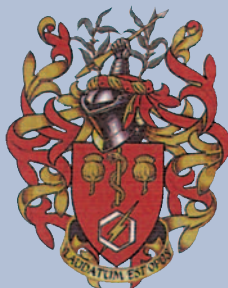




The Royal College of
Anaesthetists



The Pain Society
The British Chapter of the
International Association for the
Study of Pain

Pain Management Services Good Practice

May 2003

Summary

The relief of pain should be a fundamental objective of any health service. Good practice should ensure provision of an evidence-based, high quality, adequately-resourced service dedicated to the care of patients, and to the continuing education and development of staff.

Effective and safe management of acute and chronic pain in hospitals requires:

- 1** The provision of services for acute pain management in all hospitals.
- 2** The provision of core services for chronic pain management in all district general hospitals and most specialist hospitals.
- 3** The provision of specialised services for pain management on a regional basis.
- 4** Adequate resources to provide an appropriate number of fixed sessions for consultants (specialists in pain management), other healthcare professionals, secretarial and administrative staff, as well as appropriate accommodation, facilities and equipment.
- 5** Recognition that anaesthetists who have sessions in pain management need to have job plans that differ from those of most anaesthetists who work in operating theatres, obstetric units and critical care units.
- 6** Close liaison between pain management services and other healthcare groups (including primary care and palliative care services) in order to provide an individualised, inter-disciplinary approach to the management of pain for each patient.
- 7** Specific arrangements for the treatment of vulnerable groups such as the elderly, children, non-verbal, disabled, intellectually handicapped and those whose primary language is not English.
- 8** Equity of access and service provision for all patients taking into account clinical, socio-economic and cultural factors.

- 9 The provision of properly constructed pain management programmes which aim to promote restoration of normal physical and psychological function, and to decrease the inappropriate use of healthcare resources by patients with chronic pain.
- 10 An active programme of education in the understanding of pain, its presentation and its management, for all health professionals who care for patients with pain in both the primary and secondary care sectors.
- 11 Continuing evaluation and audit of pain management services.

1 Introduction

- 1.1 Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Acute pain is associated with acute injury or disease. Chronic pain is defined as pain that has persisted for longer than three months or past the expected time of healing following injury or disease. Patients with cancer may suffer from both acute and chronic pain. Epidemiological studies have revealed widespread unrelieved pain throughout society.¹
- 1.2 Pain management is of proven benefit in improving the quality of life of patients and in lessening the socio-economic burden of unrelieved acute, chronic and cancer-related pain.^{2,3,4}
- 1.3 Widespread provision of basic core services and the selective provision of the more advanced specialist services to relieve pain are necessary to address this problem effectively. Pain management services should provide both hospital and community care to patients with a wide range of different conditions.^{5,6}
- 1.4 Interaction with primary care teams is essential for maximum patient benefit. Pain management provides outstanding potential for fruitful working across the boundaries between primary and secondary care.

- 1.5** Efficient and effective pain management requires close links with other medical specialties including: all branches of surgery, neurosurgery, gynaecology, rheumatology, gastroenterology, neurology, rehabilitation medicine, occupational health, oncology, palliative medicine, psychiatry and addiction medicine.
- 1.6** The Clinical Standards Advisory Group (CSAG) Report on *'Services for Patients with Pain'* made wide-ranging recommendations to Health Authorities, Primary Care Groups and Trusts on the provision of appropriate pain services.³ Unfortunately little has happened in response to the CSAG report.
- 1.7** Pain management services should make special provision for vulnerable and potentially disadvantaged groups such as the elderly, children, non-verbal, disabled, intellectually handicapped and non-English speakers. Patients with impaired hearing or vision should have their special needs addressed. Particular difficulties may be encountered with problem drug users, prisoners and victims of torture. Patients from all these groups need, and should have, access to appropriate pain management services.
- 1.8** For many years, pain management has utilised a multidisciplinary team approach that matches therapy to the individual patient. This fits well with the modern day skill mix and patient-centred approach of the NHS.
- 1.9** The delivery of high quality pain services requires the allocation of fixed sessions for all healthcare personnel rather than an ad hoc or informal approach such as may have prevailed in the past. This is a clinical governance issue. Commissioning and contracting should take account of the substantial contribution made to effective pain management by non-medical team members such as nurse specialists, physiotherapists, clinical psychologists, occupational therapists and pharmacists.
- 1.10** Each pain management service should be led by a named doctor with special expertise in pain management and who takes responsibility for co-ordinating the provision of a safe and effective service.

- 1.11** The medical personnel who staff pain management services in the United Kingdom are almost all consultant anaesthetists. Inpatients under the care of a consultant from another specialty may receive a considerable amount of care and treatment from the specialised pain management team. At present, it is unlikely that this input is formally recorded thereby producing resource and revenue consequences for the pain services. This work needs to be recognised so that appropriate resources can be allocated.

2 Acute pain services in hospital

- 2.1** Acute pain is common and occurs most frequently in the postoperative period. Non-surgical acute pain is associated with low back pain, burns and trauma and many medical conditions (e.g. myocardial infarction, ureteric colic, acute pancreatitis and sickle cell disease).
- 2.2** The deleterious effects of unrelieved acute pain are well recognised. These effects are psychological, physiological and socio-economic. Unrelieved acute pain may predispose to the development of chronic pain.⁷ The provision of effective acute pain relief helps reduce stay in hospital, promotes recovery and reduces the development of chronic pain syndromes.^{4,8,9} The massive increase in day-case and short stay surgery necessitates the provision of safe and effective pain management to lessen the need for a GP visit or return to hospital.¹⁰
- 2.3** Pain and its relief must be assessed and documented on a regular basis. Pain intensity should be regarded as a vital sign and along with the response to treatment and side effects should be recorded as regularly as other vital signs such as pulse or blood pressure. The prescription of analgesic drugs and pain-relieving techniques should be reviewed regularly to ensure that analgesia is effective and appropriate to the level of pain experienced by the patient.

- 2.4** Treatments available for acute pain range from simple medication to more complex interventions such as neural blockade, spinal (epidural and intrathecal) infusions and patient-controlled analgesia (PCA). The more complex techniques require staff with appropriate knowledge and skills to ensure safe and effective application.
- 2.5** The provision of an organised multi-disciplinary acute pain team is an effective method of providing high quality pain relief in a hospital setting.¹¹ Adoption of this approach was recommended in the UK in the 1990s^{12,13} and has been endorsed by guidelines developed in Australia⁷ and the USA.^{14,16}
- 2.6** The provision of safe and effective acute pain management is a quality issue that addresses the needs and expectations of patients and their carers, as well as being a risk management issue.¹⁷
- 2.7** The objectives of an acute pain service should include:
- a** Establishment of a system for regular assessment and individual treatment of acute pain.
 - b** Provision of specialist care and advice for difficult acute pain problems such as occur in patients already taking strong analgesics for cancer pain or chronic non-cancer pain, and for patients who are problem drug users.
 - c** Seamless liaison with other healthcare teams responsible for the shared care of patients with acute pain.
 - d** Provision of back-up arrangements, education programmes and appropriate guidelines or protocols to ensure that there is continuous cover for acute pain management round the clock, seven days a week.
 - e** Information, education and reassurance for patients presented in a way that they understand.
 - f** Education for nursing, medical staff and other allied healthcare professionals leading to increased awareness of the consequences of unrelieved acute pain and of the techniques available to relieve pain.

- g** Continuing audit and evaluation of the service and the needs of patients.

2.8 Personnel

The staffing of an acute pain service should be based upon the following considerations:

- a** Consultant anaesthetist sessions are essential. There should be a named consultant anaesthetist responsible for provision of the service.
- b** The job plans of consultants in acute pain management should reflect the different nature of the work when compared to anaesthetists working in operating theatres, obstetric units or critical care units.
- c** There should be clinical nurse specialists to advise on pain management and to undertake a programme of regular review of acute pain problems. The nurse specialists should undertake education of nursing colleagues informally in clinical areas and as part of a formal educational programme for all disciplines in conjunction with medical colleagues. The nurse specialists should also be responsible for the day-to-day organisation of the acute pain service.
- d** The provision of effective acute pain management can be optimised by collaboration with colleagues from the physiotherapy and pharmacy departments. In addition some patients with acute pain will require help from a clinical psychologist.
- e** To ensure patient safety and continuous service, staffing levels should be sufficient to provide prospective cover for all personnel. Education, training, staffing arrangements and the provision of protocols or guidelines must ensure safe practice when core staff are not on duty.

2.9 Equipment

Equipment should be provided to ensure safe and effective utilisation of pain relieving techniques in adults and children. This includes specialised pumps for spinal (epidural and intrathecal) infusion, PCA devices and monitoring equipment. To safeguard patient safety these pumps and other devices should be dedicated for use in acute pain management only. It is essential that staff have formal training in the use of medical equipment. The service should ensure that there are maintenance contracts and a rolling replacement programme for equipment.

2.10 Drugs

Drugs for PCA devices and spinal (epidural or intrathecal) infusions should be supplied in clearly identifiable, aseptically-prepared containers. It is preferable that the solutions should be prepared in a central unit and not made up by staff in clinical areas.

2.11 Facilities

The acute pain service should be provided with dedicated office space as well as administrative, secretarial and IT support. There should be storage space for PCA devices, pumps and educational materials.

2.12 The recovery (post-anaesthetic) ward staff must be trained in basic pain management. The unit should have a stock of suitable drugs and equipment to ensure that optimal postoperative pain relief is established before patients return to the surgical ward or are discharged. This should be available on a 24-hour basis on all sites where operating occurs in the evening or at night. High dependency and/or intensive care units (HDUs and ICUs) should be available for appropriate patients. There must be provision for advice to be obtained from specialist pain management staff in situations where pain control is difficult.

- 2.13** The management of non-surgical acute pain occurs on the wards and critical care units, in outpatient clinics (e.g. fracture clinic), in the A&E department and in other areas such as interventional radiology suites. Staffing levels, their knowledge and skills, and the availability of drugs and equipment should be sufficient to provide safe and effective pain relief for patients with non-surgical acute pain to the same standard as for patients with post-operative pain. The provision of guidelines may be helpful in this situation.
- 2.14** Specific arrangements must be made for the treatment of children to the same standard by appropriately trained staff.¹⁸
- 2.15** Acute pain services should be able to respond to the special requirements of other patient groups such as the elderly, non-verbal, disabled, intellectually handicapped and non-English speakers. Specific arrangements must be made for problem drug users and substance abusers, patients with opioid tolerance as a consequence of long-term opioid consumption, patients with physical disability and patients with recurrently painful conditions such as sickle cell disease. Patients with chronic pain who develop acute pain problems usually require specialist pain management.
- 2.16** Patients who have undergone day case surgery should be given effective analgesics to take home with straightforward instructions about use and advice on how to obtain further help if necessary.
- 2.17** The most recent recommendations for obtaining consent require that patients are given appropriate verbal and written information about pain and its treatment pre-operatively in a way that they understand. Patients should be able to make an informed decision about the sort of pain-relieving technique they choose; medical and nursing staff should be available for advice and discussion.

- 2.18** Effective relief of acute pain has been shown to be an important contributor to the rapid restoration of normal function, reduced incidence of complications and earlier discharge from hospital. These beneficial effects will have ensuing socio-economic implications for many aspects of the NHS.
- 2.19** Purchasing and commissioning organisations should ensure that the relief of acute pain is specified as part of the contracting process. This will require identified funding for designated staff, equipment and facilities.

3 Chronic pain services

- 3.1** Many surveys have revealed that a significant proportion of the population suffer from chronic pain due to a wide range of conditions.^{1,19} Common conditions include low back pain, headache, arthritis, peripheral neuropathy and pain following traumatic nerve damage.^{20,21}
- 3.2** Unrelieved chronic pain represents a major problem for individual patients and a massive socio-economic burden for the health service and the community at large.²² Unrelieved chronic pain may lead to depression, psychological dysfunction, prolonged disability and dependency on drugs. It leads to significant overuse of medical services and increased costs to the taxpayer through social security payments and unemployment.
- 3.3** Patients with chronic pain often present with complex multidimensional problems that require multidisciplinary management.²³ Effective chronic pain management should be based upon interdisciplinary co-operation of specialist pain medicine doctors, primary care physicians, specialist nurses, clinical psychologists, physiotherapists, occupational therapists and pharmacists. There should be arrangements for consultation with other specialist doctors (such as orthopaedic surgeons, neurosurgeons, psychiatrists, rheumatologists and neurologists) when appropriate.

- 3.4** There is evidence that the multidisciplinary pain clinic approach is effective.² Pain management has been one of the leading specialties in the rigorous pursuit of evidence of effectiveness of treatments by analysis of systematic reviews and randomised controlled trials.²⁴ Priority should be given to those therapies that offer measurable health gains and cost-savings. Complementary medicine techniques may be offered, but only when supported by adequate evidence.
- 3.5** The objectives of a chronic pain service include:
- a** Alleviation of pain. This is not always possible because any pain that is described as chronic has already proved resistant to treatment.
 - b** Alleviation of psychological and behavioural dysfunction and distress.
 - c** Reduction of disability and restoration of function.
 - d** Rationalisation of medication.
 - e** Reduction of utilisation of healthcare services including consultations in primary and secondary care, surgical operations and treatments such as physiotherapy.
 - f** Attention to social, family and occupational issues.
 - g** Education for nursing, medical staff and other allied health care professionals.
 - h** Continuing audit and evaluation of the service and the needs of patients. Outcome measures for patients with chronic pain should include assessment of physical functioning, psychological status, medication consumption, utilisation of health-care resources and work record in addition to measurement of pain intensity.
 - i** Research into the epidemiology, causes and management of chronic pain.

- 3.6** A chronic pain service will be delivered in the following environments:
- a** Outpatient clinics in a hospital setting or in a primary care facility (outreach clinics).
 - b** Inpatient ward referrals. These represent a significant workload for many services. The service should allocate designated consultant sessions for dealing with ward referrals and inpatient work including the treatment of urgent pain problems.
 - c** Oncology and palliative care units within the hospital or on external sites. This work may be very demanding of consultant time and should be recognised in job plans and healthcare commissioning.

3.7 Personnel

A chronic pain service should employ the following personnel:

- a** *Medical practitioners* – In the UK, virtually all services for patients with chronic pain are staffed by consultant anaesthetists who are Fellows of the Royal College of Anaesthetists. Training in the management of chronic pain forms an integral part of the training programme for anaesthetists and there is provision for up to 12 months of advanced training in pain management for anaesthetists within the programme leading to a Certificate of Completion of Specialist Training (CCST) in anaesthesia.
- b** Non-consultant career grade doctors with appropriate experience and competencies may contribute to a chronic pain service.

c *Nurse specialists* and nurse consultants may have their own clinics to triage patients, supervise medication, provide transcutaneous electrical nerve stimulators (TENS) and to supervise patients with implanted devices (e.g. spinal cord stimulator). In addition the nurses provide assessment and follow-up for ward referrals. Developments in nurse prescribing may lead to an extended role for nurse specialists in pain management.

d Clinical psychologists.

e Physiotherapists.

The provision of sessions for nurse specialists, clinical psychologists and physiotherapists should be appropriate for the circumstances, case-load, case-mix, and nature of treatments employed in each service.

3.8 Interdisciplinary contact may be required with the following healthcare professionals:

a General practitioners.

b Rehabilitation medicine specialists.

c Occupational health specialists.

d Psychiatrists including specialists in addiction medicine.

e Palliative care physicians.

f Other hospital specialists.

g Occupational therapists.

h Pharmacists.

i Vocational counsellors and employment advisors.

3.9 There should be sufficient staff to meet current national waiting time targets taking into account the number of new referrals, the case-mix and the complexity of the treatments offered by the service.

- 3.10** Medical and nursing staff should be available for the assessment and treatment of in-patients. Some pain medicine consultants will offer support to palliative medicine and there should be appropriate sessional recognition for this work.
- 3.11** Pain management is a consultant-delivered service. In most hospitals, chronic pain services are staffed solely by consultant anaesthetists without any significant contribution by trainee or non-consultant career grade medical staff. This must be reflected in job plans and when apportioning sessional responsibilities. It also has implications for the provision of cover during consultant absences.
- 3.12** It must be recognised that the work of consultant anaesthetists who do pain management is very different from that of anaesthetists who work in the operating theatre, obstetric unit or critical care unit. The working arrangements for the pain specialist should resemble that of a consultant physician in terms of sessional allocation, support and administration services and accommodation. In addition there should be similar arrangements for audit, teaching and continuing professional development.
- 3.13** The management of chronic pain patients requires consultants to deal with a considerable amount of correspondence, dictation, preparation of reports, telephone calls, case conferences and other clinical administration. Consultant anaesthetists in other clinical arenas do not normally have this sort of workload. In addition, in specialties such as general or palliative medicine, some of this work is undertaken by trainees but this happens very rarely in pain medicine. Due regard must be taken of these additional responsibilities and workload in the construction of consultant job plans for pain management.

- 3.14** Special problems exist for those consultant anaesthetists who divide their time between pain services and other duties of anaesthesia. Their job plans must take into account the additional demands of this combination so that the consultant is able to fulfil the obligations of both disciplines and has time to complete the additional tasks demanded of a chronic pain specialist. It is important for individual consultants and their clinical directors to devise appropriate allocation of sessions between operating theatre-based anaesthesia and pain management to ensure maintenance of competency in all spheres of the consultant's clinical activity. Consultants carrying out pain management and anaesthesia should have a job plan that reflects the additional demands for teaching, administration, audit and continuing professional development in both clinical areas.
- 3.15** A multidisciplinary approach is the preferred way of managing patients with chronic pain. Consultant anaesthetists working on their own or with too few chronic pain sessions, may experience considerable difficulty providing an effective and safe service throughout the year for patients with chronic pain. In such circumstances, patients may experience unnecessary suffering and increased pain during unacceptably long waiting times. In addition, the doctors may experience considerable stress and job dissatisfaction.
- 3.16** Patients with complex chronic pain problems require thorough assessment and multi-disciplinary management so the time spent on the initial consultation may be quite prolonged. Many centres allocate 45 minutes or longer to each new patient. This will limit the number of patients that can be seen during a single consulting session. Comparison should be made with the time allocated to new patients in specialties such as psychiatry. The time allocated for each patient must balance the need to deliver appropriate, high quality care to the individual patient with overall service demands and clinical priorities.

- 3.17** There is a requirement for consultant backup on a 24-hours, seven day week basis in major specialist centres that run pain management programmes or care for patients with implanted drug delivery systems and spinal cord stimulators.
- 3.18** Chronic pain services should have designated management support that provides access to higher levels of hospital administration. In most institutions, the pain service is grouped with other anaesthetic services or with medical specialties such as neurosciences. Managerial, secretarial, clerical and IT support staff should be available to underpin inpatient and outpatient work in the same proportion that they are available for other medically-based specialties such as gastroenterology and cardiology. There should be an identifiable budget for the pain management service.

3.19 Equipment

The management of some chronic pain patients involves the use of specialised equipment such as an image intensifier or radio-frequency lesion generator. Centres that provide specialist services will require more equipment and specific consideration will have to be given to this when formulating budgets as identified in the National Specialised Services Definitions Set for Specialised Pain Management Services.²⁵ The pain service should ensure that there are maintenance contracts and a rolling replacement programme for equipment.

3.20 Drugs

Chronic pain services often use drugs beyond the remit of the marketing authorisation or licence.²⁶ Sometimes general practitioners are reluctant to prescribe follow-up treatment in this situation so that the burden for continued care falls on the budgets of the hospital pharmacy or the pain service. This must be recognised in contracts with Primary Care Trusts so that patient care is not compromised. Where possible agreed arrangements for shared care should be negotiated between primary care and the chronic pain services.

3.21 Facilities

Appropriate outpatient facilities include rooms for consultation, examination and treatment that are provided on a regular basis. There must be access for wheelchairs and disabled patients. There must be appropriate facilities for the other healthcare professionals in the team and for the pain service's administrative and secretarial support. Office accommodation should be in a separate area that provides security for patient records and information.

3.22 Information technology

The pain service should be provided with up-to-date electronic systems for maintaining patient bookings, medical records, outcome information and other audit data.

3.23 Pain management programme

In specialist centres, there should be provision of a pain management programme with cognitive behavioural therapy and restoration of physical function provided primarily by clinical psychologists and physiotherapists working as part of the interdisciplinary team.²⁷ The medical director of these programmes is usually a consultant anaesthetist. Inpatient or hostel accommodation will be required for intensive programmes.

3.24 Inpatient beds

Pain management units require access to designated inpatient beds in addition to defined operating theatre and radiology sessions for the performance of diagnostic and therapeutic procedures. The number of inpatient beds and procedure sessions should be appropriate for the case-load and case-mix of the unit. This requirement may be greater in centres that undertake specialised procedures or manage a large number of patients. Access to appropriate recovery (post-anaesthetic) areas should be available for patients following major interventions when indicated. Those centres that do have designated inpatient facilities should ensure that appropriate arrangements are in place for adequate medical cover on a 24-hour basis.

- 3.25** Specific arrangements must be made for the treatment of chronic pain in vulnerable and potentially disadvantaged groups such as the elderly, children, non-verbal, disabled, intellectually handicapped and non-English speakers. Patients with impaired hearing or vision should have their special needs addressed.
- 3.26** The most recent recommendations about consent require that written information should be available for both patient and purchaser explaining the treatments available in the pain management unit in a way that is readily understandable. This must cater for patients mentioned in 3.25 above. Patients must be able to make an informed decision about the pain management techniques that they choose; medical and nursing staff should be available for discussion.
- 3.27** There should be agreed referral and discharge policies with established lines of communication between the pain service and primary care physicians.
- 3.28** The chronic pain service should be responsive to the needs of patients and primary care professionals. Patient input should be sought through established hospital mechanisms whenever possible.
- 3.29** The effective multidisciplinary management of patients with chronic pain has been shown to alleviate pain, aid the restoration of normal function and reduce the socio-economic burden to the individual, the health service and the community at large.²⁸
- 3.30** Purchasing and commissioning organisations should ensure that the multidisciplinary management of patients with chronic pain is specified as part of the contracting process. This will require the funding of designated staff, equipment and facilities.

4 Services for pain in patients with cancer

- 4.1 The provision of pain relief for patients with cancer requires close collaboration between palliative care, primary care and pain services.^{29,30} From 11–15% of patients with cancer-related pain will benefit from specialised pain management services. To ensure the best possible pain relief for this group of patients, both acute pain services and chronic pain services should be involved in the management of patients with cancer-related pain. The demands made on pain management services will vary with the size and expertise of the local palliative care and oncology services.
- 4.2 For patients with cancer-related pain, anaesthetists are able to use a range of specialist knowledge and skills including the use of medication, interventions (such as neural blockade) or the implantation of specialised devices for drug delivery.
- 4.3 Patients with pain due to cancer may be treated in the hospital as inpatients or outpatients and outside the hospital in a palliative care unit or in their own home.
- 4.4 Consultant anaesthetists providing specialist advice and services to palliative care units will require appropriate sessional recognition in their job plans. These sessions should be recognised and funded in the commissioning process.

5 Education and staff development

- 5.1 All personnel involved in acute and chronic pain management should be trained adequately to ensure the delivery of a safe and effective service. Such training should include communication skills, the use of assessment techniques, the application of appropriate management strategies, and the use of relevant equipment.
- 5.2 There should be an ongoing programme of continuing education and professional development for all staff in pain management services. Funding should be provided for these educational activities.

- 5.3** There should be regular evaluation and audit of results, outcomes, complications and side effects of treatment.
- 5.4** Whenever possible there should be clinical research focusing on properly designed and conducted investigations with a preference for randomised, controlled trials. Pain management services in the UK are ideally set up to conduct multi-centre trials to establish a robust evidence base for treatment.
- 5.5** Trainee anaesthetists may experience difficulty in obtaining access to pain management for training purposes. One explanation for this is that trainee anaesthetists do not normally make a major contribution to the service elements of pain management, except for acute pain services. It is essential for the future welfare of patients with pain that anaesthetic trainees are guaranteed training time in pain management even if this has consequences for service delivery in, for example, the operating theatre or clinical care unit. It is too easy for trainees to be removed from scheduled pain training opportunities to provide service in the operating theatre, obstetric unit or critical care unit. This is unacceptable. Lack of adequate exposure during basic and specialist anaesthetic training will reduce recruitment to the specialty and have potentially deleterious effects on the long-term provision of pain relief services by creating staff shortages. The requirements for training in pain management at all levels have been specified by the Royal College of Anaesthetists in the four training manuals for the CCST in Anaesthesia.

Glossary

Acute pain – Pain associated with acute injury or disease.

Chronic pain – Pain that has persisted for longer than three months or past the expected time of healing.

Pain medicine – The diagnostic and therapeutic activities of medical practitioners. Pain Medicine is often used interchangeably with Pain Management to describe the work done by medical practitioners and is the term favoured in other countries such as the USA and Australia.

Pain management – A multidisciplinary approach to the assessment and treatment of patients with pain.

Pain management programme – A cognitive behavioural programme for patients with persistent pain and associated disability.

References

- 1 Crombie IK, Croft PR, Linton SJ, Le Resche L, Von Korff M (eds). *Epidemiology of Pain*. Seattle, IASP Press 1999.
- 2 McQuay HJ, Moore RA, Eccleston C, Morley S, Williams A. Systematic review of outpatient services for chronic pain control. *HTA* 1997;**1**(6):1–137.
- 3 Services for patients with pain. *Clin Stand Ad Gr (CSAG)*. London, Department of Health, 2000.
- 4 Kehlet H, Hole K. Effect of postoperative analgesia on surgical outcome. *Br J Anaesth* 2001;**87**:62–72.
- 5 Anaesthetists and Non Acute Pain Management. *Assn Anaesth Gt Br and Ir, Roy Coll Anaesth and The Pain Soc*. London, 1993.
- 6 Provision of Pain Services. *Assn Anaesth Gt Br and Ir and The Pain Soc*. London, 1997.
- 7 Acute Pain Management: Scientific Evidence. *Nat Hlth and Med Res Cou*. Commonwealth of Australia, 1999.
- 8 Carli F, Mayo N, Klubien K, Schricker T, Trudel J, Belliveau P. Epidural analgesia enhances functional exercise capacity and health-related quality of life after colonic surgery. *Anesth* 2002;**97**:540–549.
- 9 Linton SJ, Hellsing AL, Andersson D. A controlled study of the effects of an early intervention on acute musculoskeletal problems. *Pain* 1993;**54**:353–359.
- 10 Rawal N. Analgesia for day-case surgery. *Br J Anaesth* 2001;**87**:73–87.

- 11 Harmer M, Davies K A, Lunn JN. A survey of acute pain services in the United Kingdom. *Br Med J* 1995;**311**:360–361.
- 12 Commission on the Provision of Surgical Services. Report of the Working Party on Pain After Surgery. *Roy Coll Surg Eng and Coll Anaesth*. London, 1990.
- 13 The Provision of Services for Acute Post-Operative Pain in Scotland. *DOH, The Scot Off, 1996*.
- 14 Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline. *Agency for Health Care Policy and Research*. AHCPR Publication **No.92-0032**. Rockville MD, 1992.
- 15 Acute Pain Management in Adults: Operative Procedures Quick Reference Guide for Clinicians. *Agency for Health Care Policy and Research*. AHCPR Publication **No.92-0019**. Rockville MD, 1992.
- 16 Practical Guidelines for Acute Pain Management in the Perioperative Setting. American Society of Anesthesiologists Task Force on Pain Management. *Anesth* 1995;**82**:1071–1081.
- 17 Anaesthesia under examination: the efficiency and effectiveness of anaesthesia and pain relief services in England and Wales. *The Aud Comm*. London, 1997.
- 18 Prevention and Control of Pain in Children. A Manual for Health Care Professionals. *Roy Coll Paed Child Hlth*. London, 1997. BMJ Publishing Group.
- 19 Elliott AM, Smith BH, Kay PI, Cairns Smith W, Chambers WA. The epidemiology of chronic pain in the community. *Lancet* 1999;354:1248–1252.
- 20 Back Pain. *Clin Stand Ad Gr (CSAG)*. London, HMSO 1994.
- 21 Waddell G. The Back Pain Revolution. *Churchill Livingstone*. Edinburgh, 1998.
- 22 Maniadakis N, Gray A. The economic burden of back pain in the UK. *Pain* 2000;84:95–103.
- 23 Loeser JD. Desirable characteristics for pain treatment facilities: report of the IASP taskforce. In: Proceedings of the VIth World Congress on Pain (Eds. Bond MR, Charlton JE, Woolf CJ). *Elsevier, Amsterdam, 1991*.
- 24 McQuay H, Moore A. An evidence-based resource for pain relief. *OUP, 1998*.
- 25 National Specialised Services Definitions Set. Definition No.31: Specialised Pain Management Services (adult). *DOH, 2002*. **website** www.doh.gov.uk/specialisedservicesdefinitions.
- 26 The Use of Drugs Beyond Licence in Palliative Care and Pain Management. A position statement on behalf of the Association for Palliative Medicine and the Pain Society. *Assn Pall Med and The Pain Soc*. London, 2002.

- 27 Desirable Criteria for Pain Management Programmes. *The Pain Soc.* London, 1997.
- 28 Morley S, Eccleston C, Williams AC de C. Systematic review and meta-analysis of randomized controlled trials of cognitive behaviour therapy for chronic pain in adults, excluding headache. *Pain* 1999;**80**:1–13.
- 29 Management of Cancer Pain. Clinical Practice Guideline No 9. *Agency for Health Care Policy and Research.* AHCPR Publication **No.94-0592.** Rockville MD, 1994.
- 30 Portenoy RK, Lesage P. Management of cancer pain. *Lancet* 1999;353:1695–1700.

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