Pain management: re-education is needed

Sir,

Beverley Collett (vol 65(2), 2004, p. 70) has succinctly highlighted the problem that chronic pain has become, and the need to improve resources to deal with the problem. She has unwittingly highlighted within her very first sentences perhaps the prime reason for the development of chronic pain as a major problem in patients without cancer.

Traditional teaching holds that pain is indeed a warning, and that the painful part should be rested. Does this measure up and on what is it based? Pain can certainly inform of a damaging event, but it is not always an immediate accompaniment to injury (Beecher, 1946), and it does not often allow us to prevent the incident. The withdrawal reflex withdraws the limb from a harmful stimulus even before pain is felt, or in some circumstances without pain being felt. Considering pain therefore to be a warning likens it to a dial in the cockpit of an aircraft that indicates that the plane has crashed!

Hugh Owen Thomas, the father of modern orthopaedics, initiated the view that rest was essential for healing. He was convinced of the importance of complete rest in the treatment of fractures, and the Thomas's splint has saved many limbs and dramatically reduced the death rate from compound fractures of the femur. It was John Hilton, however, who developed the idea of 'resting the painful part' (Guthrie, 1945).

This working hypothesis led to the practices of the 20th century when following heart attacks, major surgery, or even bouts of back pain, patients were given total bed rest for weeks at a time. We are now aware of the mortality that this can produce, and indeed the poorer recovery. It has taken nearly a century to realize the error of these views (Linton, 1994). Certainly we are well aware of the emphasis now on rehabilitation after a heart attack.

Alongside this outdated myth we must also consider the impact of the positive *vs* the negative interview with the doctor. The positive approach is powerful medicine indeed, almost as good as any other treatments (Thomas, 1987). This lesson is being taken forward very positively in Australia (Buchbinder et al, 2001; Zinn, 2003).

So Dr Collett is absolutely right to stress the importance of liaising with primary care. Our focus should be to re-educate the entire health profession away from the general idea of resting the painful part and that pain associated with activity inevitably means damage is taking place.

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Aggression and violence in the NHS

Sir,

In their article Bleetman and Fayeye (vol 64(12), 2003, p. 728) raise several important issues regarding prevention and management of violence towards staff in emergency medicine settings within the NHS.

We wish to discuss two related aspects. First, mental illness (as the authors briefly allude to) is an important mediating factor and, second, violent incidents are as much of a concern in non-emergency NHS settings as well. We clarify these points further based on the findings of a questionnaire survey.

Evidence suggests that violence is more common among people with psychiatric disorders than the general population (Swanson et al, 1990). Within inpatient settings, the role of physical environment of wards and factors such as overcrowding, low autonomy and poor organization have been shown to be important.

Our survey covered eleven wards at a local inner-city psychiatric hospital. It involved staff and patients rating the physical environment characteristics of their wards and making suggestions for improvement. Overall, general adult wards fared poorly in comparison to old age and specialist wards. More than three quarters of the responses identified inadequate privacy, lack of activity areas and patient feelings of insecurity.

Based on these findings, we made numerous simple and cost-effective recommendations to positively alter the environment of wards. We are planning a re-audit, which would enable us to determine what changes have resulted. More research is needed into looking at the potential causative and mitigating factors of violence by patients towards staff and it needs to be evaluated in various NHS settings.

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