Airing Pain Programme 41: Inside a multidisciplinary pain team

A look at how experts from different backgrounds work together in multidisciplinary pain teams.

Presenter Paul Evans travels to Northern Ireland to meet a multidisciplinary pain team at Craigavon Area Hospital, including doctors, psychologists and physiotherapists, led by Dr Paul McConaghy. We find out how cases of chronic pain are discussed by experts of different disciplines and how management strategies are then put into place.

The importance of educating GPs about chronic pain is discussed, as well as the need for empathic and respectful professionals.Paul Evans sees how the team works by sitting in on a meeting about an example patient: Dr Sam Dawson presents the case of a 38-year-old woman with chronic lower back pain. Referred by her GP, treatment so far has not led to improvement and she is now experiencing depression.

The team discusses the strategies they would use in working together with such a patient. Psychologist Dr Nicola Sherlock stresses the importance of treating depression as it not only hinders the management of a person's pain but worsens the symptoms, and she and physiotherapist Michele McGeown explain the importance of dealing with psychological issues, particularly fear of movement, in helping patients improve their physical fitness.

The team also talk about how they could use TENS (transcutaneous electrical nerve stimulation) machines to help some patients and how medical doctors and psychologists can work together to understand how a patient is likely to respond to injections. Finally, Dr Jim McMullan explains how GPs can learn from and complement the multidisciplinary approach by listening carefully to the patient and taking into account psychological and social as well as physical aspects of their condition.

Paul Harvard Evans: Hello, and welcome to ***Airing Pain***, a program brought to you by Pain Concern, the UK charity providing information and support for those of us who live with pain. This edition has been funded by the Big Lottery Fund's 'Awards for All' Programme in Northern Ireland.

Today I'll be examining the workings of a multidisciplinary pain management team to find out how cases of people with chronic pain conditions are discussed between experts of different disciplines and how management strategies are then put into place. I visited the Craigavon Area Hospital in Northern Ireland where the team is led by Consultant in Anaesthetics and Pain management, Dr Paul McConaghy.

Dr Paul McConaghy: At the present time our team consists of three doctors, three clinical psychologists, four nurses, and four physiotherapists, together with secretarial and typing

support, as well as the interventions of a radiologist whenever we need it. We also have the support of a pharmacist and radiographer. So I'm delighted that we have such a comprehensive team and, certainly in my view, chronic pain is best managed within a team rather than by individuals. We don't say we have a complete team yet. Patients with chronic pain can be quite challenging. They're referred to us because no one else has managed to get on top of their pain.

We've also spent a lot of time educating GPs and we have very little problems with how our GPs manage things in this area. But the result of that is we now get much more difficult patients, patients who even GPs, who have more knowledge and more ability now, that they can't manage. So we're getting more complex cases, cases which have a lot of psychological and social issues, as well as complex physical issues. And it's for this reason that we, for most patients, we involve our whole team. We meet up on a regular basis, we discuss our patients, and we decide on a treatment plan.

Evans: Can I see how your team works?

McConaghy: You're very welcome to. We're just about to start our meeting and you're very welcome. Come in, and we'll give you an example of a patient that we'd like to present.

Okay, so we'll start the meeting and Dr Sam Dawson, one of our registrars, has done a clinic recently and would like to present one of the patients that he's seen. He has some concerns about this lady. Sam.

Dr Sam Dawson: Okay. I saw a 38-year-old lady who for about eight years has had a history of pain in her lower back. She's referred to us by her GP, who's concerned that she's become a little bit depressed by this situation. She hasn't responded to any changes in the medication that the GP has made. He'd like a little bit of advice about the use of morphine in her case and whether or not there are any injections we can perform that might help her.

The pain is present all the time and gets worse whenever she does housework, that kind of thing. She's afraid then that if she does anything strenuous, she'll be sore afterwards. She's quite convinced that there's something seriously wrong with her, wrong with her back particularly, despite the fact that an MRI scan recently showed nothing seriously wrong, just some bulging discs.

So far her GP has treated her with tramadol, paracetamol, anti-inflammatories, and also tried amitriptyline, but she did have some side effects. They then tried pregabalin and physio, neither of which helped this lady.

She lives at home with her husband and three children. She's struggling to sleep and wakes up stiff and sore, usually taking her a few hours to get moving. She lives at home on her own during the day, because her children are at school and her husband's at work. During this time, she's pretty inactive because of pain and because of fear about being sore afterwards. She feels quite lonely and is perhaps a bit socially isolated. I examined her today and she's got quite restricted movement. Mostly, I think, because she's afraid of provoking the pain. The tenderness is fairly general all over her lower back, but it's mostly concentrated there.

McConaghy: Okay. Thank you very much, Sam. That's a fairly comprehensive history. There are quite a few issues there that we see quite often in patients at the pain clinic. There are a number of things I think we can look at. First of all, Nicola, Sam mentioned that this lady's been calling her GP, also mentioned that she's becoming depressed. Dr Nicola Sherlock, Consultant Psychologist, do you think that there's anything you could offer this lady?

Dr Nicola Sherlock: Yes, I think it would be very important to have a look at her depression, because what we know is that depression is a significant barrier to effective pain management. That's certainly an area that we could get involved in as a pain team and would be a particular role for myself.

So what I would like to do with this lady is maybe invite her to attend myself for assessment, if she was willing to do that. During that assessment, I would take a full history in terms of her pain but also looking at other aspects in terms of the impact that the pain is having on her life and obviously a mental health assessment as well. If we think that depression is a significant problem, one of the treatments for depression would be to offer her a number of appointments for her to attend psychotherapy. Hopefully, that would help her manage her depression, which then in turn would help her manage her pain more effectively.

Evans: Psychologists and doctors talk about the pain circles.

Sherlock: Mm-hmm. Psychologists tend to like the term 'vicious circles'. I think that in chronic pain, there are a lot of vicious circles, in that people can develop a pain problem and often there can be a lot of losses associated with that pain over time. I suppose initially when someone develops a pain, there's a hope that in a couple of weeks—'I'll go to the GP, maybe get some medication. In a couple of weeks, it'll begin to feel better.' And then as time progresses and the months progress, it becomes apparent that this pain remains, and it's still there. There can be a lot of confusion as to why this pain hasn't resolved: 'why is it still here?' And that can have a significant impact on people in terms of mood as well and levels of frustration.

So that's kind of the start of the pain cycle where the mood can go down. It can be the sense of frustration. Then, potentially, it can begin to impact on work, on social life, on relationships with people in the family because no man or no woman is an island. We all live within a context of

other people in some sort of family relationship or in friendships. Pain can have an impact on all of those areas.

Over time, things can really, really spiral, where people can become more and more down about their pain, more frustrated, more angry – more angry that there's not a cure for the pain, more frustrated that they can't find the right doctor or can't find the right treatment to take the pain away. There can be all of those losses associated with pain, which then can impact on mood.

Then we have, again, the fear that I talked about earlier – the fear of movement, the fear of exercise, which can lead to people becoming quite deconditioned physically. That can have an impact then on the things that they're able to do. It can spiral and become a vicious circle where people can become very low, very down, very anxious, very worried and frustrated about their pain.

We know that those types of emotional responses are very natural and normal. But we know that they can enhance the amount of pain the person faces; it can make the pain worse. I think when I started in the field of pain about 10 or 12 years ago, I would have thought, 'well, it's that the person thinks that the pain is worse.' But the newest research would show that the pain actually *is* worse, and that the part of the brain that processes pain – when people are feeling very frustrated, when people are feeling very angry, when people are feeling very low – that the pain is actually really worse, genuinely worse.

I suppose, as you were talking as well, Sam, I was conscious of you saying that this particular lady has a fear of activity and that her activity at home is quite limited in that when her partner and when her children are away from home during the day, she's on her own. She's spending quite a lot of time not really being particularly active. And again, that's very, very common. We would see that in a lot of people who present to our clinic would be very fearful of activity.

The difficulty is that people can then become very inactive, and then that can, I suppose, exacerbate any pain problems that's there. And also if she is inactive, then she's maybe not going out socially, which will have an impact on her depression.

So, for so many people, it can become like a vicious circle. I think that in this particular lady's case, I would say probably a role for myself in terms of the management of her depression would also maybe help her to overcome some of those fears and whatever social fears are there, as well, which are maybe helping maintain her difficulties at the moment.

McConaghy: Thank you very much, Nicola. One of the other things, Sam, which you mentioned was that this lady is not very active, and Dr Sherlock mentioned about having a fear of it worsening her back pain. I'd like to ask Michele McGeown, who's a pain physiotherapist: :f this lady's already been to physiotherapy, is there any point in her being seen by a specialist in pain physiotherapy again?

Michele McGeown: Absolutely. I think it'd be really worthwhile for her to attend physiotherapy again. I think the core thing that came out with me was the MRI scan and her understanding of the bulging discs, which suggests to me – even from the information that you've told me – that this may be playing on her mind whenever she's not moving. Is she afraid of the movement because of the bulging discs? Is she afraid that, regardless of what movement she does in any particular direction, this will make her pain worse?

So a core approach that I would use with her would be, first of all, understanding, giving her the education of how chronic pain persists and what drives that chronic pain. Then that would be one of the core aspects for her to understand, even to normalise the disc bulges, which would hopefully impact on her fear and get her moving better. Even within physiotherapy, we have one-to-one treatment for those who maybe need specific exercises and will manage with a treatment approach tailored to them.

But, also, one of the services that we offer is the pain management program – so that's the disciplines of physiotherapy, psychology, and nursing combined. The way we work at the minute in the Southern Trust is that we offer a pain education class, where all patients who are interested in attending combined therapies meet and are given information about their pain.

After this session, some people are happy to manage independently just with the advice and education about self-management. Others, then, will go on to our multidisciplinary pain management program, and some, then, will undertake the pain plan, which is an approach where they're given a booklet, or a work booklet, that they work through under the guidance of one of the health professionals – a psychologist maybe seeing them once a month for three months. It goes through all the information to help them manage their pain.

So, the big thing with this lady we'd be working on is getting her more confident to move by education, by lowering all her worries and her fears in relation to movement, which hopefully will interact on her depression. And we know that for mild to moderate depression, one of the three things that is offered and is recommended by the NICE guidelines, along with medication and psychotherapy that Nicola's already mentioned, is exercise, and how important it is for her to exercise. If we decrease her fears of exercise, and encourage her independent exercise, that hopefully will impact on her depression as well as her pain.

McConaghy: Can I just ask, Michele, are there any exercises that you think this lady would not be able to do because of the MRI results?

McGeown: Absolutely not. I think the idea is giving her an exercise that suits her and giving her the confidence to exercise. So there's no reason at all that she can't. It's just finding what suits her and suits her best. But again, it's dismissing those fears and maybe information that she's been told in the past where she's been anxious.

McConaghy: It sounds as if it would be very useful for this lady to attend your combined clinic...

McGeown: Absolutely.

McConaghy: ...which I know you run, which has certainly been very productive for this team and for the patients in this area.

Evans: If I were one of Michele's patients, Michele being the physiotherapist, and she was having problems with me, or I was not exercising and having trouble with that – 'No, I can't exercise 'cause it gives me pain,' you know, 'I cannot do it' – how would you help her help me?

Sherlock: I think that one of the best ways of kind of conceptualising that worrying and thinking about it is to think about it nearly in terms of an anxiety or a phobia. Most of us will be familiar with what a phobia is, so it's like an intense fear: people could have a phobia of spiders or snakes. Most of us are familiar with that. But I think that with a lot of patients, they can have a really significant fear about activity and physical exercise, and making their pain worse.

So the way that we would treat that kind of thing is to begin a graded exposure. To use the analogy with the snake, if you were very, very fearful of snakes, and if you felt that you needed to overcome that – hopefully you wouldn't because hopefully you don't encounter too many snakes in your life – but if that was a significant problem for you, what we would begin to do is maybe initially start by talking about snakes and you would learn to tolerate and cope with that anxiety. Then we'd maybe show you pictures of snakes, then maybe have you close to a box containing a snake and, so forth, until eventually you are holding a snake.

And really, it's the same analogy that we would use in terms of management of fears of exercise, so it's very, very slow, very gentle introduction to exercise so that people see that their greatest fears don't come to pass.

I think all of us avoid what we're fearful of. It's human nature. We avoid what we're fearful of. Really, the only way of overcoming those fears are by actually doing it. So I could say to you, 'don't worry, that snake won't harm you.' But you're not going to believe me because that's so deep-rooted with you. But the only way that you really come to see that for yourself is by gradually doing it. So it's not about me throwing a snake at you, it's by moving gradually through a process of exposure to that fear. And it's the same with activity.

So for Michele to go in and say, 'absolutely ridiculous. You're absolutely fine, just go out and do the activity' – that doesn't work because those fears are so deep-rooted. So it's about gradual, graded exposure and building people's confidence. So myself and Michele, the physiotherapist, would liaise quite closely in doing that work.

McGeown: We have an idea of the impact of the pain's physiology, but what I really, really learnt from psychology over the years is really getting down to how it really impacts on their depression, how it impacts on their mood, their feeling of self-worth. Having the empathy for the patient, telling the patient that you understand, is half of the battle. Giving them the confidence that you can help them manage their pain, it's giving the respect to the patient. But at the same time, knowing your boundaries, and knowing that as a physiotherapist, you can help them with their managing their pain. But what I've really learned from psychology is knowing when to signpost on, and saying, 'okay, there's maybe significant barriers here, that your depression is too high. You need to be signposted onwards.'

Evans: And that's presumably where a team meeting like this comes in.

McGeown: Absolutely. It's great that we meet once a month, and if there [are] any patients that we're concerned about, that we can discuss them at a team meeting. Sometimes just talking it out loud and having the support from the other members of staff and getting their feedback really helps.

I think even the patient being able to say to them, 'are you happy for us to discuss at a meeting?' – they're thinking: 'This person really understands the impact this pain is having on me.' Then again, you feed back to the patient that you've discussed them at the meeting and then the outcome. So it is – it's great.

McConaghy: There's one other thing for back pain that is sometimes used and that's a TENS machine, which some people find useful. Sister McInerney, who's a pain sister, runs her own TENS clinic and also makes changes to medications as well as giving a lot of cognitive behavioural advice. Bríd, would you be interested in having a look at this lady?

McInerney: Yes, I would be interested in seeing this lady and trying a TENS machine. TENS may well be of benefit. It's a drug-free device and simple to use. I also would like to talk to her about self-management and stress the importance of self-management.

A TENS is a TENS machine: transcutaneous electrical nerve stimulator. It's a battery-operated device which can relieve pain.

Evans: You see, I've got a TENS machine. They're around the size of a packet of cigarettes, really.

McInerney: Yes.

Evans: There are four little dials on it, one with squares and one with triangles, if I remember rightly. I have no idea how to use it other than if it's making me uncomfortable, then it's doing something good. Is that right?

McInerney: Not particularly. [*laughs*] And often that is the case, you know. So it is very worthwhile to have it explained properly, because it is only when it is explained properly that the benefits are achieved.

Evans: I haven't used mine for some time. I didn't find it particularly effective. Perhaps that's because I'm not using it correctly. But from memory, there are, like, paddles that you stick to yourself or electrodes that you stick to yourself.

McInerney: Correct.

Evans: And I guess the electricity pulse travels from paddle to paddle, and you get like a tingling effect across your shoulders… [**McInerney:** Yes.] or across wherever you've done it. And if you turn it up, it actually gets sharper and sharper and sharper, like pinpricks.

McInerney: Yeah, there are controls on the TENS machine. It's very simple. Basically, there's the on switch, the off switch, and you can increase the pulse width or the frequency, basically, which is increasing the intensity. The electrodes, the sticky pads, are placed over the appropriate area and this tingling is delivered to that area. There's not every type of pain that we would suggest you use it for. It can work very well for muscular type pain or localized pain.

McConaghy: In relation to the two points that our GP mentioned, which I think we have to address specifically, namely the use of morphine and the place for injections, Dr Jacek Sobocinski is a consultant at the pain clinic who has a special interest in spinal injections. And I'd be very interested, Jacek, if you thought there was a place for injections in the management of this lady's pain, from what you've heard.

Dr Jacek Sobocinski: Obviously injections certainly play a significant role in treatment of patients with pain conditions. But as we heard already from Nicola, Michele, and Bríd, that is so important to look at the patient not only as part of the body which suffers the pain but to see the patient as a whole person and manage the situation: before we even think about the injections we seek opinion from psychologists, physiotherapists, or TENS clinic.

As what I've learned over the last fifteen years, that injections however they're really a strong and important tool in treating pain conditions, they work far better and they are more successful if there is a combined treatment with psychological approach, physio, and TENS treatment. Obviously, there is need for medication – yes, this is very important – but I would like to just highlight the importance, that injections, however they are available in pain clinic, they're not the only tool, and they're not the tool that all the time gives relief. This is very important, that I would like to pass this message on all the patients. Okay.

McConaghy: Thank you very much, Jacek. So injections may have a role, but we need to wait on an initial assessment by our colleagues first. That sounds reasonable.

The final point that was mentioned by the GP was the use of morphine, which is obviously a very strong pain killer. We're delighted to have as part of our team Dr Jim McMullan, who is a GP with a special interest. Jim, do you believe that potent drugs like morphine have a place in this lady's case?

Dr Jim McMullan: This lady, not to use too much jargon, seems to have a lot of yellow flags: lot of warning signs, that there could be mental health problems, she has signs that she's got a depressive illness: she's having poor sleep; she's tired all the time; she's having fear-avoidance; possibly some catastrophisation behaviour… all of which would make me very reluctant to move up to potent opioids.

She has been tried on co-codamol and tramadol, which are of the more weak opioid variety, with poor response. And certainly my gut feeling, without a proper bio-psychosocial assessment of this lady, would be to avoid strong opioids. I think we may be making this lady's condition worse rather than better, and of course, the long term evidence for use of opioids in chronic, non-malignant pain is very weak, particularly over, I think, over a year and a half long.

[*phone rings*]

The thing I teach at Queens University at Belfast is communication skills, and I was always told that if you didn't ask the right questions, you wouldn't be told the right answers. And if you didn't listen to those answers, you would certainly never pick up on the story. We still believe that 80% of the diagnosis would be made from the history. Examinations and scans are all very helpful, but the vast majority of our diagnoses will be made from a history taking; if you don't take a good history, you're not going to get it right.

So, communication skills, listening to the patients, believing the patients, listening to their ideas, their concerns, their expectations. Of course, in primary care, we're much more used to dealing with the chronic disease model than perhaps some of our hospital colleagues, much more through the bio-psychosocial aspect of chronic pain rather than, "Oh, drug X didn't work. Let's try drug Y." Let's look at why drug X didn't work; let's see what's going on at home; let's find out how they're coping financially; let's see what their mental health's like, find out how their children are keeping: the big picture. Not just another tablet.

Evans: Yes, but you do communication skills for health professionals.

McMullan: Yes.

Evans: What about communication skills for patients? How should I as a patient speak to you?

McMullan: I think every patient should speak to the doctor the way they feel most comfortable. I think it's up to the physician to put the patient at their ease and we always talk about the golden use of silence. Ask a good question and sit back, say nothing, and see what happens. Sometimes you can be surprised: you'll get a 20-minute answer; sometimes it could be a 20-second answer. But certainly, you should be silent and let the patient tell their story in their own words.

Evans: Many patients with chronic pain will feel sometimes let down by their GPs. They have their four-minute, their ten-minute consultation appointment. I'm thinking that the GP, doctor then says goodbye and the paper gets closed until the next appointment: "See me again in 10 days' time," whatever. It's quite interesting to see a team working in here. What do you bring to that?

McMullan: Well, again, I say, we're used to a chronic disease model in primary care. We're used to teamwork. For example, if we use the simile of diabetes, like diabetes, the doctor, the GP can prescribe the correct drugs, but he's going to need help from the podiatrist. He's going to need help from the ophthalmologist, to make sure there's no eye problem. He's going to have the clinic talk, if it was a particularly difficult case, to a diabetic specialist or a diabetic specialist nurse. You may even have to, if their control is so poor, we may even have to refer them up to the hospital for their input as well, as regards [to] perhaps injections and insulin surveys.

But ultimately, the patient has to take their responsibility as well. There's no point in me giving the best of treatment and the patient then going out and not sticking to the diet, lifestyle and exercise and completely ignoring what they're told. So it's time to get everybody on board and everybody involved.

And you're absolutely right. In secondary care, I have half an hour for a new patient and 20 minutes for a review. In primary care, I have 10 minutes. It's very hard to cover everything in one 10 minutes. The one thing I will say is this: as the patient's GP, I may be far more aware of their social isolation or their financial situation and I certainly will be a lot more aware of their family history of problems and what's going on, so I might be in a better position to make that comment and to find out whether this is a… somebody who requires more close follow up or someone who doesn't.

Evans: We say during all these ***Airing Pain*** programmes that you should always consult your own GP or your own medical professional on any matter relating to your health. And that's what you're saying, isn't it? You know them better than…

McMullan: Absolutely, we're in a very privileged position. These might be people whom you have known from birth, or from preconception, right the way through to their adolescence to their marriage to their having children of their own. You're in a very privileged position. And

that's an awful lot that's not in their notes. A lot of that's not on the computer screen. It's in your head.

And again, I know one of my colleagues in secondary care will not prescribe an opioid without having a psychological assessment done and that's because he quite honestly and rightly says, "I've only known this person for half an hour."

In primary care, we would be much quicker to make that decision because we will know about their social situation, we will know if there [are] yellow flag issues in the house, if there is alcoholism, if there is addictive personality, if there is a gambling issue or if there's something else going on. We will probably know that, and we don't have the privilege of having a psychologist to refer to for that assessment. We go on our own gut instinct and our experience from knowing the patients so well.

McMonaghy: So we've arranged this lady to be seen at the combined clinic of Dr Sherlock and Michele McGeown at the physio and psychology. We'll arrange for Sister McInerny to see her at her TENS clinic. Then we'll discuss her at our next meeting and decide if there's been any progress and, very importantly, of course, what this lady has agreed to in terms of future treatments.

Evans: You've just discussed the case of a patient who, I have to say, is not a real patient but a typical patient.

McConaghy: That would be a fairly typical patient with a pain problem, but around that, there are other psychological and social issues, and the whole thing is ingrained. They're all interlinked and trying to disentangle it does involve a team approach, as you have heard.

Evans: Dr Sam Dawson presented this patient to you, hopefully that the team could sort out a plan, really, for the patient. What happens next?

McConaghy: The next thing would be to offer the patient some appointments. Initially, she would be seen at a… be offered an appointment at our combined clinic between our psychologist and our physiotherapist. Now this can come as quite a surprise to patients because they've come with a physical problem, yet they're being asked to see a psychologist. Patients quite often wander: "Does this doctor not believe me? Do they think I'm mad?"

Now, if I had seen this patient individually, I would normally explain my reasons for this. Indeed, it's because I believe that the patient has genuine pain and is not mad that I'm asking our clinical psychologist. If I thought she *did* have a psychiatric issue or wasn't in significant pain, I would not involve our psychologist.

Soon after that or around the same time, she would see Sister McInerney, and Sister McInerney has got many years of experience in chronic pain, not only in dealing with the physical problems, but in talking to people and working out exactly what is going on. There may be other issues in relation to this lady's case, marital issues, for example, stress at home, financial issues, if she can't work. And all of those will have to be brought to the surface. We won't have the cures for any of those, but we will have advice. And if the patient is open, then the outcome can be surprisingly good.

Now, when this patient's been seen by my three colleagues, we will re-present her at the meeting and we will have an update. If she has responded well, I suspect strongly that my colleague, Dr Sherlock in clinical psychology, will want to see this lady reasonably frequently over the course of three or four months, and will perhaps suggest to the group that she's allowed to treat this lady for that time before re-presenting her. At the end of that, she will give us an update on how this lady's doing, and that will include issues around her quality of life, depression, activities, social phobias, as well as her pain.

She will then offer the group the chance to contribute, or whether one of the doctors would like to see her, perhaps to change the medication or to consider an injection. At that point, we'd be very keen to do that. Our physiotherapist Michele would then be in a position to tell us what her function is like and, as a specialist in the management of chronic pain, Michele has particular expertise and has been able to help the doctors on the role of injections. She'll quite often come back to us and say that a particular injection would be beneficial, and it would not be unusual for us to book the patient for the procedure after sending them a letter to let them know without actually seeing the patient and seeing them for the first day because we have that much faith in our physiotherapy colleagues who have had training in the management of chronic pain.

We're delighted to be able to offer almost all injections that are available for chronic pain, whether it's simple joint injections through to implanting spinal cord stimulators. But we're careful about [to] whom we do that, and injections are part of a treatment plan. For some people, they are a big part of it; for some people, they are just a minor part. But we consider all of the options in all of the patients.

Evans: My thanks to Dr Paul McConaghy and his team at Craigavon Area Hospital in Northern Ireland for that fascinating insight into the workings of a multidisciplinary pain team.

Now don't forget that you can still download all the previous editions of ***Airing Pain***, or you can obtain CD copies direct from Pain Concern. If you'd like to put a question to Pain Concern's panel of experts or just make a comment about these programs, then please do so via our blog, message board, email, Facebook, Twitter, or pen and paper. All the contact details are at our website, which is painconcern.org.uk.

Contributors

- Dr Nicola Sherlock, Clinical Psychologist with an interest in Pain Management
- Dr Sam Dawson, Registrar
- Dr Paul McConaghy, Consultant in Anaesthesia & Pain Management
- Mrs Michele McGeown, Specialist Pain Physiotherapist
- Sister Bríd McInerney, Pain Sister
- Dr Jacek Sobocinski, Consultant in Pain Management & Anaesthesia
- Dr Jim McMullan, GP and lecturer at Queens University

Additional Information

- *Red flags* – clinical indicators of possible serious underlying conditions requiring further medical intervention. Red flags were designed for use in acute low back pain, but the same principle can be applied more broadly in the search for serious underlying health problems in assessing a patient with any kind of pain.
- *Yellow flags* – psychosocial indicators suggesting increased risk of progression to long-term distress, disability, and pain. Like red flags, yellow flags were designed for use in acute low back pain but can also be applied more broadly to assess the likelihood of the development of persistent problems in patients with any kind of pain.

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