



A good doctor-patient relationship can help improve pain management. But it requires help from other healthcare professionals, argues nurse consultant [Eileen Mann](#)

Scientists are beginning to understand how and why we feel acute pain, and the complex interplay of neurones and messenger molecules that lead to its perception. However, researchers are only just starting to explain the contribution of emotional affect, cognitive function, and how the human response to feelings such as anger, frustration, depression, anxiety, fatigue, and hopelessness can have an impact.

Given the myriad influences on pain perception, it becomes clear that applying a traditional biomedical model may fail some sufferers as it does not routinely take into account the multidimensional nature of pain. If strong analgesia or surgery is offered to patients

whose pain may have become chronic and is intensified by the complex interplay of psychosocial factors, this may induce iatrogenic damage caused by the medicine or the medical intervention itself.

The general pattern of current medical training and Western attitudes to disease may make it difficult for a doctor to fully believe a report of pain in the absence of identifiable organic pathology.

Keys to improvement

On a practical level, the keys to improving pain control are the same as for any clinical activity: good communication, comprehensive assessment of the patient, and giving a proper and thorough explanation of treatment options.

Effective communication between doctor and patient and recognition of the contri-

Integrative approaches to pain management: how to get the best of both worlds

Despite the advances in conventional pain treatment, many patients look beyond the mainstream. [Brian Berman](#) considers the alternatives

Modern medicine has few good answers to the problem of chronic pain and, as a result, people with chronic pain often turn to complementary medicine. In most cases, people use complementary and conventional medicine concurrently, hoping perhaps to find the “magic bullet” cure but also realising they need to find other ways to cope. A study published in JAMA has shown that people often turn to complementary therapies out of a desire to find approaches that are more congruent with a mind-body-spirit philosophy (not merely treating symptoms) and because they want to play a role in their own healing.

None the less, doctors are often ambivalent about the role of complementary

approaches, partly from a lack of knowledge but also from a feeling that good practice should be based on scientific evidence. As commendable as the scientific approach is, clinicians may be missing the boat by resting their case on the evidence argument and dismissing complementary medicine. Patients are becoming increasingly well informed and want to be treated as partners in their care but, finding or anticipating ambivalence among their primary care providers, tend not to divulge their concurrent use of complementary medicine. This has implications for the doctor-patient relationship, which should embody mutual trust and shared decision making, and is not in

the best interest of patient or doctor.

Safety is the most obvious concern about lack of disclosure (for instance, the potential for negative drug and herb interactions such as between warfarin and ginkgo biloba). However, we should also look at the potential of complementary therapies to give people more ways to help themselves—to reduce or cope with not only pain but also other aspects of chronic conditions such as anxiety and stress, or to change to more healthy lifestyles.

Mind-body therapies

The most obvious self help approaches are mind-body therapies. Many approaches, usually cognitive behavioural methods, are already incorporated into multidisciplinary pain programmes, but others—such as hypnosis, Qi Gong, and meditation—are less well accepted. In 1996 the US National

tribution made by other members of the health team, such as nurses, physiotherapists and carers, can provide a more complete picture of the patient's experience and widen treatment options.

Clinicians need to find out details of the pain—its nature, evolution, precipitating and relieving features—as these may provide clues to its cause and treatment. If analgesics are prescribed, by asking the patient what the effect is the clinician will be able to decide if the medication is appropriate, whether the dose is adequate, and how frequently the drug should be taken.

Clinicians must also find out about the patient's experience of unacceptable side effects as many patients may regard these as unavoidable and decline further analgesia. Some people may accept pain as unavoidable and not appreciate the benefits of effective pain control. Not all chronic pain will respond to currently available analgesia, and non-pharmacological treatments may represent the

most effective approach. Non-pharmacological treatments are routinely incorporated into the care offered by multidisciplinary pain management teams.

Acute pain

After trauma or surgery, pain will be acute and may be severe, but the mechanisms of acute pain are better understood than those of chronic pain, and acute pain will usually respond well to pharmacological treatments. Patients should be told of the hazards associated with poorly managed acute pain, such as serious cardiovascular complications. Uncontrolled pain can also cause sleep disturbance, anorexia, muscle wasting, and depression. Unless the positive benefits of effective analgesia are reinforced, poor communication and misinformation may strengthen erroneous ideas, such as the concern that strong analgesics are addictive.

Nurses

Carrying out detailed and frequent acute pain assess-

ments and then modifying treatment is certainly time consuming.

Good pain management and strategies for patients' comfort are the very essence of nursing. However, many nurses, like patients, can feel powerless when doctors do not act upon their requests for additional or alternative analgesia. Even when effective analgesia is prescribed, many patients may feel they don't want to trouble the busy nurses by telling them when they are in pain, a factor that regular assessment should overcome.

It is nurses on acute wards who tend to spend most time with patients. Unlike doctors, they cannot easily withdraw when patients are distressed and in pain.

Alternative therapies

Frustration due to poor experience of pain management may lead patients to consult alternative practitioners. Alternative therapies can offer an individual approach tailored to their specific

needs. Even when the treatment fails to add substantially to pain relief, patients may still perceive benefit from a holistic, empathetic approach and the feeling that their pain is taken seriously. These valuable strategies also form the basis of care in multidisciplinary pain management clinics.

If the principles of alternative therapists could be combined with a carefully assessed, evaluated, and flexible pharmacological regimen, much of the misery of pain could be reduced. It may be time to take a multidimensional approach to managing pain.

The internet is an extremely valuable resource giving access to the latest research on pain management. Visit: www.painsociety.org; www.jr2.ox.ac.uk/bandolier/booth/painpag; and www.cochrane.org/uk

Eileen Mann nurse consultant pain management Poole Hospital NHS Trust and IHCS Bournemouth University, Poole BH21 2JB eileens_mail@yahoo.com

Institutes of Health held a technology assessment conference on mind-body therapies for pain and insomnia, which found considerable evidence for their use, especially as adjunctive treatment.

In many cases, a multidisciplinary approach that includes some form of stress management, coping skills training, cognitive restructuring, education, and possibly relaxation therapy is helpful for chronic conditions such as low back pain and rheumatoid arthritis and osteoarthritis. Relaxation and thermal biofeedback can be useful for recurrent migraines, while relaxation and electromyography muscle biofeedback, used alone or adjunctively, may help recurrent tension headaches.

Finally, hypnosis, group therapy, relaxation, and imagery can significantly improve recovery time and alleviate pain when used in childbirth, before surgery, or during invasive medical procedures.

Acupuncture

In 1997 a National Institutes of Health consensus conference on acupuncture

concluded that promising results have emerged for acupuncture, used alone or as a part of a comprehensive management programme, for several pain conditions. Although the quantity and quality of research is as yet insufficient for definitive judgments about its usefulness, its credibility as a pain treatment has been enhanced by basic science experiments showing that acupuncture needling releases endorphins and other neurotransmitters in the brain.

Some of the strongest clinical evidence is in the treatment of dental and temporomandibular dysfunction pain, and research findings are promising for idiopathic headaches, fibromyalgia, and osteoarthritis. In the case of chronic pain and back pain the evidence is inconclusive, and its effectiveness has not been supported for neck pain.

In general, acupuncture seems to be safe in the hands of experienced, licensed



practitioners, though disposable needles should be used.

Chiropractic and massage

Many people turn to chiropractic and massage for pain relief. Chiropractic usually involves manipulation

of the spine, whereas massage applies pressure and traction to the soft tissues.

Research on both is inconclusive, but a review by the US Agency for Health Care Policy and Research found that chiropractic is beneficial for acute back pain but that the evidence to support its use in chronic back pain is insufficient. Interestingly, patients often express greater satisfaction with chiropractic care than standard medical care even when the improvements in pain and disability are the same. A recent study attributes this greater satisfaction to communication of self care advice and explanation of treatment. Massage may help low back pain and non-inflammatory rheumatic pain.