



APS President's Report



It is with much sadness that I need to inform all APS members of the untimely and sudden death of Jay Govind. Jay recently took up the post of ACT State Director. He was always an active and contributing member of our society. A tribute to Jay has been added to our website (www.aspsoc.org.au) and a copy of an abbreviated eulogy is included in this newsletter. Jay was a close friend and colleague to many of us, and to the wider community involved with pain and its management. He will be sorely missed!

The APS Board and various committee members met on the first weekend of August, 2009, for a strategic planning meeting. This meeting provided an excellent opportunity to review our progress since the last strategic meeting in 2006 and allowed an in depth discussion about future directions and goals of the APS. It is difficult to provide a concise summary of the broad variety of topics and often free flowing conversations that ensued over two very full days of discussion. Some highlights included a re-commitment to maintain and strengthen our existing membership, and to represent your needs across all activities of the APS. We wish to extend and further enhance the current sub-committee structure of our organization with the addition of a communications sub-committee: this will be a relationship sub-committee aiming to develop better models to link with other key stakeholder groups and the wider community as well as expand the scientific program committee. We are investigating the ways to update the APS website in order to ensure that it provides the best possible interface for members and the general public. Other important issues involve the completion of the "Waiting in Pain" survey of all multidisciplinary clinics in Australia, to explore new options for future secretariat and administrative support to the APS, possibly develop a new one day annual scientific meeting for pain researchers, improve the format and/ or the frequency of the newsletter, and to investigate

the feasibility of a minimum data set (of clinical outcome measures) for pain management programs.

The very important news is that the APS has formally agreed to partner with the Faculty of Pain Medicine and various other consumer and professional groups in a National Pain Summit. The primary goal of the summit is to develop a national strategy with evidence based models of care and then take this strategy to the Federal Government in order to inform the direction of future policy and health funding initiatives. Four APS Board members have been appointed onto the steering committee and several other APS members have been involved in the expert working party groups to evaluate the best models of service delivery, primary care options for pain management, analysis of the scientific evidence base and consumer issues and views. The APS has also agreed to provide financial support to this important project and to be listed as a supporting organization in all media and publicity materials relating to the summit. The APS will also have a key role in taking the national strategy documents to Government in an effort to

CONTENTS

President's Report	1
Editor's Note	2
National Pain Summit	2
Progress in CRPS Pathogenesis?	3
Obituary: Jayantilal Govind	6
APS/APRA PhD Scholarships Report	7
Caring for patients experiencing severe pain in the acute hospital setting	8
Interview with Michael Jennings	10
Announcement! Radical New Membership Subscription!	13
IASP NEWS	14
4th Annual Canberra and Region Pain Day	14
Calendar of Events	16
APS New Members	16
NSW Pain Interest Group - Nursing Issues	17

influence future policy direction and funding for enhanced service provision in pain management. I firmly believe that APS representation is vital to the success of this initiative and will ensure that there is a multidisciplinary voice in the development of future health care policy for pain management. If you have any strong views or opinions on the models for future pain management practice please contact the APS secretariat or your State Director so that we can incorporate all the ideas from our membership into the final strategy paper.

Professor Stephen Gibson
President

| Editor's Note

Dear Members,

I'm pleased to present the September Newsletter. We have a range of articles all of which I recommend to you. From here on we'll be hearing about the Pain Summit to be held in March next year – the article is a must-read. You'll find a provocative article on Complex Regional Pain Syndrome from the always lucid Arthur Duggan. We sadly pay our respects to Jay Govind in the obituary composed by Nik Bogduk and Geoff Speldewinde. We have an informative report about our PhD program from Maree Smith, followed by a short description by Susan Slatyer of her Ph D work investigating nurses' responses to dealing with patients in pain. Following this you'll find an absorbing interview of NSW Director Mike Jennings conducted by past-President Amal Helou in which Mike reflects on a his years in psychiatry and pain clinics. Phil Siddall has plenty of IASP news. Make sure you look at Geoff Speldewinde's invitation to the Canberra Pain Day: he has organised a great program. Also there's an invitation to the conference being held by the Nurses Special Interest Group. As always, I thank all the contributors for their articles and I thank the staff at DC Conferences, especially Sunny and Dianna, for their assistance in preparing the newsletter.

Happy reading,

Will Howard
Newsletter Editor

| National Pain Summit March 2010

The Australian Pain Society will be a leading participant in the National Pain Summit to be held in March 2010, along with the Faculty of Pain Medicine, ANZCA and consumer group Chronic Pain Australia.

The National Pain Summit is a vitally important healthcare policy initiative which aims to elevate awareness of the prevalence and economic cost of persistent pain to the community, and address this issue through the development of a National Pain Strategy. A key aspect will be a focus on strategies in acute pain management that aim to reduce the risk of progression from acute to persistent pain.

The National Pain Strategy will be aligned with current Federal Government proposals for Health Reform and will aim to deliver major benefits to consumers by making more effective, cost-effective and accessible healthcare solutions available to all Australians.

The proposal for the summit arose from the recommendations of The Access Economics Report 2007: The high price of pain - the economic impact of persistent pain in Australia. This report was produced in collaboration with MBF Foundation using Pain Management Research Institute epidemiological data and other research. The MBF Foundation (MBFF) has provided the initial funding to begin the process of organising the summit. ANZCA and the Faculty of Pain Medicine have provided major in-kind resources and will host the summit meeting, while the APS has provided additional financial support. The following objectives have been agreed by the working groups:

- To contribute to leadership in the development, planning and implementation of persistent pain management research, education and best practice clinical services using a whole of population approach.
- To bring together experts in the field of persistent pain management, primary healthcare providers, consumers and key Government and private sector stakeholders, to achieve a comprehensive understanding of what is required to manage and minimise the impact and extent of persistent pain in the Australian community - in health, social, human, financial and economic terms.
- To achieve agreement for a national strategy for implementation of the model of best practice treatment of persistent pain and new standards for treatment of pain patients.

- To develop an effective National Pain Strategy to make best practice pain management accessible to all Australians through harnessing the expertise of all stakeholders including health professionals, private sector partners, industry, relevant non-government organisations, consumer groups, non-government payers (including general non-health insurers) and state and federal governments.

The summit will involve five stages which are integral to the development of a National Pain Strategy:

1. Preparation Stage:

This involves three parallel Working Groups who are each responsible for key elements of the strategy. The groups comprise consumer representatives, pain and other relevant medical specialists, and primary health care providers from all relevant disciplines. Their initial output will be a strategic framework for consideration and further development at the Leaders Meeting (see below). They will make recommendations in relation to the Role of Primary Care, Evidence for Best Practice Pain Management, and Optimum Model for Delivery of Services. (This preparatory stage has already commenced)

2. Leaders Meeting:

This will involve a core stakeholder group of around 50 participants. It will include members of the Working Groups and other representatives of the primary stakeholder group (see below) who will consider the recommendations of the Working Groups and agree on the strategic framework for the National Pain Strategy.

3. Development of Draft Strategy:

An experienced health policy consultant will be engaged to draft a National Pain Strategy document based on the outcome of the Leaders Meeting.

4. National Pain Summit:

The draft National Pain Strategy will be presented to a meeting of around 100 representatives of all stakeholder groups for consultation and validation to ensure an effective, comprehensive and transparent consultation process.

5. Post Summit Action:

It is proposed that the National Pain Strategy endorsed by the summit will be carried forward to government jointly by the Faculty of Pain Medicine, the Australian Pain Society and the consumer body, Chronic Pain Australia.

Recommendations for a National Pain Strategy will be closely aligned with the recommendations of the National Health and Hospitals Reform Commission Interim Report,

the recommendations of the National Primary Health Care Strategy Committee, the National Preventative Health Strategy Taskforce and the National Health Priority Action Council, especially in relation to managing chronic disease in Australia

Further information about the summit may be obtained by emailing the Pain Summit Secretariat: Project Manager Lesley Brydon: lbrydon@nscchahs.health.nsw.gov.au

Progress in CRPS Pathogenesis?

Editorials in the journal Pain usually deal with papers in the same issue. This essay was prompted by the two editorials listed below.

(1) Oaklander A.L (October 2008), 139 , 239 - 240., RSD/CRPS: The end of the beginning.

(2) Berklein F. and Kingery W. S (April 2009) 142, 177-178 Complex regional pain syndrome: A loss of inhibition?

Both deal with hypotheses and evidence on the pathogenesis of Complex Regional Pain Syndrome (CRPS) and both deal with papers by a Dutch group (de Mos et al). Both editorials are firmly on the side of the basic problem lying with small diameter peripheral nerve fibres and not with events in the central nervous system.

A Short Semantic Background

Complex regional pain syndromes I and II have interesting backgrounds which even includes semantic arguments and for the benefit of readers not familiar with the story, I shall briefly describe some of this as a prelude to discussing the editorials.

CRPS I and II are both examples of neuropathic pain. Neuropathic pain as a term does not have semantic difficulties as it indicates pain resulting from damage to, or other pathology in, the nervous system either peripheral or central. It is a useful term as it contrasts the situation from pain associated with the big three:

(1) pain following a distinctly noxious (tissue damaging or likely to produce tissue damage) peripheral stimulus:

(2) pain from a normally non-noxious stimulus delivered to inflamed tissue (in which nociceptors have dropped their thresholds) and

(3) pain originating from viscera or teeth (which have their own rules which I shall not discuss here).

Semantic problems do arise when subdividing neuropathic pain. Most terms are purely descriptive – pain following spinal cord injury, pain following a stroke, pain associated with multiple sclerosis, post herpetic neuralgia to name a few. These terms do not imply mechanisms and hopefully they will be supplanted by better terms as mechanisms become apparent.

Semantic problems so intense as to cause “official” (meaning IASP) changes have arisen with the use of reflex sympathetic dystrophy (RSD) and causalgia.

The Oxford English Dictionary defines the word causalgia as derived from the Greek *kausos* meaning heat or fever. The syndrome of causalgia is attributed to Weir Mitchell writing in 1872 of his experiences with peripheral nerve injuries during the American Civil War. There is no dispute that this syndrome of severe burning pain can be associated with distinct and usually severe traumatic damage to a peripheral nerve. It becomes more common during warfare. The syndrome usually does resolve after many months.

There have been many objections to the term reflex sympathetic dystrophy. As an operational definition of RSD I have taken one from a paper of Wilfred Janig (1991):

“Reflex sympathetic dystrophy is a descriptive term meaning a complex disorder or group of disorders that may develop as a consequence of trauma affecting the limbs, with or without obvious nerve lesion. Reflex sympathetic dystrophy may also develop after visceral disease and central nervous lesions or, rarely, without an obvious antecedent event. It consists of pain and related sensory abnormalities, abnormal blood flow and sweating, abnormalities in the motor system and changes in structure of both superficial and deep tissues (trophic changes). It is not necessary that all components are present”.

The obvious objection to the term reflex sympathetic dystrophy is that the phrase implies mechanisms which are not established and are probably even inappropriate. The term arose following the demonstration that many sufferers obtained relief from their pain by surgical (and later pharmacological) sympathectomy. Reflex means bending back and, in its familiar neurobiological use, refers to a CNS output to an afferent input. Such an event has not been shown in RSD. Sympathetic refers to the sympathetic nervous system and in particular to the role of the latter in controlling vascular tone. Dystrophy (it derives from the Greek meaning bad nourishment) refers to wasting of part of the body.

Largely due to the efforts of Stanton Hicks and Mersky, the term RSD has been supplanted with Complex Regional Pain Syndrome CRPS type I, and causalgia with CRPS type II. Personally I find these terms rather trivial descriptors but at least they do not imply mechanisms. In peacetime, it is CRPS 1 that clinicians mainly encounter.

Back To the Editorials

(1) The Oaklander editorial relates to a paper in the same issue of Pain by De Mos, Huygen, Dieleman, Koopman, Stricker and Sturkenboom - Medical history and the onset of complex regional pain syndrome (CRPS).

This is a case history analysis of CRPS 1 patients which found an association between CRPS 1 and migraine, asthma, menstrual abnormalities, preexisting peripheral neuropathies and osteoporosis. No link was found to psychosomatic disorders. The last sentence of this paper is “the association between asthma and migraine favours existing ideas of neurogenic inflammation involvement in CRPS”. The Oaklander editorial clearly favours this hypothesis. Oaklander has published previously on histological studies of skin biopsies using the nerve axon marker PGP9.5. CRPS patients had significant neurite losses in affected skin not present in controls. In this editorial she states “in CRPS, even subtle axonal injuries appear sufficient to trigger remaining fibers into inappropriate firing and neuropeptide release. This combination suffices to cause chronic pain, vasodysregulation, neurogenic inflammation as well as changes in innervated tissues.” Oakland is not an enthusiast of the CNS contributing to the syndrome as evidenced by the following statement “somatization and other pre-existing psychopathology is no more a cause of CRPS than of stomach ulcers”.

(2) The editorial of Berklein and Kingery also deals with a de Mos et al paper:- The association between ACE inhibitors and the complex regional pain syndrome: Suggestions for a neuro-inflammatory pathogenesis of CRPS.

The title of this paper grabbed my attention as I have had an interest in enzymes degrading peptides for some years but always from the viewpoint of spinal cord release and function of neuropeptides. Angiotensin converting enzyme (ACE) is a dipeptidyl carboxypeptidase which, apart from producing angiotensin 2 from angiotensin 1, degrades other peptides including substance P and bradykinin.

A few words on neurogenic inflammation and peptidases.

When trauma occurs in the periphery, the nociceptors innervating the damaged area send off impulses to the CNS but these impulses also invade the other branches of each nociceptor and there is evidence that the terminals of these branches release a host of peptides at their endings. The latter include substance P and calcitonin gene related peptide (CGRP). These peptides induce vasodilatation and increased vascular permeability. Neurogenic inflammation is normally succeeded by cellular migration into the tissues and the full inflammatory process develops.

Released peptides, are in general, degraded by a number of peptidases. Alpha amino acids all have one amino group and one carboxyl group on the first (alpha) carbon atom and peptides are formed by amide bond formation between the amine group of one amino acid and the carboxyl group of another amino acid. This means that a completed peptide, which is a string of amide bond linked amino acids, has a free amino group at one end and a free carboxyl group at the other. Aminopeptidases will rupture amide bonds towards the free amino end of a peptide, carboxypeptidases will go for the other end and endopeptidases will attack somewhere in the middle. Angiotensin converting enzyme (ACE) is a carboxypeptidase which splits off two amino acids from angiotensin1 to produce the vasoconstrictor angiotensin 2. ACE is membrane bound in many tissues.. An endopeptidase mentioned in this editorial is called neutral endopeptidase. It's proper name is EC 3.4.24.11. Thirty years ago it had the trivial name of enkephalinase. Endopeptidase splitting of substance P in the middle of the peptide chain appears to be the most important mechanism of substance P degradation.

Back to the Editorial,

De Mos et al carried out an elaborate statistical analysis of CRPS I patients whose data were on the Integrated Primary Care database of the Netherlands. I am not competent to comment on patient selection and the statistical methods used but I shall assume that they were correctly used. The use of ACE inhibitors for hypertension control was associated with an increased risk of developing CRPS I particularly in women. No such association was found for beta blockers, angiotensin 2 antagonists, calcium channel blockers or diuretics. In their editorial, Birklein and Kingery make a case that this association between ACE inhibitors and CRPS I is supportive of their work on neurogenic inflammation and the pathogenesis of CRPS I.

The title of their editorial is Complex regional pain syndrome: A loss of inhibition? What is this inhibition? I don't like their use of the term inhibition but they are referring to a purported physiological limitation of neurogenic inflammation by tissue peptidases degrading neuropeptides such as substance P and CGRP. If such peptidases are deficient or inhibited (ACE will do this) then the action of neuropeptides released from the endings of nociceptors will be increased and prolonged. Birklein and Kingery have published previously on (a) inhibition of neutral endopeptidase (NEP) and enhanced neurogenic inflammation in humans and (b) exaggerated pain related responses in NEP deficient mice subject to nerve constriction. They do not however, propose a mechanism for the hypothesised deficient endopeptidase action in sufferers of CRPS I.

A final thought

Are these two editorials compatible? I think the Oaklander approach is reasonable but leaves many questions unanswered. CRPS I is a relatively rare condition so what is the nature of the minimal axonal injury which presumably starts the remaining axons releasing mediators of neurogenic inflammation at their endings? Are the damaged and dying axons the ones which start the trouble by firing impulses and starting neurogenic inflammation at their endings? Why the dominance of women among CRPS I patients? Possibly we are deluding ourselves with some of the proposed antecedents to CRPS. Thus I am not sure how cardiac infarction or a cerebrovascular event can lead to micro lesions of small diameter afferents. The usefulness of sympathectomy with some of these patients has led to suggestions (and experimental evidence) of coupling between sympathetic efferents and somatic afferents. This may still occur but the proposals of these two editorials really put forward a different approach to the pathogenesis of CRPS. I find it reasonable that inhibiting a peptidase (ACE) will predispose towards the condition but the reduced activity of endopeptidases hypothesis is not very convincing at this stage..

Unfortunately apart from withdrawing ACE inhibitors from CRPS patients there does not seem to be a current practical use of these findings and hypotheses. Suppression of neurogenic inflammation by SP and CGRP antagonists does not seem to be clinically practical at the moment although one substance P receptor antagonist is used to reduce vomiting after cancer chemotherapy. Nevertheless these ideas shift the pathogenesis of CRPS 1 from the dismal basket to the hopeful basket.

Professor Arthur Duggan

JAYANTILAL GOVIND

Passed away suddenly, June 20, 2009.

A CAREER OBSERVED.

July 3, 2009.

The Canberra Hospital Pain Unit Memorial Service

Geoffrey Speldewinde

Thankyou so much for the opportunity to speak of my friend and colleague Jayantilal Govind.

I would like to present a précis of his life and work. Portions have been taken, with grateful permission, from a mentor to both of us, and a close friend of Jay's, Professor Nik Bogduk's eulogy last week at the funeral. (These are indicated by quotation marks in this article.)

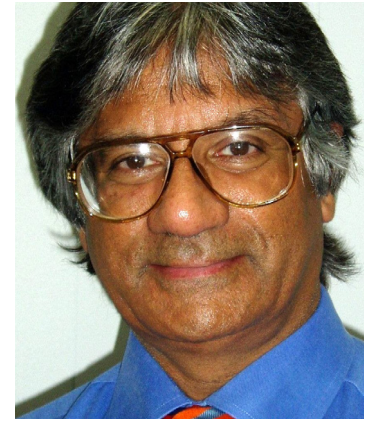
I first met Jay in 1985 when he had become Deputy Medical Superintendent at Sutherland Hospital in Sydney and where he had the important role of signing off time sheets and drawing up rosters.

Assuming he was Indian albeit with a strange accent, I was intrigued later to learn that he was in fact a refugee from a South Africa torn asunder by apartheid, and had come to Australia in 1975. This was 4 years after graduating as a doctor, with his young wife Valerie and babe-in-arms Natalie seeking a career less tainted by creed and prejudice.

"He recalled how the coloured students were treated in Medical School. They had to sit at the back of the lecture theatre. They were permitted last turn at the anatomy specimens and pathology specimens, and were allowed access only to the poorer specimens."

"All he needed was the formality of a career path, training, qualifications, and patronage. But this formality was denied to him. He recognized that doors were closed to him for a career path in South Africa. So, he emigrated to Australia where he trusted that he might succeed."

He had started in Medical Administration "where his belief in quality, dedication, and accountability" created difficulties for him, but he took that ethic into his pursuit of the newly-established Occupational Medicine College. Through the 80s and 90s, through involvement in the Executive, he strove to lift their game in Musculoskeletal Medicine, a field synonymous now perhaps with Pain Medicine. He had also worked on the 'dark side' as an Insurance Company doctor where he "explained that, in fact, there was something wrong with the patient; that



they genuinely did have pain, and that it could sometimes be diagnosed. Jay had not converted because of fashion. Unlike the many reports of his colleagues, he saw the results of new evidence, and acted accordingly."

Twelve years or so after our first meeting, I met with Jay again when we were both undertaking different aspects of musculoskeletal training under Nik Bogduk in Newcastle in 1997-98. My medical interests had taken me into the wonderful world of Rehabilitation Medicine through a strong and abiding interest in Musculoskeletal and Pain Medicine - this was a growing passion shared with Jay who had just completed his Masters in Pain Medicine at RNSH, and had become Research Fellow and Principal Instructor under Nik at Newcastle.

There he leapt on to the shoulders of other pioneers who had uncovered so much of the nature of chronic spinal pain, and he took the work of that Unit into the realm of cervicogenic headache. He established once and for all that cervicogenic headache exists. More importantly that there is a simple way, but only ONE way, of diagnosing it, and moreover that there is a highly successful and repeatable way, but again only ONE way, of effectively treating it. Through his work there are now many people around the world obtaining pain relief that they had struggled to achieve, often for decades.

His last phase was to bring that knowledge, background, aptitude, and skills, and other attributes into the direct clinical arena. After his two years at Liverpool Hospital Pain Clinic, and then dropping many non-subtle clues to him, I was fortunate to be on the interview panel that unanimously selected him for this his final work.

"It was in Canberra that he blossomed. His family affirms that the Canberra appointment was the best job he ever had. As Head of the Pain Management Unit in Canberra he rejoiced in the staff that he had, and reciprocally his staff admired him for how he looked after his patients and how he supported the department."

Here he was able to pull the Unit back from the brink of extinction through firmly establishing its quality involvement in teaching and clinical work. Most importantly for him, it allowed him to further his academic achievements. He joined the executive of an international body (the International Spinal Injection Society, ISIS), became an editor of a peer-reviewed journal (Pain Medicine), and mentored many staff in their academic pursuits.

His final recognition will indeed be posthumous.

“At the time of his passing, Jay had three publications about to appear. One of the causes that he adopted and fostered was cervicogenic headache. His own research contributed to the scientific basis of this condition, but resistance to the concept persisted despite the evidence. One of his two last papers was a review article – on cervicogenic headache – invited by the journal *Lancet Neurology*, in which he got to put his case.

His second final paper was on lumbar radiofrequency neurotomy for low back pain. In June 2009, this procedure came under attack – from guidelines committees in the UK, and from insurance companies across the USA. Jay joined members of ISIS to produce rapidly a review of the evidence for this procedure, pointing out how the procedure had been misrepresented, and how the procedure actually does work if only you did it the way that Jay urged that it should be done – properly. This paper will appear posthumously, too late for Jay to see it.

The third publication yet to appear was an epic chapter that Jay composed on neurolytic blocks and neurotomy in the treatment of pain. This chapter will soon appear in the fourth edition of Bonica's textbook of pain. Although he never became one, Jay finally had achieved one of the hallmarks of a professor: writing the book that students, worldwide, would study.”

The importance of Canberra and this Unit to him cannot be under-estimated. Whilst he was not a religious Hindu, the slight indications of it such as that small picture as you entered his room, were intriguing. Accordingly, as per his family realisation that Canberra was the highpoint, the climax, of his life's work, the family arranged for his final Hindu ceremony (to release his spirit from wandering) to be performed in this city.

Finally, the importance of Jayantilal to this Unit is inestimable- a Director who believed in his staff and patients, supported them, and grew them. We are all

gathered here today to share in the emotion of losing a much-loved man, nay, a giant who was 'just so good'.

Finally, may I quote to you from Goethe a short excerpt (from 549 'On Commitment') which epitomises a sense of Jay:

“... begin it, For boldness has genius, power and magic in it”

I commend to you all the spirit of Jayantilal Govind.

APS/APRA PhD Scholarships Report for APS Newsletter, August 2009

From: Professor Maree Smith, Chair, APS/APRA PhD Scholarships Committee

The Australian Pain Society/Australian Pain Relief Association (APS/APRA) PhD scholarship program is now in its 14th year. This training program in higher degree research is a flagship of the APS and APRA. It continues to go from strength to strength. We sincerely thank our industry sponsors, Mundipharma Australia and Janssen-Cilag, for their generous support of this important activity of the Society.

I am delighted to announce on behalf of the applications assessment panel of the PhD scholarship, that Ms Amelia Edington has been awarded our recently advertised APS/APRA PhD scholarship from a hotly contested field. Amelia's PhD project is entitled "Defining Binding Sites for a Novel Class of Analgesic Compounds" and the aim of her research project is to conduct drug discovery research with a view to identifying molecules that may have the potential to be developed as novel pain therapeutic agents in the future. Amelia's PhD research is being undertaken under the supervision of Associate Professor Robert Vandenberg and Dr Renae Ryan in the Department of Pharmacology at the University of Sydney.

Elsewhere in this Newsletter, you will find an article by our completing APS/APRA PhD scholar, Ms Susan Slatyer, in which she provides an overview of the findings of her PhD research project entitled

“Caring for Patients Experiencing Episodes of Severe Pain in an Acute Care Hospital: The Nurses’ Perspective”. Susan’s PhD scholarship was sponsored by the APS/APRA and her research using Grounded Theory was undertaken under the supervision of Dr Anne Williams and Associate Professor Rene Michael at Curtin University in Western Australia. Susan’s thesis writing is progressing well and she is aiming to complete this task by the end of 2009.

Ms Zoe Brett’s APS/APRA PhD scholarship is sponsored by Mundipharma Australia. Zoe is currently mid-way into her research project entitled “Individual differences in vulnerability to the development of chronic pain following injury”. Briefly, Zoe’s research involves the use of bioinformatic and proteomic research methods to identify possible correlations between coping styles in individual nerve-injured rats and unique patterns of gene regulation and protein expression in order to better understand the underlying ‘neuroplastic’ changes that may predispose certain coping styles to develop chronic pain post-injury. Zoe’s PhD supervisor is Associate Professor Kevin Keay and she is conducting her research in the Department of Anatomy & Histology at the University of Sydney.

Ms Mary Roberts APS/APRA PhD scholarship is sponsored by Janssen-Cilag. Mary is in the 2nd year of her PhD research project entitled “An exploration of the relationship between chronic pain and sleep problems” and her PhD supervisors are Dr Stephanie Davies and Prof Peter Drummond. Mary’s research project involves the comparative assessment of cognitive behavioural therapy for insomnia relative to non-sleep related counseling and education in patients who have both sleep problems and chronic pain. Her project is being undertaken in the Pain Medicine Unit, Freemantle Hospital, and in Murdoch University, Western Australia.

With the ongoing generous financial sponsorship of our industry sponsors, the Society is in a position to offer an APS/APRA PhD scholarship each year. Again we sincerely thank Mundipharma Australia and Janssen-Cilag for supporting this important initiative of the APS/APRA which is targeted to producing the next generation of research leaders in the pain field.

Caring for patients experiencing severe pain in the acute hospital setting – the centrality of “well-being”

As a recipient of the APS/APRA Scholarship for my doctoral studies, I have been investigating the impact that caring for a patient in severe pain has on nurses working in a Western Australian tertiary hospital. There is evidence from both community and specialised hospital settings that patients’ pain can be detrimental to nurses’ emotional well-being and that this has implications for effective pain management (de Schepper et al 1997; Nagy 1998; Nagy 1999; Wilson and McSherry 2006). My study has sought to explain the effect of patients’ severe pain on nurses caring for patients in acute care hospital wards where a variety of medical or surgical conditions are treated, to uncover the process used by nurses to manage this impact, and explore outcomes for nurses and their patients.

This qualitative study used grounded theory methodology to develop a substantive theory that explains the phenomenon being investigated. The sample was 33 nurses working on four acute care wards. Data collection encompassed 31 in-depth semi-structured interviews with nurses and 93 hours of field observation of nurses caring for patients experiencing severe pain that included structured observations of 11 nurse patient dyads. Interviews and field notes were transcribed verbatim and are currently being analysed using the constant comparison method. The Qualitative Solutions Research NVivo computer software was used to manage the data.

Preliminary findings suggest that nurses’ concern for their own well-being and their patients’ well-being were central to the day to day management of patients experiencing severe pain. Well-being was found to be multidimensional and was defined in this study as “the state of being comfortable, healthy or happy”, (Oxford Dictionary, 2007, p 1999). Dimensions of comfort, happiness and health were found to be applicable to the well-being of both nurses and patients. It was found that nurses’ well-being was affected by their patients’ pain experiences and also by whether nurses felt they had cared effectively for these patients. When nurses

saw their patients as comfortable and felt themselves to have cared effectively, they experienced a positive state of "nurse well-being" that was pleasant, enjoyable and associated with personal and professional satisfaction, "... if you think you are relieving it [pain], it gives you a lot of pleasure thinking that you are making that person feel better and making that day a bit more tolerable" (N05).

However, when nurses observed patients in distress from severe pain they experienced a feeling of failing to care for these patients, a negative state of "nurse unwell-being" that was distressing, draining and associated with personal and professional dissatisfaction. For example nurses said: "I am in pain when the patient is in pain ..." (N09); "... you get drained out ... you come to a certain level when you can't take it ... look at that patient's suffering ... your energy just wears off" (N07); "... horrible, absolutely horrible ... you feel dissatisfied that you've [not] done a good job ... because ... you haven't made them feel better by the end of the day" (N19). This data suggested that nurses promoted and protected their own well-being by seeking to care effectively for patients experiencing severe pain and ameliorate their patients' distress.

Nurses' understanding of their patients' well-being was found to provide an impetus for care that shaped effective care of patients experiencing severe pain in medical surgical wards. Nurses indicated that "patient well-being" was a state of physical and associated emotional comfort, "... they're pain free and they can relax properly" (N33). This state gave patients a sense of control, "... manageable and she can manage it and she could continue to do what she needed to do even though she's in pain ..." (N02). "Patient well-being" was linked to "... comfort and ... improvement" (N24), and was thought to be a therapeutic state for patients.

In contrast, patients' experiences of severe pain related to intense and distressing physical discomfort, "... she was in lots of pain ... she hadn't slept the whole night ... she was screaming in pain. She was in pain. She was in lots and lots and lots of pain" (N17). Nurses indicated that patients' physical and emotional comfort were closely linked, "I think pain is just generally very anxiety provoking ... And the higher their anxiety levels go, I think the more pain they tend to feel" (N15). Moreover, the experience of severe pain was understood to consume patients' mental focus thereby interrupting normal activity, "Severe pain is pain where you can't carry out what you need to do for the day ... very uncomfortable and it's all they can focus on"

(N04). Pain was also observed by the nurses to profoundly limit function, "... it just interrupts your life ... your activities of daily living mainly, interrupts ... showering and feeding and moving in bed and getting up and going to the toilet ... severe pain interrupts everything ..." (N10). Further, severe pain was thought to impact upon patients' compliance with treatment and to prejudice healing. The experience of severe pain was seen to be incongruent with comfort, health or happiness and therefore to preclude "patient well-being", providing an impetus for nurses' care:

... it's such a major role in getting someone recovered to give them the ability to be able to get out of bed and start moving ... So having good pain coverage and pain management is a huge thing to getting them rehabilitated and ready to go home. (N10)

Nurses' understanding of "patient well-being" was also found to influence the nature of care that nurses provided for patients experiencing severe pain. Effective care was thought to be holistic, with comfort considered integral, "... comfort ... holistic care ... an improvement from the treatments that you give" (N24). Further, effective care meant not complete elimination of pain but rather pain relief to a degree that enhanced "patient well-being": "Getting the pain under control he was able to stand himself ..." (N14); "... we're staying on top of the pain and looking after him holistically so much so that we're looking at discharging him ..." (N22).

This study has found that nurses aimed to deliver effective care of the patient experiencing severe pain that promotes and protects "patient well-being". By doing so, nurses promoted and protected their own well-being. This data suggests that nurses' understanding of and reference to well-being is central to the way they related to themselves, their patients and colleagues and the practice environment. These preliminary findings provide us with a greater understanding of the impact of severe pain on nurses and their pain management practice in acute medical and surgical wards. The data collected for this study so far has been immensely rich and a number of further significant themes will be revealed as the analysis is completed. I hope that the insights gained through this work will provide impetus for the development of interventions to support nurses and their patients, through new protocols and educational strategies to deal more effectively with this issue. I thank the Australian Pain Society and APRA for the supporting this project and I look forward to sharing more findings with the Society when the work is completed.

Susan Slatyer

PhD Student

18 August 2009

Supervisors:

Associate Professor Anne Williams

Associate Professor Rene Michael

Professor Linda Kristjanson

Curtin University of Technology, Perth, Western Australia

References

de Schepper A, Francke A, Abu-Saad H. Feelings of powerlessness in relation to pain: Ascribed causes and reported strategies: A qualitative study among Dutch community health nurses caring for cancer patients with pain. *Cancer Nursing* 1997;20:422-429.

Nagy S. A comparison of the effects of patients' pain on nurses working in burns and neonatal intensive care units. *Journal of Advanced Nursing* 1998;27:335-340.

Nagy S. Strategies used by burns nurses to cope with the infliction of pain on patients. *Journal of Advanced Nursing* 1999;29:1427-1433.

Wilson B, McSherry W. A study of nurses' inferences of patients' physical pain. *Journal of Clinical Nursing* 2006;15:459-468.



Susan Slatyer Biography

Susan completed her Bachelor of Nursing (Hons) at Edith Cowan University and was awarded the Faculty Medal (Honours) 2004 for outstanding research scholarship. She has been employed as a Research Nurse based at the Centre for Nursing Research, Sir Charles Gairdner Hospital Perth since 2005. Susan is currently completing her PhD studies and holds the APS/ARA PhD Scholarship 2006-2009.



An interview with Michael Jennings

**LIAISON AND CONSULTANT PSYCHIATRIST
PAIN MANAGEMENT CENTRE AT ROYAL
PRINCE ALFRED HOSPITAL.
NSW APS BOARD DIRECTOR**

I have had the honor of working with Michael Jennings for over 27 years and have learned so much from the way he engages people and the wit and wisdom he brings to his practice. So I thought it would be good to interview him for the Society's newsletter.

Amal Helou

Q. How did you get into the field of pain and who has influenced you the most?

A. Here's the short answer. In 1977 I came back from 7 years overseas and I started working in the Psychiatry department at Prince Alfred. In the first weeks in a new job you've got lots of spare time. The head of the department, Peter Beumont, said he no longer had the time to attend an outpatient clinic: could I take over his spot? Of course I said yes. So the next Monday morning I went along to the Pain Clinic. There were John Segelov, Nick Dorsch, (imagine, 2 neurosurgeons) and John Ditton and a nurse, Helen Rhule. A friendly welcoming group doing whatever they could to help some pretty complex patients. I think my first goal, as for any consultation-liaison psychiatrist in a large general hospital, was to be a "normal" doctor, not too impenetrably Freudian or desperately seeking psychoses. Anyway, it turned out to be interesting and challenging and enjoyable and I'm still there.

A longer answer goes back further. As a medical student I was firming on going into psychiatry, but I wanted to experience other terms as a resident. Neurology and neurosurgery were the busiest and the best, where you felt involved in real teamwork between the erudite

neurologist and the charismatic surgeon. Then I went into psychiatry, which in the 60's was opening up, expanding out of the asylums into community psychiatry and into the general hospitals. They were exciting times..

We went to Canada. In Toronto I was asked to be part of the ObGyn early morning rounds. I didn't know it then, but I was doing consultation-liaison psychiatry. Then in England I had a year at the Cassell Hospital and found myself working part of the time in the "marital clinic" seeing couples, supervised by Tom Main, a very impressive analyst who'd been at the forefront of developing group therapy in the services during World War II. I've stayed interested in couples ever since, and especially in the couple that is the doctor-patient dyad. The other important part of the Cassell experience was that the nurses were clearly a respected and vital part of the therapeutic team, which was in turn operating within a therapeutic community framework.

So there have been a number of key chance happenings which even before I parachuted into the pain clinic made it more likely that I would feel at home there. As a psych. registrar I would never have planned that destination. But I think that's true for a lot of us; we start out in some specialty or occupation assuming we'll stay in the mainstream but chances and opportunities take us off in other directions and we end up working with pain patients. But I'm digressing.

Back to the RPAH Pain Clinic. The place was pretty basic. About four cubicles, not soundproofed, for interviewing and examining patients, one with enough room for the four or five of us to sit around a table with the patient - yes, we did that then. The nurse would be involved and we most of the time had good secretarial service courtesy of the neurosurgery department. In 1982, Amal Helou arrived to fill the nurse's slot. Some years later in 1989, we were able to negotiate a part time honorary psychologist attached to us from the University of Sydney; it then took a few more years before we had someone in a paid position for 3 sessions per week.

John Segelov regularly went on teaching visits to country towns and was always keen to take one of us along for the journey. It was a mixture of enjoyable socialising, serious community outreach, and mutual education.

We'll get on to the issue of how things have changed a bit later.

People who have influenced me certainly include the pain clinic people mentioned above; you keep on learning from those whom you work with. There have been a number of psychiatrists amongst whom Tom Main was outstanding.

More directly connected with the pain field, Issy Pilowski has had a big impact. When I was a trainee he taught psychotherapy and we observed his sessions through a one-way screen. That was fascinating. It was only after I came back to Sydney that I got to know about his work in pain. He was always encouraging. He can bring a fresh angle to any subject and he has a great sense of history, of continuity so you feel part of some valuable tradition. And there are the patients who teach you stuff. Like how to handle dying. Or people who have come up with their own strategies for dealing with pain, or people whose symptoms or ideas or stories range from the truly quirky through really admirable to downright scary.

Q. What changes have you seen in psychiatry over the years?

A. When I started my training in the 1960's academic psychiatry was strongly influenced by various forms of the psychoanalytic tradition, especially in the USA. At the same time the development of anti-depressants and anti-psychotic medication had suddenly made mental hospital psychiatry much more interesting and optimistic. Patients who previously would have expected to spend years in a mental hospital were now responding to treatment and were able to be discharged into the community. The only problem was that even with the development of community psychiatry, ongoing care of chronic psychotic patients was still problematic. Governments all around the world found different ideological reasons for discharging long-stay patients but spent less money than was needed for proper care. This is still the case.

Over time the demands on psychiatric inpatient units have steadily increased everywhere, with pressure for fast turnover of inpatients and higher barriers to admission. In the 70's and even the 80's you could admit someone to the unit because you thought they would benefit from the treatment programme, not because you needed to put them on anti-psychotic medication. There were times I admitted chronic pain patients to the hospital psychiatric unit where the nursing staff were able to reinforce healthy behaviour and ignore illness behaviour with good results. You certainly can't do that anymore.

The other worldwide trend in psychiatry has been an increased focus on biochemistry and neurophysiology. As a result of lot of ground-breaking biological research we are starting to understand much more about brain function than we used to. As with the research in the pain field this means that you can bridge the "mind-body-gap" more successfully than used to be the case. Which is great when you are work in the Pain Clinic. Unfortunately,

to my mind, as far the training of psychiatry registrars is concerned there has been a loss of opportunities to experience psychotherapy to the extent that we used to, so that I think the pendulum has swung too far from the old emphasis on psychotherapy towards the new emphasis on biochemistry. Over the years it has been routine for psychiatric registrars to have a term in the Pain Clinic. This is one place in which the registrars experience dealing with long term ambulant patients with chronic problems and a mixture of somatic and psychological factors. It's a valued experience and means that in the future wherever they are practising they will feel comfortable with dealing with pain patients.

When I started working in the Pain clinic it quickly became apparent to me that the standard psychiatric interview leading to a diagnosis of some kind of psychiatric disorder was inadequate. It became more important to be able to develop a relationship with a patient in order to explore ways in which psychological and behavioral change could be encouraged. It seemed to me that the story of the patient's illness and how they coped with it, and their experience of various people in the health system, and therefore their expectations of what kind of things were going to happen to them in the Pain Clinic remained central. I wanted to focus on the interaction between doctor and patient. I think that one of the functions of a psychiatrist in a pain clinic is to help everybody with counter-transference. That is, the feelings that patients, particularly the difficult ones, evoke in all of us.

The other thing that I came to value was the experience of working with a multi-disciplinary team. For me the mornings in the Pain Clinic were a enjoyable counter balance to the rest of the week in private practice where I dealt with patients one-to-one. A lot of people outside the pain field tend to wonder "how could you stand it working for such a long time with pain patients?" I would agree that I would find it very difficult to work 5 days a week in a pain clinic but one to two days a week was about right for me.

While we are on the question of psychiatry, I think that psychiatrists still have something important to offer in the pain field. People tend to think of psychiatrists and psychologists being in some kind of competition. I think that we come from different backgrounds, and that psychiatrists tend to think in categories whereas psychologists tend more to think in terms of dimensions. Both have their value. The psychiatrist will certainly be useful in sorting out whether somebody has major depression for example, or considering the issue of

personality and personality disorders. While there are a lot of problems with trying to create categories for what are ranges of human personality types, I think it's still very important to think of how somebody's particular characteristics are going to impact on the kind of relationship they form with us. After all one of the main factors that I think determines whether people end up in pain clinics is the kind of relationships they have had with their doctors. This may result in them being referred, often from one specialist to another, to everybody's mutual frustration, till they end up with us.

Another issue for psychiatrists was the problem of "psychogenic pain". This had originated in the concept of conversion. I was OK with a case of conversion paralysis or conversion blindness, but conversion pain? You couldn't prove or disprove it. Basically the problem was that I had inherited the mind-body split like everyone else. I came to the conclusion that it wasn't so much a matter of the origin of someone's pain - psychogenic or somatic - it was more a matter of the person's behaviour about their pain. That is, his beliefs, coping style, attitudes, personality and how he related to doctors about it all: that was what counted.

The DSM in its various incarnations has never been a lot of help for classifying pain disorders. Mainly because it was developed by psychiatrists on the basis of populations who go to psychiatrists. Patients with "somatoform disorders" stay away from psychiatrists if they possibly can and look for doctors who don't ask questions about their emotional life.

So, clearly psychiatry has gone through major changes over the past 40 years. I still think it has a lot to offer other branches of medicine and the pain clinic is one way in which people can come out of their silos and learn from each other. On a personal level I also have had to change, for example in my methods of approaching patients, to become more flexible and to have more regular and routine contact not just with the patients but with their carers, family and GP's. This means seeing the person in his network, not just as an isolated individual.

Q. What about changes in the pain field?

A. Of course all my experience has been in the RPAH pain clinic. But the changes there have reflected changes in the wider world. We grew; bit by bit, like Topsy, hospital budgets permitting, getting more psychologist time, more regular physiotherapists, an OT, and various consultants around a basic core. John Ditton remains a constant. Our pain education programme began as a sort of mix of group therapy and CBT, but it wasn't too long before

CBT was the platform. We grew, not just in numbers, but also in our multidisciplinary range and therefore our richness of interaction.

Outside the hospital, the IASP has grown, the Australian Pain Society has grown, there are more pain clinics around the country. There is a Faculty of Pain Medicine.

Psychological approaches to helping patients and changing behaviour are more sophisticated and more central. Interventions are more evidence-based. It seems to me that the actual personnel of any pain clinic depends on who happens to be interested enough to join and to stay, so that there is a lot of variation in the kinds of specialists and professionals from clinic to clinic. We may get complacent about the job we're doing if we don't have enough contact with our pain colleagues elsewhere. Improving connections with other specialties and services is also important because good communication between us is necessary for the proper management of those patients we have in common. At RPAH we have developed better liaisons with areas such as Drug Health, Rehabilitation, Neurosurgery, Orthopaedics and Palliative Care.

Q. So what do you think is the value of a pain clinic?

A. As the health system exists now, we treat patients who otherwise fall between the cracks of the established specialties, who have accumulated a variety of disabilities and unsatisfactory experiences with the health system. We have high staff-patient ratios which need to be justified. We can say that a lot of the patients we see would be even more costly to the health system if they just kept on seeing different specialists, having tests and treatments the way they had, without a pain clinic's intervention.

Apart from the patients we treat, I think pain clinics should emphasize their education and training role. Clinics which are accredited by the Faculty train future pain specialists. But in addition, registrars from training in various specialties like psychiatry, drug health, rehab. medicine, and anaesthetics learn a lot from experiencing a term in a multi-disciplinary pain clinic which they will carry with them into their future careers. Likewise I would like to see it routine for nurses, physiotherapists, OTs and psychologists as part of their training, which they can carry in to other parts of the health system, like a benign virus. I think the experience of working for a while in a multi-disciplinary team is more powerful than a handful of lectures. I also value conversations with the primary care clinician, looking for common ground in conceptualizing what might be making things difficult in the relationship with the patient.

Q. Are there some final points you would like to share with us?

A. Getting involved in education, training and fostering of new clinicians in the field of pain has been very rewarding to me personally.

I would like to hear from any members in NSW who are interested in developing their involvement with the Australian Pain Society. They can contact me on my email address below.

Michael Jennings

mi.jen@bigpond.com
Or phone the RPAH Pain Management Centre on (02) 9515 9870.

Announcement! **Radical New Membership Subscription!**

For some years there has been unrest in the membership of the APS about some perceived inequities in our existing 'one-size-fits-all' annual subscription. After some research it was noted that a graduated income-based annual fee structure is common and is well-received. For example this approach is used by our parent body, the IASP, and by many other major chapters including the US and UK. This results in a more even distribution of the fees relative to income.

With careful deliberation and analysis of our general membership groups, the Board of Directors has agreed to the following:

< \$75,000 pa	\$90pa
\$75,000 - \$125,000	\$160pa (i.e. unchanged)
>\$125,000	\$230

Invoices will be sent out for the Annual Subscription in November. We will rely on members placing themselves into their appropriate category.

You will have noticed recently that only a half-year fee was called for whilst we change over to a calendar year subscription period.

Many thanks for your cooperation with us during this transition period.

Geoffrey Speldewinde
Treasurer, APS.

I IASP NEWS

PHILIP SIDDALL

Greetings from IASP! Executive Director Kathy Kreiter recently sent around an email highlighting some of the things that IASP has been doing over the last few months so let me fill you in on some of those activities .

The number of IASP chapters has now reached 81 with the addition of Ghana as a chapter-in-formation and Georgia and San Marino joining as chapters in May.

Over the last few months, concerted efforts have been put into selecting members for the various IASP committees and task forces such as finance, fellowships and awards, education, membership and nominations. In the past, this job of filling committees has largely been done by members of IASP council putting forward names of people they felt would be suitable. However, it was felt that there may be many members of IASP who were keen to serve in this way but were not getting opportunities. Therefore, as you would have seen some time ago, members were canvassed and encouraged to put themselves forward for committees they were interested in. Quite a large number of people volunteered for various committees and then began the task of trying to work out the composition of the committees. This has now been done and the real work will now start. I am pleased to say that Australia is well represented on these committees. Thank you to those who put their names forward or agreed to take part.

Many of you would be familiar with IASP press which has published some excellent books on various aspects of pain management. Although IASP press has provided a great service for many years, it was felt that this could be improved further, particularly in the areas of marketing and strategy. Advice has been sought on this and new steps have been put in place that will undoubtedly strengthen IASP Press which is an important part of the work that IASP does. IASP Press has recently launched a book titled Pain Management in Older Adults written by two IASP members, Thomas and Heather Hadjistravropoulos. The book received an Honorary Mention in the consumer health division of the American Medical Writers Association book awards. If you are involved in pain management in older people, it is a book that may be well worth adding to your bookshelf.

The Global Year against Cancer Pain has gone very well and I know that a number of people have been using

the excellent resources that are available through the website. This will continue until October 19th when the next Global Day will launch the Global Year against Musculoskeletal Pain. You may like to think of organizing a local event to maximize the use of the Global Day in your area and raise the profile of musculoskeletal pain and pain in general. The 2009-2010 Global Year Team is led by co-chairs Dr. Lars Arendt-Nielsen from Denmark and Dr. Kathleen A. Sluka from the USA. They and their team have been busy preparing a variety of materials, resources, and communications to help launch a successful campaign. These resources include more than two dozen Global Year fact sheets on a number of specific topics related to musculoskeletal pain, including: Evidence-Based Treatment of Acute Musculoskeletal Pain, Acute/Chronic Musculoskeletal Pain, Rheumatoid Arthritis, Basic Aspects of Joint Pain, Repetitive Strain Injuries/Overuse, and Exercise in Management of Musculoskeletal Pain. To help speakers and chapters at Global Year events, further details and resources, including an overview presentation will be available on the Global Year pages of the IASP website (www.iasp-pain.org/GlobalYear/MSP). As with this year, members will also have the opportunity to sign up to receive periodic email updates on Global Year news.

The next face to face council meeting takes place in October. If anyone has issues that they would like to raise please feel free to drop me a line.

phils@med.usyd.edu.au

I 4TH ANNUAL CANBERRA AND REGION PAIN DAY

SATURDAY, OCTOBER 10, 2009

The organising committee is pleased to have finalised the program for what promises to be another exciting Pain Day. We are honoured to be supported by generous sponsors that enable this event to continue by covering costs for our nationally-recognised and acclaimed speakers : this allows free entry to all. Thus far, at going to press, we have had confirmation from Mundipharma and St Jude as major sponsors, Boston Scientific and Janssen as sessional sponsors and Medtronic.

The purpose, as always, is to provide a pain focus in the local and regional community. There is a core of keen health professionals committed to developing and maintaining the highest levels of pain management for the Canberra Region.

This will be our inaugural event in the IASP Global Year against Musculoskeletal Pain. We are honoured this year to have:

- Professor George Mendelson (Psychiatrist) talk on pain management outcomes under the influence of litigation systems and also on assessment of difficult pain presentations,
- Professor Nik Bogduk to return to present some continuing controversies on sciatica and its management and natural history,
- Dr Henry Tsao (Physiotherapist) to talk on cortical organisation around chronic back pain and how this provides some ideas that can help in managing this common problem.

- There is also an update on the science of some aspects of acupuncture with Dr Roberta Chow (GP and Acupuncture researcher)
- Dr Brett Todhunter (Pain Anaesthetist Albury) will be finishing off with an update on some spinal interventions including some newer approaches to the sacroiliac joint.

An invitation is extended to any APS members and any other interested health professional to attend this broad-ranging and stimulating FREE program.

Hope to see you there!

Dr Geoffrey Speldewinde

Convenor, and APS Treasurer.

PS For catering purposes please register your interest at Pain Management Unit on 02 6244 3055.

CANBERRA PAIN DAY DRAFT PROGRAM 2009

Saturday, October 10, 2009
Hellenic Club (Aegean Room)

Time	Speaker	Title	Duration
0905	Mendelson	Outcomes under Compensation/litigation systems	40 mins
0945	Bogduk	Current sciatica treatment	40
1030		MORNING TEA	20
1100	Tsao	Plasticity of the motor system in chronic back pain	40
1145	Mendelson	Functional somatic syndromes/Assessment of alleged malingering pain	40
1245		LUNCH BREAK	60
1400	Chow	Acupuncture mechanisms and outcomes	40
1440	Tsao	Treating the motor brain in chronic back pain	40
1530	Todhunter	Spine procedures- the sacro-iliac joint	30
1600		CLOSE	

Calendar of Events

BI-ANNUAL PAIN DAY CONFERENCE

6 October 2009

Complex Regional Pain Syndrome

Lecture Theatre, Nepean Hospital, Sydney

Email: CastroM@wahs.nsw.gov.au

FACULTY OF PAIN MEDICINE SPRING MEETING

16-18 October 2009

Duelling With Pain

Sofitel Melbourne on Collins

www.anzca.edu.au/fpm/events/2009springmeeting

PAIN INTEREST GROUP - NURSING ISSUES ANNUAL CONFERENCE

30 October 2009

Moving with Pain

Le Montage Function Centre, Lilyfield, Sydney

Email: Susan.Lee@sesiahs.health.nsw.gov.au

9TH WORLD CONGRESS OF THE INTERNATIONAL NEUROMODULATION SOCIETY

12-18 September 2009

The Grand Hilton

Seoul Hotel, in Seoul, South Korea

AUSTRALIAN PAIN SOCIETY 30TH ASM WITH NEW ZEALAND PAIN SOCIETY

28-31 March 2010

The Impact of Pain

Gold Coast Convention and Exhibition Centre,
Queensland

www.dconferences.com.au/apsnzps

HAPPINESS & ITS CAUSES

5-6 May 2010

The Impact of Pain

Sydney Convention and Exhibition Centre, NSW

www.happinessanditscauses.com.au

THE BEST OF BOTH WORLDS REHABILITATION 2010: MIND AND BODY

6-8 October 2010

Hilton on the Park Hotel

Melbourne

www.dconferences.com.au/rehab2010

New Members

Mrs Amy Wallis Occupational Therapy

Simon Van Rysewyk Philosophy

Mr Vaskar Das Pharmaceutical

Miss Amelia Rochelle Edington Pharmacology

Dr Lidia Mayner Neurology

Dr Keith K.T. Chan Rehabilitation Medicine

Dr Michael Lee Physiotherapy

Mr James Swift Pharmaceutical

Mrs Catherine Trotter Psychology

Dr Michelle Byrnes Psychology

Ms Nanette Anderson Psychology

Mrs Annette Vandebroek Nursing

Ms Coralie Wales Rehabilitation Medicine

Ms Megan James Nursing

Mr David Anderson Nursing

Bethaney Martin Nursing

Mrs Amanda Barclay Nursing

Mrs Yvonne Stewart Nursing

Dr Stephanie Oak Psychiatry



The Impact of Pain

Sunday 28 - Wednesday 31 March 2010

The Australian Pain Society and the New Zealand Pain Society Combined

Annual Scientific Meeting | Gold Coast Convention & Exhibition Centre

Keynote Speakers	Pre Conference Workshops	Topical Sessions	
<p>Professor Irene Tracey Oxford University, Oxford, UK</p> <p>Professor Francis J Keefe Duke University, Nth Carolina, USA</p> <p>Professor Troels S Jensen Aarhus University, Denmark</p>	<ul style="list-style-type: none"> ■ Acute Pain Workshop ■ Psychology Workshop ■ Fundamentals of Pain Management <i>Back to Basics Training Day</i> ■ International Neuromodulation Society 5th Scientific Meeting of the Australasian Chapter ■ Public Forum: Play 4 Pain New tunes for creative brains 	<ul style="list-style-type: none"> ■ Advances in interventional & conservative treatments for chronic pelvic pain ■ Pain in severe burns: Beyond the acute ■ Personalised medicine and pain therapeutics ■ Interdisciplinary model of care for CRPS ■ Novel signalling pathways in peripheral pain ■ Injury management to reduce the risk of chronicity ■ The immune system, cannabinoids and neuronal health ■ Fast track surgery and implications for postoperative analgesics 	<ul style="list-style-type: none"> ■ Decreasing the risk of acute to chronic transition ■ Data collection: Minimum data set ■ Pain in the compensation system ■ Psychiatrists in the pain clinic ■ Chronic pain in children ■ Clinical pain in the brain ■ Neuropathic pain ■ Aged care ■ Doing a lot with a little ■ Does one size fit all?

DEADLINES Call for Free Papers & Posters - **23 Oct 2009** | Early Bird Registration - **1 Feb 2010** | Register online from **Nov 2009**

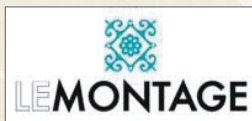
For further information or for sponsorship & exhibition opportunities, contact the APS/NZPS Secretariat: DC Conferences Pty Ltd | PO Box 637, North Sydney 2059
 P 612 9954 4400 | F 612 9954 0666 | E apsnzps@dconferences.com.au | Online submission: www.dconferences.com.au/apsnzps

30 OCTOBER 2009

MOVING WITH PAIN



**PAIN INTEREST
GROUP - NURSING
ISSUES**
Annual Conference
Le Montage



38 FRAZER STREET, LILYFIELD

The ACT Chapter of the Australian Pain Society in conjunction with
ACT Health invites you to a FREE seminar

CANBERRA and REGION PAIN DAY

Saturday 10th October 2009

Time: 0845am to 4pm

**Aegean Room
Hellenic Club of Canberra
Cnr Launceston and Easty Street
Woden ACT
(Pay Parking)**

RSVP: 2nd October 2009 (for catering purposes)
Telephone: (02) 62443055 OR 62443011
Email: heather.collin@act.gov.au

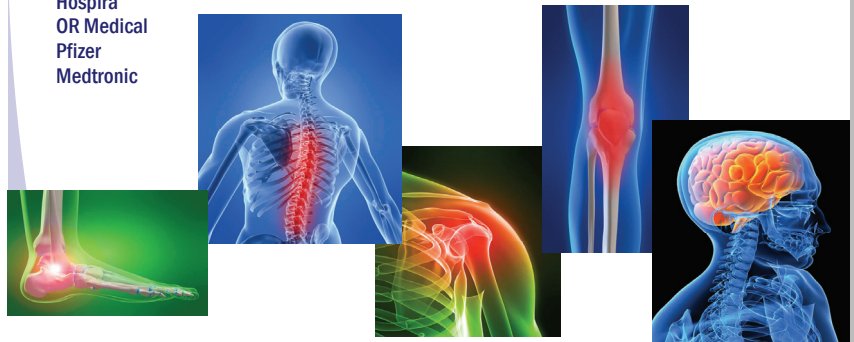
Major sponsor:

Advanced Neuromodulation Systems (ANS)
Mundipharma
Janssen-Cilag

2009 Global Year Against Musculoskeletal Pain

Other sponsors:

Hospira
OR Medical
Pfizer
Medtronic



THE FACULTY OF PAIN MEDICINE
IN CONJUNCTION WITH THE ACUTE PAIN
SIG 3RD ANNUAL SPRING MEETING
IN MELBOURNE, AUSTRALIA

'DUELLING WITH PAIN'



The Organising Committee extends an invitation to attend this stimulating meeting which brings together some great minds to address some of the most difficult problems facing those who treat pain.

The Theme 'Duelling with Pain' encompasses the precision and attention to detail clinicians must embrace to win the battle with the more complex aspects of pain management in many settings. The meeting will focus on the emerging collaborations between pain medicine and other specialties such as addiction medicine as each brings new information to aid the patient with pain.

Invited speakers are: Roman Jovey, Canada, Suellen Walker, United Kingdom, Damien Finniss and Andrew Somogyi, Australia.

This meeting brings together a diverse group of clinicians and scientists from Pain Medicine, Addiction Medicine, Basic Science, Palliative Medicine, Respiratory Medicine, Geriatric Medicine and Trauma and Disaster Medicine.

Presentations on topics include: Opioids, New Analgesics in the Pipeline, Prescribing for the Elderly, Intrathecal Analgesia – New Findings and Improved Practice, Cancer Pain, Acute Pain, Placebo Revisited and Victorian Bushfire Retrieval.

We hope you will join us in October to learn and also share your ideas in the many interactive sessions.

Enquiries should be addressed to:

Ms Marta Dzedzicki, Conference Secretariat, ANZCA
Tel: (+61 3) 9510 6299
Email: mdzedzicki@anzca.edu.au
www.anzca.edu.au/fpm/events/2009springmeeting



“Moving with Pain” One day Pain Management Conference

Friday 30 October 2009

Le Montage Function Centre at Lilyfield

2009 Global Year Against Musculoskeletal Pain

Dear Colleagues

On behalf of the NSW Pain Interest Group - Nursing Issues (PIG-NI) I wish to invite you to a very special educational one day Conference "Moving with Pain ", on Friday 30th October 2009.

The professional development day promises to be interesting with presentations from many sought after speakers who are leaders in their field of Pain Management. The topics covered will help equip clinicians to deal with the challenges they face in caring for patients with pain.

We seek your support and request that you nominate nurses and allied health staff from your institution to attend. Please distribute details about this conference as widely as possible. We look forward to seeing you all there. Programme details on http://www.apsoc.org.au/special_interest_groups_pigni.php

Registration information contact

Sue Lee, Tel 02 91131623 or 91131111 page 5114

[<Susan.Lee@SESAHS.HEALTH.NSW.GOV.AU>](mailto:Susan.Lee@SESAHS.HEALTH.NSW.GOV.AU)

Sincerely
Sonia Markocic
President NSW PIG-NI
CNC Pain Management, Wollongong Hospital

Sponsored by



Advancing Wellness™ Astra Zeneca - Baxter - Chattanooga Whiteley All Care - Jansen Cilag - Inova
Medtronic - Mundipharma - St Jude Medical - Surgical Specialties - University of Sydney

APS Directors 2009

President: Professor Stephen Gibson

National Ageing Research Institute
Royal Melbourne Hospital
PO Box 2127, Parkville VIC 3050
Tel: 03 8387 2329 Fax: 03 9387 4030

Vice President/ Secretary: Dr Timothy Semple

Royal Adelaide Hospital Pain Clinic
North Terrace, Adelaide SA 5000
Tel: 08 8222 5403 Fax: 08 8222 5904

Treasurer: Dr Geoffrey Speldewinde

15 Napier Close, Deakin ACT 2600
Tel: 02 6282 6240 Fax: 02 6282 5510

NSW Councillor: Dr Michael Jennings

Pain Management Centre, Royal Prince Alfred Hospital
Missenden Rd, Camperdown NSW 2050
Tel: 02 9515 9870 Fax: 02 9517 1832

NT Councillor: Dr Gavin Chin

Royal Darwin Hospital
PO Box 41326, Casuarina, NT 0811
Tel: 08 8922 8888 Fax: 08 8922 8900

QLD Councillor: Mr Micheal Deen

Multidisciplinary Pain Centre,
Royal Brisbane Hospital, Herston QLD 4151
Tel: 07 3636 6141 Fax: 07 3636 6142

SA Councillor: Ms Lynne Haley

Royal Adelaide Hospital
North Terrace, Adelaide SA 5000
Tel: 08 8222 5163 Fax: 08 8222 5904

TAS Councillor: Dr Gajinder Oberoi

Royal Hobart Hospital
460 Churchill Ave, Sandy Bay TAS 7005
Tel: 03 6222 8308 Fax: 03 6225 4423

VIC Councillor: Dr Malcolm Hogg

Department of Anaesthesia and Pain Management
Royal Melbourne Hospital
Parkville, VIC 3052
Tel: 03 9342 7540 Fax: 03 9342 8623

WA Councillor: Dr Stephanie Davies

Anaesthetic Department and Pain Medicine Unit
Fremantle Hospital Health Service
Alma St, Perth WA 6160
Tel: 08 9431 3296 Fax: 08 9431 3696

APS Office Bearers 2009

Immediate Past President: Ms Amal Helou

Pain Management Centre, Royal Prince Alfred Hospital
Missenden Rd, Camperdown NSW 2050
Tel: 02 9515 9739 Fax: 02 9515 9831

SPC Chair: Dr Michael Farrell

Howard Florey Institute
University of Melbourne
Melbourne VIC 3010
Tel: 03 9857 3273 Fax: 03 8344 1941

IASP Liaison: Dr Philip Siddall

Pain Management Centre,
Royal North Shore Hospital
St Leonards, NSW 2065
Tel 02 9438 8420 Fax 02 9906 4079
Website: www.iasp-pain.org

Website Coordinator: Mr Michael Deen

Multidisciplinary Pain Centre
Royal Brisbane Hospital
Herston QLD 4029
Tel: 07 3636 8111 Fax: 07 3636 1308

Newsletter Editor: Dr William Howard

Department of Anaesthesia
Austin Health
Studley Road, Heidelberg VIC 3084
Tel: 03 9496 3800 Fax: 03 9459 6421

PhD Scholarship Chair: Professor Maree Smith

Department of Pharmacy
University of Queensland
St Lucia QLD 4072
Tel: 07 3365 2554 Fax: 07 3365 1688

Secretariat: DC Conferences Pty Ltd

PO Box 637, North Sydney, NSW 2060
Tel: 02 9954 4400 Fax: 02 9954 0666
Email: aps@apsoc.org.au