PAIN SYMPOSIUM — WORKSHOP

Nine workshop groups were set up to discuss the implications of pain, problems encountered and some solutions in various aspects. The groups were each led by a physiotherapist and a medical specialist and reported back to the plenary session after an hour.

The **obstetric workshop** considered pain in this instance as functional and temporary. For pain control in labour the following were advocated: early reproductive education; psychological anaesthesia including physiotherapy, psychotherapy and general education; husband's involvement; drugs and induction only when indicated, the patients having been taught to cope with these situations.

The **pharmacology** workshop discussed analgesic drugs and their potential addictive property on depression of the central nervous system (CNS). They concluded these should be used thoughtfully and rationally in treating severe pain. Ketamine (ketalor) received parti-

cular attention as it does not depress the CNS, but can produce hallucinations. They noted with interest that medical students receive an intensive education in pharmacology but know very little about physiotherapy in the management of pain.

The **orthopaedic workshop** noted that 90% of out-patients present with *pain* due to trauma and sequelae or acquired conditions such as back and neck pain which are largely undiagnosed. The problems in these cases are that the patho-physiology is usually unknown and it is difficult to assess pain scientifically. Some solutions that were proposed are to assess the patient's *disability,* i.e. how pain affects his life; the use of a team approach with one person in charge of total care; to spend *time* on questioning, listening to and examining the patient; and that it is essential to overcome inter-disciplinary communication problems.

The **paediatric workshop** concluded that the recognition of pain would depend on the age or level of development of the child. It is essential to recognise pain early and explain it to the child, at the same time establishing rapport and trust with the child and parents. The cause of acute pain should be removed if possible, lest it becomes chronic. Chronic pain is influenced by sensory stimulation, environment and activity, and is best handled by a multidisciplinary approach. The psychological overtones to organic pain and the function of pain were discussed. The group also touched on the relief of pain by means of physiotherapy, drugs and surgery.

The **respiratory workshop** concentrated on practical management of pain in various respiratory conditions. In injury the value of ventilation, epidural block, intravenous morphine, entonox, reassurance and physical support was discussed. The role of analgesics, anti-inflammatory agents, muscle relaxants and reassurance in managing obstructive lung disease was stressed. In pleurisy anti-inflammatory agents and reassurance were thought to be essential. Pain after chest surgery could be controlled by Continuous Positive Airways Pressure, intravenous morphine, reassurance and physical support, whilst pain in malignant disease responded best to morphine. In all instances physiotherapeutic management was thought to be beneficial in handling pain.

The **neurological workshop** approached the problem from three points of view. The *physiotherapists* felt that chronic pain was a problem area as they could not deal adequately with it. Training in counselling techniques was necessary to develop an approach where the patient was actively involved in his management by accepting responsibility for himself and his need of his pain. The *surgeon* felt that acute pain should be treated enthusiastically, that negative aspects should not be highlighted in front of the patient and that chronic pain is better managed by teaching coping mechanisms such as postural control. The patient should be motivated to accept personal responsibility. A *psychologist* felt that the patient should be accepted as a whole person, his self esteem being respected without becoming his psychological crutch.

The **rheumatology workshop** felt that physical measures used to treat pain (such as heat and ice) should be more scientifically evaluated. Mobilisation techniques were discused. Care should be taken not to produce a placebo effect when evaluating drugs, physical measures or other treatment modalities. The conclusion was that personal contact and caring, such as in counselling were of prime importance.

The **anaesthesia workshop** concentrated on a discusion of the pain pathways, the gate control theory of pain and mechanisms whereby physiotherapy modalities such as transcutaneous electrical nerve stimulation (TENS) is thought to be effective. The rôle of the body's natural opiates, the endorphins, in blocking certain synapses was thought to be important. The final conclusion was that it is important to involve the patient in the treatment of his own pain.

The **neurology workshop** concluded that it is essential to take an adequate history, being careful how language is used and how the patient interprets it. Communication about symptoms and treatment has to be full. The patient has to be approached as a person with special reference to cultural and environmental aspects. Again the multidisciplinary approach, ensuring physical contact and rapport with the patient was stressed. Physical treatment and TLC were thought to be important. Attention was drawn to the fact that pain memory is usually lost, but that there is easy recall of past pain.

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