of older people, there's certainly more research coming out now [that is] focused directly on that: the research that we're doing with EOPIC, the Smart project that Chris is involved in, is focused on older people – so in X number of years in the near future there should be more knowledge coming out.

Closer to this time I think perhaps what's needed is better education of health professionals, so we're getting a more intelligent and thoughtful application of what we already know for younger groups in order to apply that to older people. There is some good existing knowledge which I think could be applied with some effort and thought.

Speaker 1: Can I just add a point there? I think that the whole real fact that new students get taught twice as much pain in terms of their training at veterinary school than medical students do – I don't know how accurately that applies now.

The second point would be: my experience as a lead in the acute management team in the trust where I work is that junior staff and middle staff don't know anything about pain management. One of the problems is that we set ourselves up in acute pain teams, in critical care liaison teams and other specialist groups. Partly through their lack of training, their lack of time on the wards, they don't know how to do basic care. And somehow a return to managing that or giving them a bit more responsibility, but

I'm not entirely sure how you would do that because they just don't have the skills. I think we really need to reflect on how we're going to get junior doctors to be better trained, so they can do basic stuff.

Prof. Peter Passmore: I couldn't agree – that's interesting, because I did mention this. For such a chronic problem, there's certain things that are never taught in medical school, like management of constipation or of vascular or varicose ulcers. But even over and above that is pain.

We have the fourth years and we send them out and our simple way of doing this is: they survey a group of drugs, but we always make sure the analgesics are on there, so that people who get the constipation ones won't feel like they've drawn the short straw. We've tried to indicate that there are problems and difficulties with the drugs that are used.

But I don't know. I think one ought to be able to impact on the GMC – when you think about the prevalence, etc., and we've heard about this – to really look in depth at the undergraduate curriculum and you'll see that some things, I guess, are being overlooked.

If you look at what's prescribed in the wards, and we're published extensively on this, 68 per cent of our drugs in the hospital are analgesics in the geriatric wards. That's more than even in the nursing homes. But if that is the case, how can you not train people about that?

Evans: Professor Peter Passmore. He's Professor of Aging and Geriatric Medicine at Queen's University Belfast.

Now, before we continue, please bear in mind that while we believe the information and opinions on ***Airing Pain*** are accurate based on the best judgements available, you should always consult your health professional on any matter related to your health and well-being. He or she is the only one who knows your and your circumstances, and therefore the appropriate action to take on your behalf.

You're listening to ***Airing Pain*** with me Paul Evans, and we're at KT EQUAL 'Growing Old with Pain: Innovation, Creativity and Development' event at the Royal Pharmaceutical Society in Edinburgh.

Michael Morrison: My name's Michael Morrison, this is my wife Rosemary. We are involved heavily with the Pain Association in Scotland, with the support group up in the Grampian region.

I hurt my back originally playing cricket and for ten years I was diagnosed wrongly. I was being treated for sacroiliac problems but what had happened was, I had three bust discs in the base of my spine. So during those 10 years from '81 to '91 I was just on painkillers. I always felt that another week will go by and then I'll be okay, but then in 1991 I became immobile. I just couldn't walk; I couldn't put one foot on the floor.

I was in a wheelchair for 12 years and two and a half years ago a friend of my son who's a surgeon at Woodend Hospital – my son said to him 'My dad's coming to see you. Do a good job!' [laughs] So he called me in and I explained all that had gone wrong, so he said 'Another operation might sort things out for you'. So I eventually got a call, I went to the hospital, had the operation, had all the discs in the lower spine fused and all the scarring tissue that had been in there cut away and dispensed with.

And when I came through from the recovery room, I was in awe because I had no leg pain, no foot pain, nothing. I thought well, maybe it's just the effect of the anaesthetic. But no, it's lasted, and now I'm out of my wheelchair, I don't use the wheelchair anymore.

Evans: Tell me how important Rosemary was.

M. Morrison: A lot! I don't know what else I would have done without her! She's been a rock, as far as I was concerned, because she wouldn't let me get so low. She used to pull me up by the throat and say 'Right, you're not getting into that situation!' She was the one that pushed me and pushed me... because I would have probably fallen at the first hurdle and said 'Oh, well, that's my lot. End of story.'

R. Morrison: I wouldn't let you!

M. Morrison: She wouldn't have let me, no. So she was very, very supportive.

R. Morrison: Well, we've been married 40 years this year, and… you know, he was very, *very* bad. He couldn't walk, I was lifting him [laughs] and how I did it I don't know! But you do it; you find the strength, you know? I just said to him 'You are NOT

going into depression with this! You may think your life's over, but it's not. *Mine* certainly isn't!'

I was probably being rotten to him, but it was the only way I could get through to him, because he was going into himself…

M. Morrison: Once I'd been through all the previous departments at the hospital, the surgeon the third time said to me there was absolutely nothing else he could suggest, apart from going into a residential pain management program. So I was one of the ones who was sent from Scotland to Manchester for three weeks. While I was there I got really good advice and it was at that time I felt something needed to be put back into the community. That was when our connection with Pain Association Scotland started.

Evans: So tell me about Pain Association Scotland. What do you do there?

M. Morrison: We have two meetings every month: the first and third Wednesday of every month. During our meetings we normally have a session of light exercise, progressive. We also a session on pain management techniques that people can use for handling their pain – not curing it or whatever, but actually being able to manage their pain and do the things they want to do, without having the stigma for days after. And then we finish off with a session of relaxation. I think that's the best part! [chuckles] I think that's what everybody comes for.

R. Morrison: I think when we're doing the exercise, which is very light, they all go 'Ohhh!', they groan, but they do it! It's good to see them! I mean they know that we can't cure them, because we tell them that right from the start, but we've got a good group.

M. Morrison: They all support each other.

R. Morrison: Yes, yes they do. It's amazing.

Evans: But you, Rosemary, must be a very valuable part of the group, because you're not living with pain but you've pulled somebody who *was* living with pain through it.

R. Morrison: Yes, I think because of the way Michael had been, and because I became stronger… I mean, Michael always looked after me – and still does – but at that time, he needed *me*. So it was my turn to help *him*.

Some of the group sometimes like to speak to me and sometimes they like to speak to Michael, it just depends. Also, some of them will phone us. We say to them 'You can phone us at home, if you're having a rough time phone us!'

Evans: When you went down to Manchester, to the pain management clinic, how far did you have to travel?

M. Morrison: Maybe about 400 miles each way.

Evans: Well, [ironic] that's easy if you're in pain!

M. Morrison: [chuckles] *No.* I was in a wheelchair and I was really struggling.

R. Morrison: I wasn't allowed to go down, you see, he had to go down himself.

M. Morrison: I was flown in. The health board paid for the whole session, so I was flown into Manchester and there I was picked up at the airport. Rosemary didn't want to let me go on the plane from Aberdeen.

R. Morrison: But before they would take you on they were saying you had to walk for…

M. Morrison: ...Aye, for 200 yards.

R. Morrison: For 200 yards. And they said 'If you can do that then we'll take you on'.

M. Morrison: Yeah, I wasn't accepted initially, because my health was so poor. So they gave me certain criteria and they said 'If you meet that we'll put you on the program'. And I battled, I really battled to get me in the situation to go down for that course.

R. Morrison: And he was there for three weeks and it was very, very basic. Oh!

M. Morrison: Yeah, you had to do everything for yourself. You had to make the bed, prepare your breakfast, your lunch, your dinner – all within the confines of a hospital ward at Salford. But the way the program went about it, they could get a video of how you dealt with seven aspects within a house situation; then, at the end of the course, they also video-d the same thing again. And for me the difference was enormous! I didn't think I was as bad as I was, when I saw the first video, but the second video was just… Chalk and cheese. There was really such a difference!

Evans: Has the benefit stayed with you?

R. Morrison: Yes.

M. Morrison: Absolutely.

Evans: Why did you have to do an 800-mile round trip?

M. Morrison: There's nothing else in Scotland. I had two options, one was to Manchester and the other one was down to London. Mind you, I'd said no to start with!

R. Morrison: Yes. You did.

M. Morrison: I wasn't prepared to go and put myself through that. But she kept at me, she said 'Don't give up! You try it! It will maybe do you good'. And it did! [laughs]

Evans: Michael and Rosemary Morrison.

You're listening to ***Airing Pain*** with me, Paul Evans. And we're eavesdropping at the Royal Pharmaceutical Society in Edinburgh where Dorothy-Grace Elder's chairing the KT EQUAL question time event on 'Growing Older with Pain: Innovation, Creativity and Development':

Elder: A lot of elderly people are told by their doctors that pain is an inevitable part of aging – something you just have to put up with. What does the panel think? Is it inevitable?

You know what, if you've led a perfect life – never smoked, never drank – you're dying of boredom, but nevertheless… [audience laughs] What if you *should* be in very good condition, but you're very old? Well, is it inevitable that you should suffer pain?

Martin: I think that disability and the suffering associated with it is not inevitable. It's manageable. The suffering and the disability associated with it, it's not inevitable, things can be done.

Passmore: I think prevalence has been converted into inevitability. When you think about it, everybody complains about [pain]. That's a prevalence statistic; it is a *real thing*. So I think people now are translating prevalence into inevitability and that's not right.

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M. Morrison: I think certainly as time goes on – you asked the question of what can you expect in older age from pain – I think you'll find challenges; you'll probably be challenged to the full. Because between pain in a younger person and pain in an older person, the pain is almost exactly the same; it's how you handle it that is completely different. And I think that's really the way to look at it: you're certainly going to have the challenges, but hopefully through the group that we are involved with we'd be able to provide you with the tools to meet that challenge.

Evans: Can you just give me a checklist of the tools that you can offer?

M. Morrison: The tools that we're looking at are: taking a Pain Association program through the likes of exercise initially; then some pain management; then relaxation. What we'd be looking at is using IT to the best, and having people involved right from when they join Pain Association Scotland, for example, for £5 a year or whatever. For that membership you'll be able to log onto the website, then you'll have a number of medical questions asked – very basic medical questions – to calculate what you would be capable of.

We also talked about using the Wii; but the Wii program type benefits from using IT. And I think hopefully over the next two, three years – these things are expanding so rapidly that we'll see those [developments] I would say probably in the next five years.

Evans: OK. I'm quite excited about this because you obviously know about the Nintendo Wii – and I think Sony have brought out something like that as well now. I bought my wife a Wii for Christmas. I suffer from fibromyalgia. I have avoided it but obviously you, with pain, and people in your group have found a way of using it.

M. Morrison: Even the fibromyalgia sufferers in our group have found benefits from using the Wii. Before they came to the group, they were stressed every day and a lot of them were very angry over what was happening, because the doctors in the hospital were unable to diagnose or give them any hope for the future. But now...

grandchildren are a great thing as well – you learn to like having grandchildren who are very involved with computers and IT and these little fiddly phone things. And I think that's a beam of light as far as getting older is concerned: having grandchildren who would be able to teach you… And I think as time goes on it will be faster and faster, and everybody hopefully will do it.

Speaker 2: Back to the exercising side of things: in many instances the Far East are way ahead of us. They have their elderly coming up to retiral. Over a period of time, they will actually get them into doing T'ai Chi or whatever, It may be something that we will have to take on board in this country as well.

Passmore: Oh, in Hyde Park there's a new area converted for older people's exercise now. Isn't that right? Dedicated to it? So I think you're right, it's something to take on board. But seeing the people cavorting around lampposts in Hong Kong – it's a great thing! It's all about the core and all, absolutely. And that in itself will have an effect on pain.

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Evans: And that was Professor Peter Passmore who's a panellist at the KT Equal event on 'Growing Older with Pain: Innovation, Creativity and Development' at the Royal Pharmaceutical Society in Edinburgh. And he sadly brings to an end not just this edition of ***Airing Pain***, but the series. The programs were produced by me, Paul Evans, for Pain Concern: the UK charity providing information and support for people who live with pain.

Now, once the program takes the summer break, please do keep in touch with us. You'll find all our details at our website at painconcern.org.uk and there you'll find a wealth of information about managing your pain, how to contact us about information on our sister magazine ***Pain Matters***, and how to download or order all our old editions of ***Airing Pain***. We'll be back in the autumn to look at the issues affecting 7 million of us in the UK living with chronic pain, but until then I'll leave you with a thought for the future from Michael Morrison:

M. Morrison: Old age, they say, doesn't come alone. But it comes with a Wii, a wife, so many grandchildren etc. [laughter all around] that you can use to your benefit in later life.

Contributors

* Michael and Rosemary Morrison, Pain Association Scotland

* Ron Marsh, Patient

* Dorothy-Grace Elder, ex MSP, campaigner

* Jeanette Barrie from ex-Quality Improvement Scotland

* Dr Beverly Collett

* Professor Dennis Martin, Director of Centre for Rehabilitation Sciences, Teesside University

* Professor Peter Passmore, Queens University Belfast

* Dr Pat Schofield, Director of Study for Advanced Nursing, Centre of Academic Primary Care

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