Life & Times

The problem of prescribing for pain

Friends recently sent us, as lockdown entertainment, the boxed set of a BBC series called *A Very Peculiar Practice*,[1] which may be familiar to many. A satire set in a supremely dysfunctional university practice that ran for two series in 1986 and 1988, it covered many of the challenges and personalities seen in primary care. The second episode has a truly terrifying depiction of a consultation where the patient, aptly named Professor Furie, wants a prescription for an amphetamine-like stimulant and the doctor is reluctant to prescribe it. Despite using textbook consultation techniques and attempting to explore the underlying concerns and issues relating to the request, the doctor is bullied into prescribing against their better judgement and left anxious and scarred by the interaction.

REDUCING PAIN

This came to mind while I was reading the draft NICE guidelines for the management of chronic primary pain.[2] They advocate the use of acupuncture, psychological approaches, and exercise to reduce pain rather than analgesia. In addition, they recommend a discussion and an acknowledgement that it may not be possible to reduce the pain experienced by many patients, and the application of acceptance and commitment therapy. This is a form of psychotherapy that uses a combination of cognitive and behavioural therapy, and aims to reduce rigid and inflexible approaches to problems in life, developing strategies based on acceptance, mindfulness, and a commitment to changing for the better. The draft guidelines also state that frequently used medication such as opioids, non-steroidal anti-inflammatory drugs, benzodiazepines, anti-epileptic drugs including gabapentinoids, and paracetamol are not recommended, and that there should be discussions regarding reducing and stopping these drugs.

This approach has also been advocated recently by a Channel 4 programme, *How to Beat … Pain*.[3] Individuals living with a variety of problems such as migraine, rheumatoid arthritis, fibromyalgia and chronic headache were allocated to a series of different programmes to try alternative methods of pain management and their efficacy evaluated in a discussion at the end of the programme. Interventions used included acupuncture, cold open water swimming, meditation, and tai chi. Some found this a very helpful process, but it was difficult to see how most could participate in activities such as cold-water, open-air swimming and so the applicability of some of these techniques appeared limited.

UNDERLYING TRAUMAS

It is true that there is widespread use of ineffective and addictive pain medication of questionable benefit. However, implementing any change in this area will depend on a cohesive approach across primary and secondary care clinicians of all levels and a re-education of public expectations. It is not unusual to have protracted discussions regarding reduction in the use of oramorph or gabapentin with a patient who suffers from fibromyalgia, only to see them subsequently consult with a colleague or attend the ED and receive a prescription for pregabalin and buprenorphine.

The issues regarding patient access to psychological therapies, acupuncture, and exercise for chronic pain syndromes are significant, and, for many, a group-based approach may be challenging in view of the nature of the underlying traumas that need to be addressed. Bessel van der Kolk describes some of the predisposing traumatic events that may lead to complex pain syndromes in his excellent book, *The Body Keeps the Score*, and illustrates the sophistication and long-term nature of some of the supportive therapies required.[4] For those who are still consulting in 10-minute aliquots in the post-COVID environment, applying these new guidelines may well prove problematic.

Many may be faced with their own Professor Furie experience, and it is worth watching this enactment of a difficult prescribing consultation and taking time to reflect on how to manage this negotiation in light of the new guidance.

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