

## **Airing Pain Programme 96: The British Pain Society at 50**

**Andrew Baranowski:** Dear friends and colleagues it is my great pleasure to welcome our members, guests and of course the fantastic faculty. Both international and home grown as well as both our loyal and new exhibitors to this years British Pain Society Annual Scientific Meeting.

This meeting is truly significant as it is the 50th such meeting. The intractable Pain Society of Great Britain and Ireland was formed in 1967 making our society probably the oldest pain society in the world and this our 50th anniversary. Their first meeting was in Manchester with 17 attendees.

Since that meeting we have grown in strength and we have nearly 600 attendees at this years meeting. This year in recognition of the achievements of the British Pain Society we'll be launching the national awareness campaign. All of you can and please must help by raising the awareness of those living with pain.

We can also raise awareness of what you do to support the individual living with pain, their carers and the family and what the British Pain Society does to support you to provide the best evidence based multidisciplinary team approach. Thank you all for your support in attending.

this, the 50th ASM of the British Pain Society (applause)

**Michael Bond:** I started pain research or an interest in pain in 1963 when I was given the task of doing an MD on chemotherapy in women with carcinoma of the cervix and during the course of my work I observed that even though they had the same condition, the same level of development and were getting basically the same treatment the pain they experienced seemed to differ quite a lot and I wondered why.

What could be the reason? Now it happened that about the same time I changed over from surgery for reasons which I don't need to go into. I became a trainee in the university department of psychiatry in Sheffield and wanted to carry this interest in pain with me and as it happened, there were two people in the department one man called [Harold Merscey], who is world famous in pain research literature and the other is a man called [Isi Polovski], who is also in his time very famous and so I had these two men who were eminently able to help and I said "what we need to do is think of a way of measuring pain in the women that I've been studying."

And [Polovski] and I set about it and in 1966 we published the first account of the measurement of pain using something called an analogue scale which is really a zero to ten scale and that's how I got started. In 1967 and I don't know how it happened, I found myself with a group of anaesthetists, consultant anaesthetists, I think it was in [Solford]. They gathered to talk about the treatment of pain. They were all interested and practicing pain management by various forms of injection, put it that way and over the next two years they have further discussions about establishing a society and in 1969, they decided to found the British Intractable Pain Society.

So, I was there at the initial discussions and I was the only person there who was not a consultant and not an anaesthetist and I happened to have in my pocket the slides I had used in a talk elsewhere the previous day about pain and personality and women with carcinoma of the cervix and they said "would you like to

give us the talk." So, I did, that's how I got involved with what became to begin with the Intractable Pain Society.

In the treatment of pain at that time was quite different from the way we approached the problems now, for example it was the pain that was treated not the person so as a consequence, people like those women I was talking about earlier, would all be given the same drugs for their pain however much they had or didn't have and one of things I did was to measure pain using the analogue scale in a ward of women who had painful conditions of various kinds and a ward full of men.

I divided the drugs they had into three groups, powerful, medium and mild. Well the first thing I noticed was that the men were never given the powerful drugs irrespective of what their scores were and I asked why and the reason I was given was that men are expected to bare pain well. Now that was a cultural characteristic that was quite strong at that time. The second thing was that having recorded their pain levels amongst the women who did all receive analgesics.

There was no relationship between what they were given and what they recorded, so the tablets could have been in a bucket in the middle of the room and each one could of taken anyone they fancied, I would have been much the same I suppose but it showed that pain medication was given according to a ritual that had been established over the years, for this condition you give this and for that one you give that and all that almost immediately changed until we realised that this was completely unacceptable way of dealing with pain problems and at that time relating, getting the person to tell you about their pain and measuring their pain, looking at the medication that might be needed for that pain became very much more common practice, where I was at the time.

So that's where it was when I started. The individuals who came together felt that there was a degree of isolation and what they wanted to do was to come together to talk about ways of improving pain management and that's how it started. I mean the first ten years almost, it was consultants in anaesthetics only and the senior registrars were brought in but it didn't become multi-professional until about 1987 after the foundation of the international association, which was founded as a multi-professional organisation.

So, the psychological and social aspects of pain in the early years wasn't their major consideration although they acknowledged that these issues were something they should be considered but they came together to share knowledge for the early pain meetings it was primarily the presentation of anecdotal material. This is how I do it. I've done ten cases of this and these are what my results are.

There was no question of people doing trials of any description but they were transferring information from... you know one to another and presumable improving their technique and so forth until ultimately it was decided it had to be put onto standardised footing and membership, proper structure and Mark [Inaudible] was really the driving force behind that and he became the first chairman I think it was of the society

**Andrew Baranowski:** Most of the members if not all of the members apart from yourself were anaesthetists

**Michael Bond:** They were, yes.

**Andrew Baranowski:** and they were interested in the injection treatment management

Commented [LA1]:

**Michael Bond:** Correct, yes.

**Andrew Baranowski:** And of course, the injections have changed over the years because they were, some of the injections were what we might call destructive (unintelligible) treatments which we rarely use as specific indications in cancer patients and specific indications for spinal pain where we use those sorts of things.

**Michael Bond:** The only other group of people who were doing that kind of work were neurosurgeons and they did operations for facial pain Trigeminal Neuralgia and they did operations on the spinal cord for cancer pain.

**Andrew Baranowski:** So, what did they think of you?

**Michael Bond:** I don't know really. I was at least in neurosurgery at that point but they seemed to accept me without any hard feelings or I think they were quite interested because I brought to the proceedings a slightly different slant. See at that time it wasn't until 1964 that psychologists actually had a clinical position in the health service.

There were psychologists working in health service but they were doing things like intelligence testing in mental hospitals and they did the thing called the Rorschach test or ink blot test where interpretations were made of what patients said about what they saw in the ink blot.

I mean it was not clinical psychology as we know it but then a Professor [Troughouen] who was a professor here at Birmingham was given a task of carrying out an investigation into whether or not psychologists should become clinically trained and should work clinically and the answer was, yes they should and that's when clinical psychology in Britain appeared on the scene or began to appear as a profession and in my department in Sheffield we had a course.

Usually eighteen entrants a year of people who had a psychology degree, but then came in and did a training in clinical psychology and that's how it all started with respect to psychology.

**Andrew Baranowski:** But at what point did you realise that there was more to pain than the brain was involved as much as anything else?

**Michael Bond:** Well if you think back to what I said about when I entered the department of psychiatry for training and I encountered those two people. [Harold Murscu] was working on depression and pain and had shown that 45% of people with severe depression have pain. It's part of the depressive illness and it goes when you treat the depression.

There are other people who become depressed because they have pain but these are people who develop pain because they are depressed. So, there was clearly a relationship between mind and pain obvious at that stage. The other guy [Izzy Povolski] he was interested in Hypochondriasis, what was called illness behaviour. In other words, how did pain show itself in terms of alterations in behaviour and was it possible to approach the management of pain through analysing the behaviour and helping to change that and their experiences.

So, I learnt about these connections right at the beginning. Pain sometimes occurs in the most extraordinary circumstances and pain that is driven by psychological factors. This relates to a girl of about 20-22 and she was admitted to the hospital where I was surgically training and the surgeon who admitted

her said he didn't think that her abdominal pain which she'd had for six months had any obvious physical cause but he wanted to check so would I go and see her given my interest in these things.

So, I went to see her at bedtime which is a good time to see people and they're more relaxed then. You know I said to her, this pain you know in your stomach and how long has it been there? She said, "six months." And I said, "did it start suddenly?" She said, "Yes." I said, "Well did anything happen about that time that was significant in your life?" and she said, "Well on the day before it started I went with my boyfriend to a dance. We were going to get engaged and when we were on the dance floor somebody came up to him and said I wouldn't get engaged to her unless you know about this."

Where upon she got hold of her lovely red hair and locks and pulled them off and underneath she was bald. So, somebody on the dance floor had pulled her wig off and exposed her to everybody as a bald young woman and she fainted and was taken home and the next day she had abdominal pain and every time she tried to go out of the house the pain became much worse. So, in other words it was protecting her against further exposure and embarrassment. So, we made the connections, also she had virtually no fingernail and toenails. She had some abnormality of the production of keratin which makes hair and so had her mother.

Now I pointed out, her mother had managed to marry and was successful and so forth and this is something that she will be able to get over and she did, the pain disappeared and the pain appeared where a year before she'd had an appendectomy and something else I've learnt about that kind of event. The pain quite often appears in a site where there has been previous surgery. Suggesting that there if you like there's a memory trace that still exists and can be lit up by psychological factors.

**Andrew Baranowski:** You can see that when you do an epidural on someone for labour or whatever and you actually trigger off a pain from previous surgery because again you're manipulating the nervous system but in a completely different way. Which is a physical way rather than a psychological. So, the nervous system is quite complex from that point of view.

**Michael Bond:** Well it's certainly, the traces of what has happened are still there quite a long time afterwards. What happens in the case of the women who you were dealing with, is their pain disappear again.

**Andrew Baranowski:** Or it can become persistent. [inaudible] you can open up the pathways [inaudible] I guess once you've opened it up then the risk is that it reinforces itself.

**Michael Bond:** Well I was a resident in Neurosurgery and I was on duty one night at the hospital and telephone rang and a woman crying on the other end and said I want to kill myself and I said "hang on you know, what's wrong?" She said "I want to kill myself, I've got this terrible pain." I said, "Where is it?" She said, "It's in my back and legs." I said "Hasn't anybody dealt with it." She said, "Oh yes I'm attending Mr so and so." And she named one of the surgeons and he said he's going to do major surgery on me to deal with it, but I can't wait any longer.

So, I arranged for her to be admitted and she came in and they went to bed when she came in having examined her and she didn't just have pain she was paraplegic. She arrived in a wheelchair and she'd been like that for I think it was three or four years, anyway plus pain. So about six o'clock in the morning I got a telephone call, would I come over to the ward.

The lady was having epileptic seizures and indeed she was, she was in status epilepticus and we dealt with that but it was about 36 hours before she was fully (inaudible). And I went to see her in the ward and said, "How are you feeling Mrs X." She said, "Oh I feel rather groggy doctor, what's been happening to me?" I said, "Well you've not been very well, but I'm pleased to say you know made a good recovery, how are your legs?" She had this big bed cage over her "legs. She said, "Oh there alright aren't they." So, I got the ward sister to lift off the covers and I said, "Let me see." And she moved her legs up and down the bed and I said, "That's very good." The sister looked astonished and she said, "Well why are you interested in my legs." And I said, "Well when you came in you couldn't move them at all." She said, "Oh that wasn't me." I said, "You came in in a wheelchair." And she said "No well, I can't remember that at all."

So, I went off and I found the surgeon who was going to operate on her and I said, "I want you to come and see something." I said, "would you like to show Mr X your legs? She said, "You're very interested in my legs." I said, "we are." So, then the same thing happened, he just turned pale and walked away realising what could of happened and hadn't. So, I said, "Well that's fine Mrs X, we'll get the physios in and you'll get walking and be fine and then said to her "Well when all this started were there any really serious problems in your life?" She said, "Well there was a big one, there was a steaming row." She became paraplegic, you know it was a psychologically induced paralysis with pain.

**Andrew Baranowski:** But it's a real paralysis isn't it, because, I mean I can tell similar stories. I can think of a patient in particular who kept going to casualty with paralysis and then it would get better and so she came to see me and she was fine and went to leave the hospital and then I got a phone call saying this lady can't move her legs and so on.

When I did all the reflexes, this that and the other, you know she was paralysed and he said, "ok. Better get her admitted." But over time it became apparent that in this ladies case, that severity of the pain was such that to a certain extent she was dissociating from her limbs and turning off the connection and I think we can all feel like that sometimes, can't we feel like we can't get out of bed or whatever and it really is just to another level, so it's a real physical problem but generated from a psychological (inaudible). And I guess we also have to really appreciate that these things are really physical as you alluded earlier, about the depression.

You know depression can cause pain but obviously those living in pain can feel as if they're being tortured on a regular basis and therefore they're going to become depressed and there is a strong link between thinking about your pain, so this emotional thing which we call ruminating and dwelling on things and depression. The more you are aware of your circumstances the more likely you are to be depressed and one of the big risks which I'd be interested in having your opinion on Michael is actually if you treat the depression you can actually make the patients worse because you can actually remove something that is a protective factor for them and you can remove something which is actually protecting them from self-harm because they realise actually my pain is bad but the depression has been (inaudible).

**Michael Bond:** Well I ran an inpatient pain rehabilitation service for about 10 years at (inaudible) hospital. Basically, we had three groups of people. We had people who were not coping with pain that they had left with as a consequence of trauma of one sort or another and they came from various departments and they were on massive doses of analgesics often dihydrocodeine.

The second group were those who came in with a depressive illness and pain but no cause for pain other than the fact it was part of their depression and the third group of people were those who had pain which

was clearly being, it was an integral part of the way they managed their lives. We did well with the people who came in as a consequence of their trauma whatever that was and if they were habituated to dihydrocodeine, we had a five-week withdrawal program.

So, we would give them their regular dose of dihydrocodeine in cherry flavoured syrup and we told them that over five weeks the amount would be reduced. In fact, the last week there wouldn't be any dihydrocodeine at all, they didn't know that. The most difficult part of the whole operation was getting them off the cherry flavoured syrup at the end. Which there was nothing. But we did a lot of treatments of that kind and the depressed group we treated as depressed patients and of course obviously that went into the background of why the depression was there and why this defence mechanism as you might call it was operating.

So, it required possibly psychotherapy of one kind or another as well as antidepressant therapy to unlock and resolve the problems. The third group, those who used pain as a way of managing their lives were almost impossible to deal with. We never got very far or if we did it was a revolving door and do quite well. They go out two months later, three months later, they'll be back again with the same problem.

**Andrew Baranowski:** We've been talking a lot about patients as subjects. The third party who is examined and treated and whatever, but when did patients become important to the management of pain?

**Michael Bond:** As people you mean?

**Andrew Baranowski:** A person as opposed to a patient.

**Michael Bond:** Good question. I suppose it began to appear when we decided how to define pain, again going back to I think round about 1976. ISP set up a working group and I was part of the group. Work steadily on what the fundamentals were for the experience of pain and the definition came out of that as an experience which has physical, psychological and social components. I can't remember the exact wording but that's basically what it is, that was the essence really, that definition of the change over to seeing pain as a multi-dimensional experience and there could be any or all of these operating at the same time or differently.

**Andrew Baranowski:** And that was key to how we now assess patients. When you look at managing your patient as a whole [inaudible] and the individual as a whole, you're looking at the effect on the social side, relationships, the family, their physical ability to do things whether that be work or even simple things like going out for walks and so on as well as the emotional effect on their thought processes. What they think about the pain and the emotional responses [inaudible]. And that's where pain management programs come into this and their usually [inaudible] and patients assessed by doctors to make sure things aren't being missed to give the explanation [inaudible] and there run by psychologists, physiotherapists, nurses.

**Michael Bond:** There's also, something else to rise out of that, a definition and that was another way of measuring pain called the [Magill] Pain Questionnaire and what [Ron Melsak] and his group in Montreal did was to analyse the words that people used to describe pain and categorize them into emotional, cognitive, can't remember what they all are, but, and then the strength of the words is identified. You might say one to ten and by building up a picture, a word picture of the pain you can define the nature of the pain and at the end there is an analogue scale, an overall one to ten measurement, but it's primarily used for research, it's not something you use in the [Inaudible].

**Andrew Baranowski:** So, one of the things that I believe is going to be announced soon is that [Nice] is going to take on board looking at guidelines for pain medicine and the British Pain Society involved in that and that would be from primary community care through to specialised services. [Inaudible] what you say and one of the working groups that we've set up recently is looking at some sort of assessment, some sort of patient outcome measure that can be used, which will be used certainly in secondary and tertiary care and that's a joint project with BPS. The faculty of Pain Medicine and [Nice] have actually [inaudible] someone to work with us on that project. That would be some sort of holistic measure, simpler than [Inaudible].

**Paul Evans:** Well let's turn to the third member of our little [Inaudible] Heather Wallace, you are a patient. When did you turn from being a patient to a person, how did you get involved with this?

**Heather Wallace:** I was... developed pain when I was very young. I couldn't even describe this pain. I just felt very strange but I was gradually being told that there was nothing wrong with me and that it was all in my mind and the problem was nobody helped me. You know, I used to go home thinking, if it's all in my mind and I did kind of believe that because I'd been brought up to believe what your doctor said.

I used to lie in bed thinking, why am I doing this to myself? I'm destroying my life, why am I doing this to myself? And nobody helped me with the answer to that. Anyway, it did get quite bad and I was felt bullied. I can remember at some point particularly once I actually got under... in fact it was the psychologist who had trained in Canada on the Pain Management Program. I'd gone to him for a hypnosis for my pain, he actually said to me, "I think you've got nerve pain." So that got it sorted and then there was this sense, nobody does that to me, how dare people treat me like that. I'm afraid it was a bit, you know, I'm going to get my own back here, but, there was no point in carrying on a situation of conflict because we couldn't really solve the problem of pain and it was destroying, if you didn't get help it was destroying your life. So, the solution really was to get doctors who understood pain, were interested in pain, were interested in helping you restore your life and patients working together to really just bring about change that would help patients in the long run.

**Paul Evans:** How revolutionary was that Andrew?

**Andrew Baranowski:** Well actually when you started that question before you actually specifically asked Heather. I was thinking to myself, well I sort of was a junior doctor in 1984 and that's when I got involved with pain and I was thinking well, as far as I was concerned I was always working with individuals living with pain. Although that terminology has become much more common now as a doctor and the reason I got involved because I was working on the chest cancer wards and slowly [inaudible] just being developed and it was interesting with people didn't really know how to use the medication and things haven't changed much in some ways.

That's why I got involved because I said well actually we've got people here living with pain. There's a particular group of people who were potentially dying in pain as well and so for me, I've always seen it in that way but if you look at how things are talked about now days, there is a much stronger group and that's what the British Pain Society represents is the multidisciplinary pain teams and is the only society that has the mandate to do that, because actually our membership is of psychologists that you've alluded to as well as pain management physiotherapists which help with the physical disability side of it as well as the pain [inaudible], we work as a group and I did my MD thesis and my research [inaudible], in fact the history from when Sir Michael was telling his story, I was sort of being locked into the next stage really

which was understanding the neurological mechanisms for why people like Heather have nerve pain and why when you do an epidural why the psychological things switch on these pain memories and so on.

So, that was the research and that was in the 1990's, so, having trained as anaesthetist. Which was the only way to become a pain doctor, guaranteed was you had to train as an anaesthetist. So, I did all my higher qualifications, anaesthesia and then after about four years of being a consultant I gave up anaesthetics and became full time in pain medicine and then from an early stage I was a part of the British Pain Society. I can remember the first meeting, so, I was always involved in that culture of working with people living with pain rather than people we treat with pain.

**Michael Bond:** There is an interesting point that came to mind about pain, what is pain? And most people say it is a symptom of something, but, there was a big argument in the early 1990's that went on right up to WHO about pain as an illness. Pain itself can be an illness, WHO wouldn't accept that for a long time, eventually they did. So, it is now accepted that pain need not be a symptom of something else. It can arise [Inaudible] as really a malfunction of the nervous system, if you like, in one way or another. You might say well it's just a symptom of the malfunction of a system. But, that's not quite really what it means.

**Paul Evans:** Heather as a person with pain and driving force of Pain Concern what difference would that make?

**Heather Wallace:** Well, you've got something real, so it helps counter that disbelief because when you're producing pain and you haven't got the tumour or whatever the doctor can see and investigate then you're rather left wondering what's wrong with you. So, I think it's about being believed and also being able to come to terms and to a sense of peace that you don't have to be searching for a diagnoses anymore and that's really helpful because that allows you the energy to actually start dealing with the problem that you've got living with what's effective and you have to learn it's incurable and I think that's another stage of difficulty, but at least you know what you've got to deal with.

**Michael Bond:** I think one of the points really comes out of those comments is that often patients would turn up at turn up at the clinic saying and people say it's all in my head. What's really wrong, it's really not a diagnosis. It's a doctor who doesn't really understand what we've just been talking about, that is that the pain could be a disorder in its own right. I don't think that has completely filtered through. It takes me on another step to an issue that we have still to solve and that's the teaching of medical students about pain. I think they are still very poorly educated.

**Andrew Baranowski:** The Faculty of Pain Medicine which is part of the Royal College [Inaudible], they have this, they now have [Inaudible] into a number of universities, where they're educating students, but the general sort of quote is that actually medical students get less training in pain medicine than vets do.

**Michael Bond:** Yes, that's right. It's true.

**Andrew Baranowski:** I think that is changing, but, building on what Heather has said as well, I think providing the patient is open to it. One of the most rewarding things that they find, by coming to a clinic such as the one I run, is actually an explanation and we can explain and sometimes yes you have to say, I don't understand that, but, actually some really weird and wonderful symptoms that patients have, you can quite often explain them in terms of the function of the nervous system.

So, if you look at associations and conditions, patients with bladder pain syndrome often have widespread muscular [Inaudible] type symptoms. They also have weird things like low thyroid function and dry eyes which are related to, because the nervous system controls the immune systems. So, they get auto immune disorder type problems which cause strange sensations which are nothing to do with the main focus the pain which may be in [Inaudible] and so on are actually, you know when I started as a consultant and I was asked to see pelvic pain patients, I could understand all these weird and wonderful things. I'd say to patients, "well actually you're not as crazy as you think." So that's some of these things actually do have a basis and where as maybe I can't explain everything, I can explain a lot of things which other doctors have actually labelled you in some way as being a...

**Michael Bond:** Labelled is the word.

**Andrew Baranowski:** I hate labels.

**Michael Bond:** And you have really, from what you have said, pointed that out.

**Heather Wallace:** Yes.

**Michael Bond:** That's how you were treated for.

**Heather Wallace:** Oh, yes.

**Michael Bond:** It's quite a long time.

**Heather Wallace:** It was so destructive for me because, you know, that self-doubt, self-blame. It was quite a burden for me and there was no answer and you had to... because I was young with pain, you soon learnt you lost your friends if you moaned about this. So, you were really stuck.

**Andrew Baranowski:** Following on from that, the World Health Authority, they're now looking at their classification system and in the ICD 11 are next classification system. There will be pain as a condition in the classification. So, we'll now be separate to that. The other thing which I sometimes upset my neurologist with, which is explain what you're talking about as pain as a symptom versus pain as a condition.

Coming back to your story about the epileptic in a sense. Epilepsy is a condition and fitting, even though my neurologist doesn't like the term, fitting is like the symptom as it were and you can immediately see that there are two things. But, the problem with pain, is pain the term can describe a symptom and it can describe the condition and that's been one of the problems. I don't think there's anyway around that. I can't think of a different term that we would use.

So, we're slightly stuck with that. But, we need to separate them out in the same way as you might say were an epileptic fit, the fitting is the symptom, where as the condition is epilepsy and in some cases there maybe underlying cause like a tumour. Like you can understand in another case is the epilepsy maybe a neurological functional disorder.

**Michael Bond:** Just going back to the lady who had seizures or fits. The reason she had them was because we didn't realise that she was taking large doses of barbiturates and she didn't get anyway and she was admitted and it was in effect, the fits were a symptom of barbiturate withdrawal.

**Andrew Baranowski:** And that again raises the issue about the harm that we can do by treating the symptom, rather than treating the patient as a whole. So, we're now obviously going into these areas where a lot of the things are patients that have complained about a lot of the symptoms that actually generated by the intervention, where they've been medically intervention or whatever. I think all interventions; even psychological ones have risks that we need to be aware of.

**Michael Bond:** Well you're changing the system, with psychological treatment your changing the system deliberately.

**Paul Evans:** So, what we were saying is that the patient, the person with pain is so important, what involvement does a person in pain have within the system if you like.

**Andrew Baranowski:** So, there's certain separate patient agencies, but, then within the British Pain Society we have the patient liaison committee and I think what is significant about that is also been the patient reference groups we're linked into some six other individuals. So, that group can help inform the professionals and perhaps Heather would like to talk a bit about her experience in that.

**Heather Wallace:** Well, it was Sir Michael who took the initiative to say you'd like the society to look into setting up a patient liaison group. So, I think we spent quite a few months working on that. I can't remember [inaudible]

**Michael Bond:** Mrs [Gaffin] became the first chairman.

**Heather Wallace:** And indeed I still worked with her, she's a trustee now, of Pain Concern So, we've formed a long continuous relationship and in the initial days we had to tread very carefully because we were breaking new ground and a lot of health care professionals did not feel that there was a role for patients within a professional society and I think we succeeded in that because we wouldn't not to threatening that was what we aimed to achieve so that we would become accepted and that has happened and I think now, the society would simply not be without.

**Andrew Baranowski:** [Inaudible] And in fact I would like, I've got my own ideas about further developing that and I don't know Heather if you've got any thoughts that you'd like to give me, any suggestions about how you feel that patients should be more involved.

**Heather Wallace:** I think closer cooperation, I think pain world is so small and so vulnerable, compared to the big conditions, cancer and what not out there, which are very worthy, very important, but, pain is also important to people's quality of life and I think it is that quality of life we're trying to restore. So, coming together will make us more powerful.

**Andrew Baranowski:** But, I think also you're slightly belittling or downgrading the level, the problem because, you know the national pain [inaudible] that living with pain, your quality of life can be worse, not everyone, but, can be worse than living with any other condition and if we also take on board actually about half the population over the age of 50, have chronic or pain, persistent pain lasting for more than three months at a time.

Then, actually it's a big problem, but, it is not maybe if I dare use the word, as sexy as some of the more emotive type of things. One of the things has been suggested and I've been dwelling about and may happen due to my presidency, depending on other people's views and politics would be to expand the [Inaudible] group to maybe friends of the British Pain Society.

Change that terminology would be that you would have the professional section but then you would have the friends of the society as well as the patient liaison committee which would be the direct body responsible for coordinating the viewpoint of the patients. I'm slightly looking at maybe strengthening the relationship with the patients and maybe it's quite nice to have to have in this room both Sir Michael and myself and yourself.

**Heather Wallace:** I think policy needs to be strengthened and that's where you do need to bring people together but there is chronic pain policy coalition really has a really important role to play in this and getting parliamentarians on board, getting the Department of Health on board and getting clinical guidelines adopted perhaps voluntarily but just mandatory, this is how you treat pain.

**Andrew Baranowski:** I strongly agree with you, that's why we set up the coalition which is a group, we meet every four, five times a year. Which is the Chronic Pain Policy Coalition, the Faculty of Pain Medicine of the Royal College Anaesthetists, The British Pain Society and because of its... the politics around it, the [Inaudible] group is co-opted to that. Patients on that have been represented through the BPS and they're ongoing conversations as to whether or not they should be a direct patient agency on that other than through the BPS at the moment and there is an argument for strength in that I think because you say working together is key, if we're fragmented then we won't survive.

**Paul Evans:** I'm very conscious of the time. Can we just finish off, firstly congratulations on 50 years of The British Pain Society. I think we know where you started and where you are now, well where we are now because patients are persons with pain and we're part of the team. Where would we like to be in the future?

**Andrew Baranowski:** I think one of my driving forces before I became president of this society, I was chair of The Clinical Reference Group for NHS specialised services and quite aware that there's a [dirth] of services but we're also aware that hospitals cannot provide, if you look into... take into account the instance of pain and the figures vary but suffering from pain is quite significant. There's no way hospitals will be able to take on board all of that, so it comes back to the education is key. So, it really is important that we educate all medical professionals into the complex dynamics of living with pain and then to look at networks of services and that was my real driving force when I was chair of the Clinical Reference Group, was I envisaged that we would have in England [Inaudible] we'd have maybe six specialised services or 12 specialised services, which would work with District General Hospital Services, which would work with community services and we would have a true network.

So, what I would like to see in the next ten years because I think it's certainly doable in ten years, but it may take 25 or 50 years, is that you have a network of services so that the person living in pain has someone to turn to, they see the right person at the right time, in the right place, so it should be local where possible but obviously the more complex patients may need to go to the more specialised services. So, in terms of the future for provision of services, that's what I think needs to happen. Much wider education and a much wider ability for the primary community care services to support patients.

**Michael Bond:** I know that the other dimension is of course educating the public which is what Pain Concern is all about. They need to be educated over and above the doctors.

**Andrew Baranowski:** So, that brings us to the British Pain Society in a sense and when I became president, with all the problems that the society is navigating at the moment, which we're also navigating in one way

or the other with current politics, is what is the role of society and we've looked at our values, we've looked at our mandate and so on and I think raising awareness of pain, [Inaudible] the big thing that we're launching at this 50th anniversary is our national awareness campaign and we've had a number of meetings about that, it's taken three or four years to get to where we are.

At the moment we've now got the posters which I hope that all those living with pain will share on social media to raise the awareness. Each poster has a poignant point. It sort of makes it clear statement about something to do with a living, suffering of chronic pain and so on and it covers war veterans, it covers women, it covers children, it covers all ethnicities and specific problems and so on and that will develop.

So, that will be a part of our education problem, raising awareness but also on the back that we're raising awareness of what the British Pain Society does through its membership so the British Pain Society supports its members, to actually provide services for those living with pain. There's no doubt we have to accept that we need to have financial responsibility now days and so I'm hoping that that awareness campaign will also bring in more money because the British Pain Society has done over the past 10, 20 years particularly and Sir Michael Bond has been involved more recently than when he was president originally and see's the huge amount of work that's now done with government, with [Nice], with Royal Colleges, with patient support groups.

All of which we can't do without money and industry is shrinking in terms of what it's providing and so, where would I like to see the British Pain Society. I'd like to see independent of industry, financially so that we can act with financial stability through raising awareness of what we do to support living with pain. So that we're in a position to actually continue drawing up guidelines, steering agencies such as [Nice] and the government and so on to try and provide that network of services that sort of support which patients need.

**Heather Wallace:** Public awareness is really important, I mean there has been initiative and indeed there was a declaration in Montreal a few years ago. That pain treatment, pain assessment and treatment is actually a basic human right.

**Michael Bond:** That's right.

**Heather Wallace:** And it would be wonderful to have that culture throughout and indeed the focus from treating the complex pain patient, to actually moving towards prevention of that occurring in the first place and I think science is moving that way, not convinced you're there yet.

**Andrew Baranowski:** Only an education and understanding will prevent a lot of [Inaudible] and one of the things that was interesting when I was chair of the Clinical Reference Group is that we managed to get pain management as being a cornerstone service, therefore if you have a specialised services for kidneys or brains or whatever it may be, you can't have a service without a pain service linked to you, but, I agree completely with Heather, is that the more that we sort of [Inaudible] away at this, the more likely we can prevent [Inaudible] by actually providing earlier support.

**Michael Bond:** And that is becoming increasingly relevant as one of them, the population grows older because there are increasing infirmities of all kinds amongst the elderly and if we can anticipate some of those, we may be able to reduce them.

### Contributors:

- Dr Andrew Baranowski, British Pain Society President
- Professor Sir Michael Bond, founding member and former president of the BPS
- Heather Wallace, Pain Concern Chair and BPS honorary member

More information:

For more information about The British Pain Society, please visit their website:

<https://www.britishpainsociety.org/>

International Association for the Study of Pain: <https://www.iasp-pain.org/>

Pain Concern: <http://painconcern.org.uk/>

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