



# Chronic Pain Ireland

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*help is at hand*



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## Chairperson's Welcome

### Dear Members

By the time you receive this Newsletter we will be heading into autumn and hopefully an Indian summer. Back in November 2009 the Governing Body approved and adopted a Charter of Rights for people living with Chronic Pain. That was almost three years ago and one of the rights referred to was a declaration made almost eight years ago in Geneva. That declaration stated that: "The Relief of Pain should be declared a fundamental human right as per the central theme adopted by IASP, EFIC and the WHO at a conference in Geneva on the 11th October 2004." Very little has happened since then. The article in this edition by Professor Frank Brennan and also the article by Phil Sizer have the theme of Human Rights in relation to Chronic Pain relief and are well worth reading.



There is something very wrong in our society when there appears to be more concern in relation to animals suffering pain while 20% of the population in Europe are living with persistent debilitating pain and often left in the wilderness. Despite the best efforts of a dedicated few working to address the relief of pain it is utterly regrettable that those in a position of power who could effect change and address this gross injustice are ineffectual or inert.

Living with Chronic Pain on a daily basis, particularly where there are no clear clinical pathways is a huge challenge and also leads to an unacceptable waste of healthcare resources especially in the current climate within the Health Sector. There is an urgent requirement to address the serious deficits in under graduate training of medical students in relation to Chronic Pain. Veterinary students spend considerably more time on pain management than their medical student counterparts.

We in CPI continue to fight and lobby on your behalf. We are pushing for meetings with relevant people in the HSE to see how services can be improved and as I write we have just received a communication from HSE South that they will see what they can include for Chronic Pain in their 2013 Service Plan. We are seeking meetings with HSE senior executives but so far all we have had is an acknowledgement of our correspondence.

We are continuing to give talks on Chronic Pain at Spinal Injuries Ireland (SII) meetings and also at the Pfizer Healthcare Ireland (PHI) meetings in Primary Care Units. We are really pleased to be involved in these meetings as not only does it attract members to CPI but it also creates a greater awareness of Chronic Pain among a wider

audience. We are also very pleased to have met up with Dr Alice Witney, Assistant Professor of Physiology in Trinity College Dublin. Her department has a section dealing with Chronic Pain and one of her students is keenly interested in research into Chronic Pain and in particular Neuro Modulation. We have introduced a Medical Device Company to Dr Witney and they may support the research. We shall keep you updated on developments.

On the European front we are continuing to work with all relevant stakeholders. We are particularly excited about a project related to Chronic Pain which, with the backing of a leading pharmaceutical company, will be launched on a European wide basis in January 2013 and CPI will have a central role in its launch and development. Further details will be in the next Newsletter. In the first half of 2013 Ireland holds the Presidency of the European Parliament. We have requested meetings with Minister James Reilly TD, Minister for Health and Children and also with Minister Lucinda Creighton TD, Minister for Europeans Affairs. Both Ministers have been very supportive in the past and we would hope that they will continue with that support.

Back on the home front again you will have received notice in relation to the Creative Writing Classes. We would encourage as many of you as possible to get involved. You do not have to be an expert in writing stories. The purpose is to improve your writing skills no matter what your standard and to enable you to express more clearly what it is like living with Chronic Pain. Please give it serious consideration. This is a pilot programme and will be launched nationwide if successful.

For various reasons we have been unable to organise as many workshops and members meetings as we would have liked. However we will shortly be announcing dates for the Annual General Meeting, workshops and members meetings on specific topics.

In the meantime we would welcome your comments on any topic including how you feel the organisation should progress. Feel free to pass on your comments in the most suitable media available to you.

Chairperson  
Chronic Pain Ireland.

## PAIN MANAGEMENT IS A BASIC HUMAN RIGHT



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Frank Brennan is a Palliative Care Physician based in Australia. In 2003 he worked at St Luke's Hospital, Rathgar in Dublin and Milford Care Centre in Limerick. He is also a lawyer and has written extensively on the human rights dimensions of pain management and Palliative Care. He spoke on the topic of pain management and human rights at the Cuisle Beatha Conference in Galway in October 2011.

### **“Pain Management is a Basic Human Right”**

*...to leave someone in avoidable pain and suffering should be regarded as a serious breach of fundamental human rights.”*

*Margaret Somerville, 1995.<sup>1</sup>*

A 72 year old woman has fractured her hip. She is taken from her village to her local clinic over difficult terrain. The local clinic does not have any opioids. Indeed, only two hospitals in the country are permitted to stock opioids. A 22 year old man with HIV/AIDS has worsening pain. His doctors try simple agents but are very reluctant to try stronger medications. In a neighbouring country the health ministry does not have any policy on pain management and unofficially states that it does not see pain management or palliative care as priorities.

The care of people in pain is a fundamental part of medicine. Unfortunately, multiple barriers may stand in the way. Inadequate education of doctors and nurses, firmly held views and fears about analgesic medication by patients, families and clinicians and nations so fixated on controlling illicit drug use that their opioid laws restrict the availability of morphine for medical purposes.

Acute pain is a worldwide phenomenon. Surgical emergencies, elective surgery, medical procedures, trauma, child-birth, burns and acts of war and torture all contribute to the burden of acute pain. In many countries, inadequate availability of analgesia, political

conflict and social dislocations all conspire to make the provision of analgesia for acute pain sporadic at best.

The management of musculoskeletal pain is a growing imperative globally especially as the population ages. Of patients with cancer approximately 70 % will experience pain that is caused by the cancer or its treatment. Equally, for the growing numbers of people suffering HIV/AIDS, a majority will experience pain at some stage in their illness. There is a growing recognition that untreated or poorly treated pain may lead to inability to do simple daily tasks, depression, absenteeism and changes in the central nervous system – that chronic persistent pain is a disease entity in itself.

How well is pain treated around the world? Despite an increasingly sophisticated understanding of pain, pain management throughout the world remains inadequate. Studies across multiple areas of pain – acute, chronic persistent, cancer-related pain, pain and children, pain and the elderly - consistently find that there are clear deficits in pain management. A striking fact is that 83 % of the world's morphine use for medical purposes is used by 7 countries only.<sup>2</sup> The vast majority of the world's nations either use no or very little morphine for medical purposes. A vicious cycle forms where nations have very restrictive opioid laws, opioids are either simply not available or very restricted in access, doctors have little if any experience using opioids, teaching to medical and nursing students about pain management, generally and the safe use of analgesia, specifically is absent or cursory, myths about morphine are unchallenged and nations continue to report that their morphine needs for medical purposes are miniscule.

Into this climate a refrain entered : that pain management should be seen as a basic human right. This sentiment, an assertion of advocacy, emerged slowly but has gained considerable momentum in recent years. In essence it emerged with two foundations :

1. The recognition of the significant discrepancy between pain theory and practice on a global level, and
2. An attempt to both promote an ideal and enforce an obligation.

It began with statements by clinicians and academics. In 1993 James stated that “freedom from cancer pain ... should be a basic human right.”<sup>3</sup> In 1995, Margaret Somerville one of leading medical lawyers in the world,

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wrote “To leave a person in avoidable pain and suffering should be regarded as a serious breach of fundamental human rights”<sup>4</sup>. In 1999 Michael Cousins, a leading pain specialist from Australia, in a major address in the USA said “I put it to you that the relief of severe, unrelenting pain would come at the top of a list of basic human rights.”<sup>5</sup>

These comments were followed by statements by professional and regulatory bodies to this effect. That culminated in 2004 in the Inaugural Global Day Against Pain. Co-sponsored by the World Health Organization, the International Association for the Study of Pain (IASP) and the European Federation of IASP Chapters (EFIC) its theme was “The Relief of Pain Should Be a Human Right.”

The world Palliative Care community also commenced to articulate a related right - that Palliative Care should be seen as a basic human right. Finally, the pain and Palliative Care communities united in proclaiming the *Joint Declaration and Statement of Commitment on Pain Management and Palliative Care as Human Rights in 2008*.<sup>6</sup> In 2010 the inaugural World Pain Summit was held in Montreal. It promulgated the *Declaration of Montreal* which called on all governments to meet their obligations under the international conventions as they relate to health care generally and pain management specifically and clinicians to view this area as a central part of their professional responsibilities.<sup>7</sup>

Beyond advocacy what are the foundations for these statements? Broadly, there are medical, moral and legal foundations to the provision of pain management. The medical foundation lies in the fact that pain management is simply good medicine. To neglect pain and allow it take hold in a patient leaves a greater problem for the future. The moral or ethical foundation lies deep in the nature and aims of medicine. There is a clear imperative on doctors to always act in the best interests of the patient. To not adequately assess, investigate or manage pain or worse, to simply walk away and ignore a patient in pain is a breach of medical ethical and professional responsibility.

The legal foundations to rights to pain management emerge from several possible sources. The first is international human rights law under the international right to health. The second is national constitutions. Some countries include a right to the provision of health care in their constitutions. The third are statutes. An

example is California where it was successfully argued that an egregiously poor pain management of an older man constituted elder abuse under a state law.<sup>8</sup> Finally, inadequate attention to pain management may constitute medical negligence under the common law.

### Foundations in International Human Rights Law

*“There are few things more elemental than pain, they tell us of the fundamental equality, the fundamental dignity that all of us should enjoy.”*

*Simon Longstaff, 2012.*<sup>9</sup>

The origins of any assertion of an international human right to pain management lies in the international right to health care. Here we need to turn to the conventions of the United Nations. The main statement of health as an international human right occurs in the International Covenant on Economic, Social and Cultural Rights (ICESCR) : “The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>10</sup> Other UN Conventions include an international right to health.

There are several steps in the argument. Firstly, there is no express right of pain management mentioned in these UN conventions. Nevertheless, given that pain management is a critical component of every area of health care, a right to pain management can be implied from the overarching international right to health care.

If so what is the content of that right and what obligations flow from it?

A guide to the answer to that question comes from the Committee that oversees the ICESCR. In 2000 it made a General Comment on the right to health care.<sup>11</sup> There it stated that all signatory nations, irrespective of their resources had certain “core obligations”, irrespective of resources. They included obligations to :

1. Ensure access to health facilities, goods and services on a non-discriminatory basis ;
2. To provide essential drugs, as defined by the WHO, and
3. To adopt and implement a national public health strategy.

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Interpreting this Comment in the context of pain management this would oblige nations to :

1. Ensure universal access to services;
2. The provision of basic medications for pain management, including analgesics, and
3. The adoption and implementation of national pain policies.

### *How has the UN responded to the advocacy?*

While admirable in abstract the advocacy of pain management as a human right could only truly find a foundation in international human rights law if it were expressly endorsed from within the United Nations human rights establishment. That endorsement came in three statements made by senior UN officials overseeing specific human rights. In 2008, in an address to the UN Human Rights Council the Special Rapporteur on the Right to Health stated “Many other right-to-health issues need urgent attention, such as palliative care... Every year millions suffer horrific, avoidable pain... Palliative care needs greater attention.”<sup>12</sup> In 2009 The UN Special Rapporteur on Torture, Cruel and Inhuman treatment stated “The de facto denial of access to pain relief, if it causes pain and suffering, constitutes cruel, inhuman or degrading treatment ...all measures should be taken to ensure full access [to pain treatment and opioid analgesics] and to overcome current regulatory, educational and attitudinal obstacles to ensure full access to palliative care.”<sup>13</sup>

The two Rapporteurs also made a joint statement to the Chairperson of the Commission on Narcotic Drugs in late 2008. After reviewing the inadequacies of pain management and Palliative Care around the world, they stated that “The failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to the protection against cruel inhuman and degrading treatment. International human rights law requires that governments must provide essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health...Lack of access to essential medicines, including for pain relief, is a global human rights issue and must be addressed forcefully...”<sup>14</sup>

### **Conclusion**

Pain, in all its forms, is undertreated globally. Significant barriers - cultural, legal, structural and

professional – exist to good pain management. One response to this undertreatment has been a simple statement of advocacy – pain management should be seen as a basic human right. The international right to health care provides a foundation for that statement. Support has come from within the structure of the United Nations. The challenge that this statement makes is to all governments. What can they do to ensure that pain management of all their citizens is not a luxury but a fact? The management of pain may be challenging but it should never be an impossibility.

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## POSTOPERATIVE PAIN



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### Postoperative Pain

Dr. David Finn's laboratory and research group at the Department of Pharmacology and Therapeutics and the Centre for Pain Research, National University of Ireland (NUI), Galway is one of Ireland's most active research groups investigating the basic science of pain. The research of Dr. Finn and his collaborators is investigating diverse areas of pain neurobiology including: the impact of stress and anxiety on pain, the physiology of the body's own in-built pain suppression systems, the potential of cannabis-based medicines for the treatment of pain, new approaches for more effective delivery of analgesic drugs in the body, and the impact of pain on cognitive functioning. In this, the fourth of a series of short articles summarising their research in these areas, Mr. Dara Bree an MSc (by research) student describes his research into the development of postoperative pain.

Pain is an important protective mechanism of the body, defined as 'an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage' (IASP Task Force on Taxonomy, 1994). Pain following surgery, termed postoperative (or postsurgical) pain, can be quite common and is usually related to the degree of local tissue injury. Postoperative pain can be somatic, visceral, inflammatory or neuropathic in origin, or indeed a combination of these. It can be defined as either acute or chronic. Acute postoperative pain can last for a few days post-surgery and tends to resolve once the underlying tissue damage begins to heal. Chronic or persistent postsurgical pain is defined as pain that develops after surgical intervention and lasts at least two months (Macrae, 2008). Although most patients expect to experience some pain following surgery, the pain experience in this setting can be exaggerated by

psychological factors (De Kock, 2009). For example, preoperative anxiety is correlated with postoperative pain experience. Katz (et al). (2005) reported that increased preoperative anxiety levels as measured by the State-Trait Anxiety Inventory led to clinically meaningful acute postoperative pain that persisted from 2-20 days post surgery.

Acute postoperative pain can usually be well-managed with the administration of analgesics, although some individuals and surgical procedures do still present a challenge. Chronic postoperative pain, where the pain persists after the surgical wound has healed, remains a significant and sometimes under-recognised clinical problem. The incidence of chronic postoperative pain can vary significantly depending on the nature of the surgery being performed. Surgeries with a high estimated incidence of chronic pain include; amputation (30-50%), thoracotomy (30-40%), inguinal hernia surgery (10%) and caesarean section (10%) (Kehlet *et al.*, 2006). These statistics are worrying, especially when one considers the total number of patients worldwide that undergo surgery each year - 70 million surgical procedures are performed annually in America alone (Rawal, 1999). It is of little surprise then that almost 25% of 5000 patients referred to chronic pain treatment centres have chronic postsurgical pain (Rashiq, 2008).

The causes of chronic postoperative pain are not fully understood but are thought to be a consequence of either ongoing inflammation or a manifestation of neuropathic pain resulting from surgical injury to peripheral nerves (Kehlet *et al.*, 2006). The transition from acute to chronic postoperative pain is thought to be a highly regulated and complex process involving changes in gene expression and nerve function (neuronal plasticity) in the peripheral and central nervous systems (peripheral and central sensitisation). Surgery represents a form of injury which can result in changes in the peripheral and central nervous systems within the body. The physical processes of incision, retraction and cutting of tissues stimulate free nerve endings and special pain receptors called nociceptors. Normally these nociceptors remain inactive unless their activation threshold is exceeded by what is known as a painful or noxious stimulus e.g. a scalpel blade cutting through skin. As a result of surgery, the activation threshold of these receptors is modified by the local release of chemical mediators of inflammation such as bradykinin, prostaglandins and substance P which sensitize nociceptors and reduce their threshold of activation, all of which results in a phenomenon known as primary hyperalgesia, where even gentle stroking of the incisional area can cause exquisite pain. A number

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of key risk factors for the development of chronic postoperative pain have been highlighted and include: genetic susceptibility, age, sex, and level of anxiety. The most relevant risk factor appears to be the severity of acute postoperative pain. Multiple findings have consistently found a strong correlation between the severity of acute postoperative pain and the development of persistent postsurgical pain. For example, Callesen *et al.* (1999) reported that the frequency of severe pain in patients one year following inguinal hernia repair surgery was higher in patients with moderate to severe pain in the days and weeks following surgery.

As chronic pain can be very difficult to treat, the onus is on the scientific and medical communities to find new methods to prevent the development of persistent postoperative pain. Clinically, the goal is develop simple, safe and effective therapies that will greatly reduce the incidence and severity of postoperative pain. There are a number of potential preventative measures including refinements in surgical technique and multimodal analgesia. The use of laparoscopic or "keyhole" surgery is a promising avenue as it avoids tissue damage associated with large incisions as well as reducing the risk of unintentional nerve damage. Laboratory studies have shown that the administration of analgesics prior to surgical injury reduces the excitability in dorsal horn neurons which is thought to be a major contributing factor in the development of chronic pain states. The administration of analgesics to patients prior to surgery (pre-emptive analgesia) as well as postoperative analgesia, should, therefore, result in reduced incidence and severity of chronic postoperative pain. However, results here are somewhat equivocal and further research is required to determine optimal pre- and post-surgical analgesic regimes.

The goal of our research is to develop and fully characterise an anatomically relevant animal model of postoperative pain. Once the model has been fully developed and characterised we will use it to better understand the neurobiological mechanisms underlying postoperative pain and to test the efficacy of standard and novel analgesic treatments.

### Acknowledgements

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(References see page 9.)



*Dr Pamela Bell is Chair of the Pain Alliance of Northern Ireland. She was a Consultant in Pain Medicine at Musgrave Park Hospital, Belfast until her retirement from the Health Service in December 2010. Her special interests include the management of neuropathic pain, pain in children and the relationship between chronic pain and work. She is a past Convenor of the*

*Northern Ireland Pain Society and chaired the CREST Guideline Development Group on the management of neuropathic pain. She has been instrumental in developing a multi-professional Masters degree in the Science and Practice of Pain at Queen's University, Belfast.*

## Northern Ireland's Road Map for Action on Chronic Pain

### The Background.

Northern Ireland (population 1.75 million) has the highest prevalence of chronic pain in the United Kingdom (19% of the adult population), on a par with the average in Europe, yet studies by Dr Foster a decade ago and others more recently have shown that provision of services for those who suffer lags behind considerably.

With these facts in mind last year the Pain Alliance of Northern Ireland, a group of concerned patients and healthcare professionals, looked towards progress being made in other parts of the world. We were particularly influenced by the International Association for the Study of Pain's (IASP) Declaration of Montreal which called for pain management to be a fundamental human right and also by the work undertaken in Australia and in England in engaging a wide varied of political, patient and healthcare professional organisations to raise awareness of the personal and economic burden of chronic pain on society.

Furthermore, the Royal College of General Practitioners had recognised the importance of chronic pain as a long term condition and had appointed a Clinical Champion. Reorganisation of the Health and Social Care Service in Northern Ireland, begun in 2007, had reached a degree of maturity and the agenda for the management of long term conditions had been set out in the publication 'Transforming Your Care', with the responsibility for commissioning services resting primarily in the hands of General Practitioners.

We felt that it was timely to seek to influence the shape, and direction of travel of pain services.

## NORTHERN IRELAND'S ROAD MAP FOR ACTION ON CHRONIC PAIN

### Developing the Road Map for Chronic Pain in Northern Ireland.

In seeking to influence the Minister for Health, Social Services and Public Safety, as well as the Civil Servants of the Department of Health, we recognised that our ideas for strategic development would only be successful if presented in the form of a limited number of achievable actions.

We were aware of the work which had been undertaken by the European Federation of IASP Chapters to develop a Road Map for Action on Chronic Pain, begun in 2009.

### This Road Map calls for all European Governments and EU Institutions to

1. Acknowledge that pain is an important factor limiting the quality of life and should be put at the top of the priority list of the national healthcare system
2. Activate patients, their families, relatives and care-givers through the availability of information and access to pain diagnosis and management
3. Raise awareness of the medical, financial and social impact that pain and its management has on patients, their family and care-givers, employers and the healthcare system
4. Raise awareness of the importance of prevention, diagnosis and management of pain amongst all healthcare professionals, notably through further education
5. Strengthen pain research (basic science, clinical, epidemiological) as a priority in EU framework programme and in equivalent research road maps at national and EU level, addressing the societal impact of pain and the burden of chronic pain on the health, social, and employment sectors
6. Establish an EU platform for the exchange, comparison and benchmarking of best practices between member states on pain management and its impact on society
7. Use the EU platform to monitor trends in pain management, services and outcomes and provide guidelines to harmonise effective levels of pain management to improve the quality of life of European Citizens

Whilst supporting the ideology of this road map, we reflected on the progress already made in Northern

Ireland (where chronic pain has been recognised as an entity in its own right since 2005) and the capacity of a small and relatively under-resourced specialist healthcare community to contribute significantly to research and so we determined to develop a road map that would reflect our local needs and priorities. For example, there was a strong feeling that education, particularly of healthcare professionals, should address the perceived deficit in training at undergraduate and post-graduate level and that there should be someone with overall responsibility to drive service improvement.

General Practitioners should be encouraged to maintain and develop their skills and that this should be reflected in their remuneration. After not-inconsiderable debate, the following road map was developed and was presented to the Members of the Legislative Assembly at a Pain Policy event at Parliament Buildings on 1st May.

Here it received considerable support from the members of the Health Committee, the Deputy Chair saying in a radio interview immediately after the event, that the seven actions set out in the map were achievable.

### The Northern Ireland Road Map

- 1) **Education and training in pain management** for all clinical professionals at all levels should be formalised and expanded, including ensuring the availability of relevant professional qualifications. This would both increase capacity in Health and Social Care services to treat the condition, and help manage demand for hospital services as GPs would be better aware of what treatments are effective in managing patients with chronic pain
- 2) **A clinical lead specialist for pain in Northern Ireland** should be appointed to lead the development of a high quality network of services for chronic pain both at a GP and hospital level
- 3) **Community based pain management services should be developed** building on successful local initiatives which have been shown to improve patient outcomes
- 4) **Patient self-management should be supported** by signposting patients towards providers of the Expert Patient Programme and self-management initiatives such as the Pain Toolkit which can assist patients in managing their condition better.

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- 5) **Assessment of pain should be included in the Quality and Outcomes Framework (QOF) GP incentive scheme.** This would encourage GPs to ask patients proactively about their pain, to treat it as promptly as possible and to ensure that the treatment given is effective in controlling the patient's pain
- 6) **Guidance on commissioning effective pain management services** should be developed by the DHSSPS to support Health and Social Services Boards in planning the best package of services to meet the demands of local patients
- 7) **An indicator focussed on patients' experience of their pain** should be included in the plans for national outcome measures announced in the Department of Health Social Services and Public Safety's recent Quality2020 strategy, to ensure the quality of pain management services continually develops

The Pain Alliance of Northern Ireland intend to monitor progress against these seven actions and hope that those who give strategic direction, commission or deliver pain services will find them a useful tool in benchmarking the quality of and access to care for sufferers.

Dr Pamela F Bell  
Chair  
Pain Alliance of Northern Ireland  
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(References from page 7.)

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## EXPECTING THE WORST - AND GUARDING AGAINST IT



*Mr. Phil Sizer, Specialist in Self-Management of Chronic Pain*

### **Expecting the worst - and guarding against it**

It is normal to guard against things going wrong in life and it would be daft not to be careful at all or to let our guard drop too easily; but constantly expecting the worst, being in a state of high alert, causes problems.

Expecting the worst is a bit like stress, some stress helps us to focus and deal with an urgent situation, but as a constant companion it makes everything more difficult.

The guard in the picture shouted at me because I crossed a painted line that I didn't know he was guarding. It was obviously important to him because that was his job for the day. When he shouted it was a shock, I was embarrassed but I didn't take it too personally because I realised he was guarding something just for show. He was also probably reacting like that because otherwise all the tourists would swarm around, pose with him and try to make him smile.

There are some important similarities with real life where we may be guarding 'lines' that aren't really important on the grand scheme of things, or expecting things to happen that are unlikely.



Guarding takes effort, the soldier wasn't there for very long before he was replaced by someone else who came marching in to guard the painted line.

Being on guard in real life also takes effort and if it goes on for a long time we can get worn out and 'worry ourselves sick'. It is not so obvious that we're 'on guard' because we don't wear a uniform, but we can easily become permanently wary, constantly thinking 'what if' or 'if that happens it will be terrible' or 'if I don't do lots people will think I'm lazy'. The difference is that unlike our Blues and Royals sentry, there isn't a change of guard and no-one else comes to do our 'expecting the worst' for us.

Ironically, being on guard too much can cause the very problems that we may be seeking to guard against. This is because the more attention we pay to a situation, the more problems we often find and the more difficult it becomes to sort out. A quick 'think' about a situation may come up with a simple solution, but think too much about something and it starts to grow legs.

Some people say that they 'always expect the worst' and say things like 'knowing my luck...'. This can be partly helpful if you are prepared in case something goes wrong – for example you always have a spare tyre, but don't expect to have a puncture every trip. Hikers are advised to make plans for emergencies, but again, if they really expected an emergency they would be foolish to go out in the first place.

Living with the expectation that things will go wrong rather than 'go right' is unhelpful and misleading. It means that we can be in a constant state of alert with high levels of anxiety and stress which make staying calm and thinking straight much harder.

When we expect the worst, we still jump if it actually happens. This means that all that time spent anticipating it hasn't helped in any way, in fact it may have prepared you in a bad way.

Expecting the worst ruins the now and does not help us to prepare for what we fear. We end up rehearsing what will happen and running through different versions of how bad things could be.

It would be better to be prepared for a difficulty rather than rehearsing how bad it could be. This is why it is important to be realistic about what is most likely to happen. It's also useful to put effort in to doing something to improve things, rather than using all your energy up thinking that you can't do anything to affect things. Good questions to ask yourself are:

## EXPECTING THE WORST - AND GUARDING AGAINST IT

What's the worst that could happen?

What's the best that could happen?

What happens most of the time?

What's most likely?

What do others think about the situation?

Is it just me that thinks like this?

Why do I tend to think like this?

What am I imagining? What are the facts?

What could I do now to make it less likely that what I fear might happen?

If I can't change the situation, how could I improve my reaction to it?

It is quite likely you have a worse view of a situation than other people. It may therefore help to talk to them to find out what they think and put your view of things in perspective. You may of course fail to see how they could possibly think like they do, but at least you'll have an alternative reality to conjure with.

Oddly we often have the ability to sort out a problem which shows when we give other people sound advice about a difficult situation like:

Don't worry so much  
Think of your own needs  
It won't be as bad as you think  
People like you more than you realise  
You should be easier on yourself

But when it comes to something that is personal, then all the 'good advice' that we give to others disappears in a puff of introspection. Put simply, we don't take our own advice.

It is more realistic and helpful to think of what's most likely rather than what's least likely. Obviously we pay more attention to thinking that things might go wrong but, being logical, in terms of probability, you're more likely to have average experience than always the worst.

Guarding the wrong line ?

The soldier in the picture was guarding a painted line that didn't seem significant to me.. This can happen in life where we might get caught up worrying about things that maybe aren't that likely to happen, or might not be as significant to the rest of the world as they have become to you.

Here are some examples of 'lines' that we guard how some things become more significant to us individually than they might be to others:

Proving that you're not lazy by being on the go all the time

Thinking that others are always judging you harshly

Feeling guilty so that you always feel the need to justify yourself

Thinking that everything might go wrong because you've have a bad experience in the past

Thinking that the house has to be spotless all the time

Needing everyone else to be happy all the time

Trying to maintain impossibly high standards despite a change in health

It's worth asking yourself 'Am I guarding the wrong line?' Or am I on guard too much of the time? The guard in the picture goes on duty and then has time off.

Perhaps it would be useful to think in these terms; that there is time for being 'on duty' and then you deserve time off. If you're on duty all the time you won't perform well when you are on guard and will always be exhausted. The effort of over-guarding, of being in a high state of alert, blocks out the good things in life that are vital to help us to cope better with the world.

Being on alert is useful short term, especially if there is real danger (not just painted lines). But if it becomes part of life we can feel like rabbits in the headlights. Always on the brink of thinking that things are about to go very badly wrong. In this situation, everything becomes a big issue. It's worth making the effort to distinguish between real problems and 'painted lines'.

There is big difference between being prepared in case things go wrong and living your life expecting that they actually will.

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