

The current state of pain management

Pain is a universal human experience. It is a necessary sensation for survival. Acute pain acts as a warning sign. It tells us to rest and protect the affected part of our body and sometimes to seek medical intervention. Acute pain usually resolves and is soon forgotten. However, nearly two thirds (61%) of patients taking part in a survey of hospital patients said that they were in pain all or most of the time (Bruster et al, 1994). The study – which included 5150 randomly selected NHS patients discharged from acute hospitals in England – showed that pain management was one of the main problems reported by patients. Similar concern in the USA has led to the measurement of pain being considered ‘the fifth vital sign’ and a call for pain assessment to be performed whenever routine observations are made.

Pain is the most feared symptom in patients diagnosed with cancer. One in three people in Britain will have cancer at some time in their life. Between 70 and 90% of patients with advanced cancer have pain (Portenoy and Lesage, 1999). A recent survey by the leading cancer information charity CancerBACUP showed that more than 70% of the 157 cancer patients who took part in the survey had experienced pain as a result of their cancer, but that even more (77%) have suffered pain as a result of their treatment (CancerBACUP, 2003).

Cancer pain can be difficult to control. Studies in the last year of life have shown that pain is common, causes serious distress to the patient and their carers and that GPs generally do not manage cancer pain well (Addington-Hall and McCarthy, 1995). Even with palliative care taking on a more important role, it is estimated that 10% of patients need more specialized pain management services.

Chronic non-cancer pain is a persistent problem in the community. A sys-

tematic review of the prevalence of chronic pain from various countries revealed that 10.0–55.2% of the population worldwide suffer with chronic pain. In a postal survey of over 4000 individuals from Western Scotland, 13% were moderately to severely disabled by chronic pain (Elliot et al, 1999). Back pain and arthritis are the most common pain complaints, but at least 500 000 people in the UK suffer from neuropathic pain. The prevalence of persistent pain increases with age and thus will be an expanding problem in the future.

Pain can have a devastating effect on people’s lives and has grave social implications. Quality of life is reduced, most patients are less physically and sexually active, almost half experience depression and one third take time off work. Pain is the single biggest cause of disability in the UK. It is the second most common cause of days off work through sickness. A total of 119 million working days were lost per year as a result of back pain alone (Phillips, 2001). In 2001–2002, the total cost of persistent pain in terms of benefits claimed in the UK was £6.7 billion, with musculoskeletal pain costing £1.46 billion (Department for Work and Pensions, 2003). Chronic pain patients account for 4.6 million GP appointments per year, equivalent to 793 whole time GPs (Belsey, 2002).

CURRENT PAIN MANAGEMENT SERVICES

In May 2003, Dr Foster surveyed adult chronic pain management services in the UK. Dr Foster is an independent organization which collects and analyses information on the availability and quality of health services in the UK. They questioned 214 hospitals across the UK and gained responses from 158, representing 75% of hospitals currently providing services. They found the provision of specialist services to manage persistent pain in the UK to be highly variable.

Staffing

Staffing levels vary from a single-handed service run by a consultant anaesthetist with no administrative support, to a multidisciplinary service of nearly 50 team members treating 3500 patients per year. Chronic pain clinics are not treated as a separate hospital service but as a secondary aspect of anaesthetists’ work. In many hospitals, budgets are not available for the pain management service as they are intertwined with anaesthesia. Many services operate in inadequate surroundings, with limited space and facilities.

Waiting times

The national average waiting time for patients referred by their GP is 20 weeks. Patients referred from consultants on average wait longer at 23 weeks. However, the range is from 4–110 weeks for GP referrals and 4–133 weeks for consultant referrals. The shortest waiting times recorded were those for cancer patients at the Royal Marsden Hospital who wait less than a week to see a pain consultant. This may reflect the benefits of receiving pain treatment as part of a service that has been made a national priority as defined by a National Service Framework. Demand for services has led to nine services closing to new patients over the last year because they were unable to cope with demand. Currently, four services are not accepting GP referrals as part of their efforts to reduce waiting times.

Consultation

The first consultation with a patient in persistent pain is the most important. It is at this appointment that the patient has the opportunity to share their individual story and to explain their views regarding the aetiology of their pain and their concerns and fears. Sometimes messages from earlier consultations have been misinter-

preted and this may lead to confusion and to the patient 'catastrophising'. This, in turn, may lead to the patient avoiding any action that may exacerbate the pain in case they 'damage' themselves further. On average the first appointment in a pain clinic was 34 minutes, but again the range was large from 10–90 minutes.

Pain management programmes

Treatments offered varied greatly and do not appear to reflect the evidence base (McQuay et al, 1997). Only 58% of clinics offer a pain management programme despite there being evidence of efficacy in the management of patients in pain. Many services cited increased psychological input as one of their top three funding priorities. One third of services do not collect nor audit outcome data. The reasons for this were lack of computer equipment or clerical resources and clinical pressure.

THE FUTURE

The NHS is changing. Primary care trusts are becoming responsible for commissioning pain management ser-

vices. Many GPs prefer to treat the disease rather than the pain and do not fully understand the complex nature of persistent pain. Pain management services usually function as multiprofessional teams with doctors, clinical psychologists, clinical nurse specialists and physiotherapists working together. Such teams do not currently exist in primary care. Further education in the recent advances in pain mechanisms and in treatments options is vital.

In addition, pain management services need to become better organized. Communication between services needs to be improved, so that if a patient requires a particular treatment that is not available locally, then the referral pathway is straightforward. Patients are better informed and want to be part of the decision-making process regarding their treatment. We need to be innovative in our thinking to better structure pain management services across the primary–secondary care interface.

Pain management services have been called the 'Cinderella' service of the NHS. However, John Reid, the Health

Secretary, in a speech to the New Health Network said: 'The prevention of preventable pain for everyone is a fundamental obligation on any progressive government, and the hallmark of any civilised society'. More recently, to the Labour party conference, he said: 'These are our fundamental values, our fundamental purpose – the relief of human suffering'. Let us hope that this was not only political rhetoric and that we may be able to advance pain management up the political agenda. **HM**

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KEY POINTS

- Persistent pain is a common condition: 13% of the UK population are moderately to severely disabled by chronic pain.
- Persistent pain reduces quality of life, causes depression, disability and loss of employment. Economic consequences are immense.
- Patients have patchy and variable access to pain management services, which are generally poorly resourced and coordinated across regions.
- Multiprofessional working, common within pain management services, is highlighted in the NHS Plan.
- Recent advances in the understanding of pain mechanisms help to clarify the nature of persistent pain states.
- Primary/secondary care pathways need to be better developed to improve patient care.