Programme 70: The case for pain management

Movement as medicine and putting pain management centre stage.

Make sure you stand up and do a few stretches after listening to this episode of Airing Pain! 'Movement is medicine' for people in pain, says consultant physiotherapist Eve Jenner. But it's about more than just exercise – physiotherapists can help people understand pain, know the difference between 'hurt and harm' and get a better night's sleep.

Understanding pain matters for doctors and public health officials too, argues pioneer of pain management services Professor Michael Bond. It's not just political correctness to look at pain as a problem in itself, it's a question of biology: changes in the spinal cord make pain persist.

Getting that message across could be a matter of life and death. Research suggests that delays in the diagnosis and treatment of persistent pain can reduce life expectancy, Dr Manohar Sharma says. He explains why working as a team of different specialists, including the person in pain, is crucial for making the complex spinal interventions he specialises in succeed.

Paul Evans: You're listening to ***Airing Pain,*** a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain and healthcare professionals. I'm Paul Evans and this edition's been funded by a grant from the Hospital Saturday Fund.

Is chronic pain a condition in its own right or is it a by-product – for want of a better word – of other conditions? Is it important to make these distinctions? Sir Michael Bond is a retired professor of psychological medicine. He's been an influential voice on the international stage in arguing that pain should be classified as a condition in its own right.

Sir Michael Bond: Until very recent times everybody, doctors included, regarded pain as a symptom of some disorder or other, one organ or an injury, or whatever. Pain is just a symptom. And it's extremely difficult to convince people that you may have an injury that recovers but you're left with persistent pain, although there is now no tissue damage evident.

But what we do know, from neuroscience, is that if pain is present for a certain period of time, in some people, there will be changes in the cells in the spinal cord that are permanent. So although the tissues that were originally involved are not responding to injury anymore,

the cells in the spinal cord are behaving as though they were. So we have pain as an illness in its own right, it's in fact a consequence of channels through which noxious stimuli pass not recovering.

Evans: That's interesting because I've been aware of making this thing pain as a condition in its own right, but I thought that was a political act to get it taken more seriously, but you're saying that the injury has changed the body in a certain way.

Bond: Indeed, that does happen.

Evans: What difference does that make?

Bond: Well it means, generally speaking, that the doctor or doctors who examine the person, who are not aware of this, believe the patient is faking it, or for some reason or other complaining of something that isn't really genuine: 'It's not genuine. There's nothing wrong. How could it be genuine?' And yet, it is genuine, but the reason is because the damage is elsewhere and those who are not aware of these things don't know that. So that's the reason, I think.

Evans: But if you do know that and if other people know that, and if it's accepted, then why is there an argument?

Bond: Well there isn't the same argument now that there was, when people said pain was just a symptom. It took us a long time to persuade WHO (World Health Organisation) that pain could be a disorder in its own right. And it's only in 2008, I think, that the Scottish Government accepted that pain is a disorder in its own right. And even more recently in England. So accepting that pain can be a disorder in its own right is very new in the British Isles, it doesn't go much further back than that outside the British Isles, so it's a concept which probably hasn't percolated through to quite a lot of the community yet.

Evans: The implications, I guess, of all of us with persistent pain now having a *disease* could be quite enormous.

Bond: I'm not sure it would be called a disease: it's a dysfunction of part of the nervous system, but it's not a disease in the sense of an infection, or a direct injury; it's an alteration of function, that's brought about by a stream of traffic which has now ceased. So you've got a differently functioning spinal cord than you had before this event occurred, but it's not a disease: we would regard it as an alteration in function that gives rise to this experience called pain.

Evans: For people living with pain that's all semantics [**Bond:** yes], disease or dysfunction.

Bond: Yes, well what I used to say to people was: 'your original injury, the actual site is no longer a site of damage, but things have changed in your nervous system such that you continue to feel pain.'

Evans: Since it's been recognised as a condition in its own right, what difference has that made?

Bond: I think perhaps the difference is that the government now accepts that that is one of the causes of pain. And I suppose if it comes down to costs, it can be costed, as you might cost a broken leg, you know, this is the value we attach to that; whereas before we didn't attach any value to it because we didn't believe it existed in that form. I don't know.

Evans: I suppose the cynic might say – and I hope I'm not a cynic – but the fact that there is a cost to pain may have been one of the barriers for having it recognised as a condition in its own right.

Bond: Well, that's a subtle point – I don't know [laughter]. You may be right. It certainly wouldn't have been the case at WHO: I think they just said 'no it can't be true: it's a symptom, it's always a symptom'. There was a discourse going on between IASP and WHO for quite a number of years about this topic, and...

Evans: IASP is the International Association for the Study of Pain.

Bond: That's right, yes, that was founded in 1973. Whereas in Scotland the formation of groups of people who are interested in pain and want to make changes in the conditions for pain patients is a much newer development. I mean there have been pain clinics in Scotland… I remember going to a pain group meeting back in the late 1960s. I had a pain service, an in-patient, pain rehab service in the 1980s in Glasgow, but there wasn't a nationwide body that pulled things together. The North British Pain Association came along in 1988 – that was Scotland and Northern England – and that did something to begin to pull things together. And it's in more recent times – Pain Concern came along, later still – that there's a national movement really, to give far better services to patients in pain in Scotland.

Evans: But you were a pioneer in pain management services…

Bonds: We had the first in-patient unit for rehabilitating people with chronic pain, back in the early eighties – that lasted for about ten years. So, yes we were right in at the very beginning, but at that time there wasn't anything happening elsewhere in Scotland. There were other pain clinics, out-patient clinics, but no in-patient facility. And the curious thing is that the pain rehab unit was on a psychiatric ward in a general hospital. That was simply

because of my position in the system, but it was regarded as a slight oddity, to have a pain rehab unit in a psychiatric ward.

Evans: But that was very forward thinking. People might not have seen it, people might have judged it as pain patients are psychiatric cases, but in today's thinking it must have been very forward thinking.

Bond: Well I think the point was I didn't see them as psychiatric cases: those were the only beds I had access to. They didn't, for the most part, didn't have any form of mental illness, they had behavioural problems, they had chronic pain. There were three groups, really: one group had pain which followed surgery of one kind or another and they hadn't come to terms with it, they just couldn't cope with it – we treated them mostly successfully.

The second group did have a psychiatric disorder – usually a depressive illness – and treating their depressive illness got rid of their pain disorder. I mean 40 per cent of people with depressive illness have pain as a symptom of it and we had people in whom the pain was far more obvious than the depression, so their doctors were treating them for pain when in fact what was needed was treatment for depression.

And then the third group were people who had long-standing chronic pain, had seen every doctor under the sun, none of them had been able to do anything for them, or explain what it was they had and they were very resistant to treatment of any description. Oh, and the fourth group were people who were habituated or addicted to powerful drugs, mostly dihydrocodeine, df118; we had a detox programme for them which was generally very successful too.

Evans: It seems obvious to me now – I'm not an expert, I'm not a professional, I'm a patient – but it seems obvious all those people you're talking about should have been treated, as you were treating them, with a psychological bent. And that's exactly what you were doing.

Bond: That's what we were providing, yes. Again it comes back to the problem of the education of doctors. We know that medical undergraduates even now get very little instruction in the nature of pain and its management, although it's one of the commonest symptoms that will be presented to them.

Now, I may be demeaning them, but for them to make a decision to send a person directly to someone like me I think would be a step too far. They would almost certainly send them to a physician or a surgeon in the first instance and they, after investigation, would send them to me, sometimes with a cryptic note and sometimes with no note at all and the patient saying, 'well, they haven't told me what's wrong with me, they said I should come and see you.' The

system wasn't geared to thinking in those terms, given that mine was the only clinic, or in-patient facility, perhaps it wasn't unexpected that they didn't think firstly of sending a patient to see me. Nowadays they would.

Evans: Thirty years on since you had your ward, are you pleased with the progress pain management has taken?

Bond: In general terms yes, I think the British Pain Society, the North British Pain Association, the pain networks in Scotland in recent years have done a great deal to improve the lot of people who have particularly acute or chronic pain. And I am pleased in the sense that, it's taken time but things have developed in the right direction, yes.

Evans: That was Professor Sir Michael Bond.

Well, staying with the pioneers or torchbearers for the management of chronic pain, the Walton Centre in Liverpool has been at the forefront in the battle against chronic pain since the 1960s. It's recognised for its expertise, both nationally and internationally. Its clinical director of pain medicine is Dr Manohar Sharma, who shared some of his expertise on working within a multidisciplinary team at the British Pain Society 2014 Annual Scientific Meeting.

Dr Manohar Sharma: Chronic pain is a very complex field, complex presentation, so we need different specialties, specialists, who are involved in managing these complex pain problems. So, typically, we will have a psychologist, who is trained in pain management issues; we'll have a physiotherapy specialist; and then we'll have a pain specialist, who typically may have an anaesthetic background, but they may also be a general surgeon, they may be a spinal surgeon, or a neurosurgeon… So there are different disciplines, they have core skills in their own field but they bring those skills together in a group, so that the patient gets a one-stop shop and they get all opinions in one go.

Evans: Wel,l pain is a bio-psycho-social phenomenon. It seems fairly obvious to me that all those people should get together to talk.

Sharma: Yes, they should get together to talk, but it doesn't happen as uniform across the board. There are some units in the country who are very good, very well linked, but equally there are other units who haven't got that system up and running for a variety of reasons.

Evans: So what are you telling the delegates here?

Sharma: We were actually telling the delegates more about patients with chronic pain who really have a very complex chronic pain, meaning that the pain – they may have a spinal

pain, they may have had spinal operations and those operations haven't helped the patient – they are still very disabled and psychologically distressed and financially also very upset, because of the consequences of chronic pain. So their lives are in a misery.

So we have some specialised techniques, complex invasive methods to control pain. But we can't really introduce those methods just like one person deciding it. These are expensive, invasive treatments, so we need different disciplines, like psychologists, physiotherapists, pain nurses, pain doctors, maybe surgeons, coming together and making sure that the patient has fully understood and they are fully taking part in their management, so they get the best benefit out of it.

Evans: What would be a typical discussion, if there is a typical discussion, in a multidisciplinary team meeting?

Sharma: There are many treatment options for chronic pain patients and they are all fitted around patients' expectations, what they can or cannot do. Some patients maybe, for example, need a spinal implant to control the pain. They may not have many other issues, psychological or behavioural issues, they may have a very small localised area of pain and if they have a very good understanding of what their pain problem is and how it can be treated, they may go straight away, they may just need an implant. But they still need to be seen by psychologists and physiotherapists and nurses, to make sure that they have understood what they're getting into, so that they are able to manage it afterward.

On the other hand, the same patient, but different set of problems, they may be psychologically quite disturbed, affected by it, they're kind of...they may have lost the track of it and it's overwhelming for them. In those patients, if you just do the implant it actually may be counterproductive and might make the situation worse. So they need psychological treatments first, to optimise... so that's the balance we have to strike: we have to decide which way we go with the same patient.

Evans: How important is it for the patient to know that they are being discussed and taken care of by this quite large team of different disciplines?

Sharma: I think it's vital. I think it gives them a sense of confidence and sense that they are in a system, that not one person can just say yes and no and just make a decision which could go either way. I think when that decision is taken within a large team it's a thorough and vigorous process and we all talk to each other in a discipline, making sure that we have ruled out any other possibilities, you know, which could be applied to make them better, before going to complex treatments which sometimes can have complications. So I think it's

vital, I think it's important: we have less resources; we have to make sure we apply those resources where they are most likely to give us benefit. So I think it's important from both perspectives, from patient perspective, from commissioner perspective, that we have the best possible decision from all perspectives.

Evans: But from a patient perspective – and I am a patient – to feel that you are at the focus of everybody's attention, that you are the centre, rather than just a patient who comes in, has a twelve-minute appointment and leaves believing, 'well, that's done, that's sorted, one man is making that decision, I am no part of it' – psychologically that must be very valuable for him.

Sharma: Absolutely, I think typically in our hospital in Liverpool when a patient comes for a multidisciplinary assessment we spend at least an hour and a half or even two hours for one patient: they see a psychologist, they see a specialist physiotherapist, they see specialist nurses and that process takes two hours. But that doesn't finish it: they then write their summary report, which then goes to their consultant in charge, who must have referred this patient into that process. And then the consultant will decide what to do, and they will decide it based on their reports.

But also we will again meet the patient in the clinic and spend twenty minutes or so or more. And then we'll put everything together. So there is a lot of attention: it's patient centred and the patient has an equal opportunity to come back and say 'I don't think I can do that'. So now how can we make progress? So we have to consider what they can and cannot do. So I think it's like a jigsaw...

Evans: And the patient is part of the team?

Sharma: Yes, they are part of the team. And it's an evolving process when they are assessed by the team, and if there is an issue that the patient tells us that hasn't come across to the consultant in the initial consultation then that issue is taken further and then we try to see how it can be optimised, for example, some patients the team will say, you shouldn't have an implant now, but maybe you go on this rehabilitation course. And that may be better at this stage, but it's a very delicate… it's an important discussion, but it's introduced in a way that patients are able to understand the reasoning behind it and take part in it and be fully involved.

Evans: Shared decision making.

Sharma: Absolutely, absolutely spot on, yeah.

Evans: At what stage do people with pain get to be referred to your multidisciplinary team?

Sharma: It varies widely. In the UK I think there's huge variation. Typically they wouldn't come to the pain service initially; for example, some patients with acute sciatica may go to orthopaedics or a spinal surgery – they have an operation. And then they are told typically that they give it about six to nine months after surgery to settle. So typically in a pain clinic, if that person doesn't do well after surgery, they may come in the pain clinic maybe a year after onset of chronic pain. And we will consider that to be early.

Evans: It seems to me as a patient that a service like you offer in Liverpool is treated as a last resort when, perhaps – tell me if I'm wrong – the earlier a patient sees you in his pain journey, the better the chance of management?

Sharma: You're absolutely right: earlier treatment of chronic pain makes it less intractable, makes it also more likely to respond to treatments. And there is now a good evidence base being published and made available generally, that, chronic pain patients, if they're not treated early and well in time, it has an impact on their overall lifespan. And this is quite a strong statement to make. But it's not a simple thing – 'chronic pain, we can let it go' – it has a huge impact on their overall health and the longevity of life. So this is quite a serious discussion point, that access to early treatment, appropriate treatments, is vital.

Evans: So what could we do about it, is education the answer?

Sharma: I think the British Pain Society has worked very hard and worked very hard with the Map of Medicine to devise pain pathways and they have many sorts of pathways now for different pain conditions; for example, spinal pain or back pain is a huge problem and they have now devised extensive pathways as a guidance for primary care, secondary care and specialist pain management centres, as to how, typically, a patient with that condition should be managed. So these are all available on the Map of Medicine, which gives guidance to commissioners, to family care physicians and even the general public should be able to access those pathways.

So, guidance is out there, it's just being aware of what is the guidance and then commissioners buying into and implementing good practice guidance. And these are evidence-based guidance: a large working party has contributed to the pain pathways. So information is out there, it's just being more aware and uptake and implementation of those pathways by commissioners.

Evans: The Walton Centre, where you are, is a gold standard in pain management…

Sharma: Absolutely, the reason for this is we have different disciplines working together: neurosurgery, spinal surgery, psychology, palliative medicine, gynaecology and pain consultants, physiotherapy… all working together. And this is unique, a model where we are able to work so closely together for the benefit of the patient. This has taken about 40 years to develop this collaboration, that's why it's unique. And it's not something which can be purchased: it's the different disciplines who have strong passion, common passion, a common goal, that they want to treat, for example, cancer pain, very well, so different disciplines come together and provide rapid access to diagnosis, rapid treatment and aftercare. So I think that passion and motivation in the team, that develops with their confidence in the treatment offered and the outcome data for patient management... that gives more confidence to the team. That's why it takes thirty, forty years to come together and know each other and how they come together to make the best result for the patient.

Evans: That word passion speaks volumes.

Sharma: Absolutely, I think we have members of my team and it doesn't matter whether it's a Friday, or Saturday, or Sunday, I can pick up a phone and if this person needs a neurosurgical operation to manage a cancer pain, my colleagues are so passionate they'll come on a Sunday to come and see a patient, then operate on Sunday or Monday. So that's how we feel for cancer pain, or any other chronic pain management, we take it very seriously. These patients need to be given quick access and quick treatment if that is what is appropriate for the patient.

Evans: That was Clinical Director of Pain Medicine at the Walton Centre, Liverpool, Doctor Manohar Sharma.

I'll just remind you of Pain Concern's usual words of caution, that whilst we believe the information and opinions on ***Airing Pain*** are accurate and sound, based on the best judgements available, you should always consult your health professional on any matter relating to your health and wellbeing. He or she is the only person who knows you, your circumstances and therefore the appropriate action to take on your behalf.

Now, one of the members of the multidisciplinary team approach to pain management will be a physiotherapist. Eve Jenner was a consultant physiotherapist in the chronic pain service in Birmingham. Now she works independently of the NHS and is an advisor to the Chartered Society of Physiotherapy.

Eve Jenner: When you're looking at people who've got long term pain it's important that the approach is slightly different from what we sometimes call 'the medical model', or 'the find it

and fix it model'. As you know, unfortunately for chronic pain, with people who have long term pain, there often isn't a medical or a physiotherapy solution to take away that pain. So physiotherapists who work with people in chronic pain need to learn the skills and strategies to help people learn to understand their pain and learn what they can do to manage their pain effectively so they can get on with their lives.

Evans: You see most people will see a physio as somebody who inflicts pain on somebody.

Jenner: Yes, unfortunately that has sometimes been people's experience, but what we're really interested more in doing is helping people regain their fitness and their activity levels, so that they can do the things they enjoy. That might be by giving specific exercises, but often it's about helping people understand how to manage their activities and manage things like sleep and also things like breathing and relaxation, so that they are able to keep their pain under control so that they can get on with their lives.

Evans: So how would you help somebody manage their sleep?

Jenner: Well, sleep's really interesting because there are lots of things that we know that can disturb people's sleep and people often think that it's the pain that's the main problem – and it is sometimes – but what we also know is there are lots of things people can do themselves to help their quality of sleep. And that might be things like making sure they've got the right sort of mattress and bedding to keep them at a comfortable temperature and in the best position. To understand that their environment is really important, so we know, for example, that having things like televisions and mobile phones or computers in bedrooms is really detrimental to sleep.

And we also know that taking some activity during the day can help people sleep. And not taking cat naps – often people with chronic pain, they have poor sleep during the night and they try to catch up during the day, although that can seem like a good plan, what it can mean is that you use up your need for sleep during the day and then you find yourself awake at two o'clock in the morning.

Evans: But you can work yourself up into quite a sweat by thinking about going to bed.

Jenner: Absolutely, and that's one of the problems because the brain is very good at associating things and if beds become a really uncomfortable and unpleasant place, then just thinking about going to bed can make sleep seem a really long way away. But there are techniques people can do to help address that.

Evans: From what you're saying it seems to me that you're working as much with the mind as the body.

Jenner: Well, I think it's really important that people understand the different between hurt and harm, because often when people start to exercise or start to move they do get a few aches and pains and that can really cause a lot of concern. And physiotherapists can be very good at helping people to get the right level of activity for them and to understand that some soreness after exercise doesn't mean they've done any harm, but is just the normal system of when you start doing an activity after some time.

Evans: How would a patient get referred to a specialist physiotherapist for chronic pain?

Jenner: Most people get referred to physiotherapy through their GP and there are physiotherapists working in all areas who have experience in chronic pain. Some people can self-refer to physio, but usually if you have a problem with long term pain you may need help with a multidisciplinary team, with doctors and psychologists as well as physios, and in that case you'd usually go through your GP or a specialist pain consultant. But lots of physiotherapists in the community now are having experience with managing pain and can give people advice and support to help them learn to self manage their problem. And there are lots of resources out there as well, things like the Pain Toolkit and the Pain Management Plan, which is a development of the Pain Toolkit, which is to help people who need a bit more support and encouragement to learn how to manage their pain.

Evans: But should GPs and commissioners really be looking to spend more money on physiotherapists?

Jenner: I absolutely think they should, yes, certainly we know that in many parts of the country there are still long waits for specialist physiotherapy and for people to have specialist help for their long term pain problem.

Evans: That's physiotherapist Eve Jenner.

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Last words to Eve Jenner:

Jenner: Movement is medicine for people with chronic pain, so it's a really good idea to get into the habit of moving frequently because our bodies generally don't like to be in one position for too long. So even if you're sitting at a desk or watching television, it's a really good idea to remember to get up and stretch every twenty to thirty minutes and just change your position, give your body a bit of a break from sitting down.

Evans: You're looking at my static position [laughter].

Jenner: I'm looking at your static position. I think it's time for a stretch.

Evans: Thank you very much.

Contributors:

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