

Pain management programmes in the UK: lessons for us all

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This issue contains several papers on pain management programmes with valuable insights and implications for all those working in – or referring to – pain management. They run from an audit of assessment and selection for an inpatient programme (Knight et al.), through a comparison of litigant and nonlitigant patient gains from a pain management programme (Twiddy et al.), to styles of emotional expression or suppression (Bowers et al.) and a demonstration of substantial reduction in GP visits – and reduction in associated costs – after a pain management programme. I have also reviewed a study on loneliness and social isolation, and important and rapidly growing area of research that is particularly relevant to chronic pain (Smith et al.).

Few teams publicly dissect their data on selection for pain management of any kind, as Knight et al. have done. This is a model of scrutiny of practice with a view to Of 200 consecutive patients, just over half were offered treatment of some sort after assessment, while 45% were discharged. The most common reason for exclusion was that the patient was judged not ready for pain management, although this did not necessarily exclude her or him for ever. It would be interesting to know how many subsequently returned after, for instance, treatment of a more pressing psychological problem, or completing a planned course of medical treatment for pain, but that is another study. The authors comment that a substantial number of patients at assessment were still seeking pain reduction, and therefore were not willing to consider pain management, but this raises questions of their referral pathway and preparation (if any) for the shift of focus from pain to overall quality of life. These are difficult to characterise, and details are not given. The authors also check that they are not inadvertently discriminating on grounds of age, sex, and ethnicity, something that all pain clinics should do routinely. They do ask a question at the end about possible under-referral of older adults, among whom chronic pain is most prevalent.

It might be useful to examine the clinician judgements of ‘readiness for pain management’ further, for variance between assessors, by referral origin, and possibly other variables, but ultimately we do not have the answer to why some patients are able to take on pain management, or even to declare their ambivalence but willingness to try, whereas others seem determined to continue to seek pain relief, despite attempts at explanation by referrers and pain management programme staff. Is there a desirable level of acceptance for pain management by staff (the Clare et al. study records 35% of referred patients completing pain management), below which staff should query their judgements or procedures? A strong line would be that patients decline if the explanation of pain management is not sufficiently persuasive or matched to their needs, but that would be to deny patients agency. A study of patients’ and doctors’ accounts of first consultation at a pain clinic showed worrying mismatch on their beliefs about of the long term plan for pain (White et al. 2016). Is pain management framed as the only resort after all else fails, a consolation prize for sticking with the health service? Or as an evidence-based approach to addressing the wider problems of living with chronic pain, and one which might (again, referring to systematic review evidence) bring about some reduction in pain? Does that framing make a difference to patients’ decisions?

Another judgement that is often enacted at assessment and selection is that patients with ongoing litigation are unsuitable for pain management, but Twiddy et al. show in a large sample (over 850 patients, 110 of whom were litigating) that although their scores were worse than non-litigants at the outset of pain management, their gains were comparable to those of non-litigants over the course of treatment. The authors also calculated this in terms of clinically significant change, showing that from 30-80% (depending on which outcome) in both litigant and non-litigant groups

achieved clinically significant improvement. They covaried age, sex, and pain duration in their analyses, important not least because litigants were more likely to be young and male than non-litigants. They also pick up possible confounding of employment status with litigation in other studies. Given the consistency of their results, and support from the research literature, they declare that litigation should not be grounds for excluding patients from or delaying pain management, and while they are not the first study to find this, as they make clear, there is substantial clinician prejudice to overcome that needs just such studies to challenge it.

One of the main aims of a pain management programme, but surprisingly rarely assessed, is to enable patient-graduates to manage their health needs more independently. The study by Clare et al. of GP consultations for pain in the year before and after a pain management programme shows over 40% reduction in median and in overall appointments across 50 patients whose records were obtained from GPs, with a saving of over £6000. The same team has previously shown a much larger reduction in specialist consultations following pain management, and their review and interpretation of the literature shows a thorough grasp of the issues and methodologies. It is essential reading for anyone considering a similar study, or could be presented to commissioners in support of the value of programmes, provided that they match the substantial improvements achieved on almost all outcomes in this pain management programme.

By contrast, a study of fibromyalgia patients treated in five different programmes in the UK (Bowers et al.) showed small and nonsignificant changes except in overall quality of life, and such substantial dropout from the original sample that any conclusions must be fairly tentative. The research question is a fairly novel one: on emotion regulation and expression of emotion, and changes over 12 weeks of pain management programme. It is an area about which we know relatively little: there is unlikely to be one 'right' way or 'right' amount of emotional expression across individuals, and even within individuals across different situations and emotions. Further, people's accounts of how they express themselves and how often they show particular behaviours are notoriously uncorrelated with accounts by observers or close others of the same behaviours: we do not have the scales we require, and constructing good ones will be very difficult, but older ones such as alexithymia scales unacceptably incorporate cultural and class norms. All these difficulties in formulating the research question, and finding the right tools to answer it, will need to be addressed to define what better adaptation is, recognising that it could be in different directions for different groups, even for men and women.

In this light, the study in this issue of social isolation and loneliness is particularly relevant (Smith et al.). In a representative (non-institutionalised) sample of more than 9000 over-50s, there are marked sex differences: women were less socially isolated (in terms of network size) but more lonely (in terms of feeling left out and alone) than men, but the adverse mental and physical effects – even mortality – of both social isolation and loneliness are possibly greater for men (Holwerda et al. 2016). Social activity in terms of community participation has even emerged as a protective factor against the development of chronic pain, along with vigorous but not moderate physical activity (Fancourt & Steptoe 2018), in a 10 year prospective study of people who were at the outset pain free and in their 50s.

Surprisingly, musculoskeletal pain (represented in the survey by a yes/no question that does not identify chronicity) was associated with less social isolation, perhaps (the authors suggest) because of formal and informal carers, but with more loneliness. Depression was associated far more strongly with loneliness: a fivefold difference. Older age, lower socioeconomic status, and more sedentary habits/less physical activity were also associated with greater loneliness. It is very helpful to understand that for people with chronic pain, increasing social network size may be important,

particularly when the patient identifies it as a goal, but loneliness may be more important and is not a function of social network but a cognitive bias in representing the social contacts the person has (Cacioppo et al. 2015; Shankar et al. 2017).

All this gives us material to consider not only in pain management but more broadly in our contact with people with chronic pain at all stages of their treatment. The papers discussed above mostly concern pain management programmes, but the issues raised apply from the start of pain treatment. Are we raising issues of managing daily life even when we still have a stack of medications and other interventions to try? Are we making fair and evidence-based decisions when we refer patients for pain management programmes, or assess them for such programmes? Are we recognising when anxieties or depressed mood are important factors beyond pain intensity in making life harder, and not leaving it to be addressed after everything else? Are we recognising loneliness, and social isolation, when we see them, and discussing with the patient what might be done? There is plenty to do to integrate care of pain better, and these studies all make a real contribution to understanding the landscape of good quality care in the UK.

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