MEETING NOTES

Date: **17 November 2009, 5-7pm**
Subject: **APIL East Anglia Regional Group Meeting and Costs and Funding SIG**

Location: Holiday Inn, Ipswich Road, Norwich, NR4 6EP

Attendees: **Neil Austin, Simon Bransby, Samantha Collins, Ian Comer, Mark Copley, Emma Crawley, Julie Crossley, Simon Davis, Heather Duffy, Stephen Green, Jeremy Ives, Geraldine Kerrison, Jacqueline Lake, Siobhan McWhinney, Chris Moore, Jan Parry, Tim Parsons, Hannah Rutterford (Regional Co-ordinator), Mick Upton (Regional Secretary), Geoff Young.**

1. INTRODUCTION

Hannah Rutterford (HR) welcomed attendees and briefly introduced the speakers, Richard Nieveen, Prosthetist (RN) and Dr Brian Marien. Unfortunately there was no EC update at this meeting as there were no EC members free to be able to attend.

2. DR MARIEN PRESENTING ON : RISK FACTORS FOR DEVELOPING COMPLEX CHRONIC PAIN CONDITIONS. OCCUPATIONAL STRESS – UNDERSTANDING RISK FACTORS FOR DEVELOPING STRESS, ANXIETY AND DEPRESSION. COGNITIVE BEHAVIOURAL THERAPY (CBT) – AN EVIDENCE BASED TREATMENT

After spending 15 years in general medical practice Dr Marien (Director of Positive Health Strategies) (BM) trained in CBT at the Institute of Psychiatry in London. He specialises in occupational stress and continues to research its causes, the consequences and prevention of stress and stress related illness. He has written numerous articles on the subject of occupational stress and recently contributed to the writing of two books.

BM's talk focused predominantly on the issue of chronic pain and the risk factors for developing chronic pain.

BM outlined that chronic pain does not fit neatly in the medical model as it is a subjective emotional experience so the vast majority of pain experienced does not relate to pain caused in the tissues of the body. (There is not always "linear causality.")

BM discussed medically unexplained symptoms (MUS), namely that there is not always an organic explanation for pain. MUS account for 30-70% of all consultations in primary care and 35-50% of new medical outpatients. Many perceive these people as the "worried well" but BM feels they should be perceived as the "worried sick."

The impact on the NHS, from MUS, is significant as those suffering with MUS have more consultations, more medication and more investigations. 90% of back pain cases have no definitive cause.

Some specialists expect to see linear causation/a correlation between disability and damage, i.e. the more damage there is, the more disabled the person is. BM stressed that those suffering from chronic pain do not follow this correlation.

There is great interest as to why some people are more resilient than others. There are now ways to teach resilience through CBT. Research has suggested that the way a person thinks

at the time of the accident will determine the trajectory of their recovery. For example, if the event is traumatising and creates emotion it will create/"lock" in a longstanding emotional memory in the brain. If, on the other hand, an event is not seen as traumatising it is unlikely to create a longstanding memory. If a longstanding memory is created by the event, the memory regenerates fear which is gained through an instinctive/mid brain process rather than through a cortical/reasoning process, so just thinking about the event can trigger anxiety and this can lead to patients becoming sensitised.

BM gave an example of this process. If a person is about to be rear-end shunted in a car but thinks "I've got airbags, the car is robust so I'll be ok" it may not lead to him viewing the accident as traumatising and the reasoning process he went through means he probably will not get PTSD. If, on the other hand, the person did not go through this reasoning process and consequently saw the event as frightening and threatening, the person would be more likely to develop psychological symptoms.

BM stated once a frightening has locked a memory onto the brain it can be triggered and cause fright again very easily, for example by hearing noises which occurred when the event caused fear, or sensing similar smells which were present at the time of the event. BM described this as a survival mechanism in the primitive brain which becomes distorted. There are other physical symptoms often associated with these patients, the cause of which doctors are often unable to determine, such as dilation of pupils, patients feeling "scared sick" and urinating more frequently. The failure to be able to identify the cause of these symptoms in itself can cause friction as patients can feel as though their doctor does not trust them.

Anxiety and depression can lower a person's pain threshold.

A combination of these processes can lead to the brain changing the way it interprets data.

A person's approach to their recovery can have a significant effect on their outcome. If a person takes a positive approach, mentally, they have a better chance of making a good recovery, but if they think negatively then it can almost predict a poor outcome. Anger can also prolong and increase pain suffered by a patient.

Psychological factors are a potential cause of some acute pain becoming chronic pain. Pre-existing depression is a risk factor for chronic pain.

A New Zealand study found that if patients are given hope of rehabilitation, then suffering and disability can be reduced. BM's view was that doctors and law firms should work together to try and push this approach because if patients are given no hope of a way out they learn to become helpless. He gave an example of a study which showed "learnt helplessness." In study 1 an experiment was carried out on two sets of dogs (group A and group B). Dogs were kept in an enclosure in which the floor was charged so that they were electrocuted. Dogs in group A were kept in a pen where they were able to jump over a barrier to escape the electricity. When they were electrocuted, the dogs in group A jumped over the barrier to their escape. The dogs in group B had no escape route in study 1. In study 2 both groups were in a pen with a low barrier so escape from the electrified side of the pen was possible for both groups. The dogs from group A jumped to their escape but the dogs from group B did not even try to escape. They had learnt helplessness.

There was lively discussion about CBT and chronic pain after BM's talk. It was felt by some attendees that the more failed treatments their clients have, the worse they get. This was acknowledged by BM. It was also felt by attendees that it was very difficult to get adequate treatment under the NHS where liability is not admitted and therefore no funding available.

More information about BM and Positive Health Strategies can be obtained via their websites (www.positivehealthstrategies.com and www.londoncognitivebehaviouraltherapy.co.uk)

3. RICHARD NIEVEEN – PROSTHETICS AND REHABILITATION FOLLOWING AMPUTATION)

RM works on the rehabilitation of amputees. He gave a fascinating talk on developments in prosthetics and the important factors to bear in mind when focusing on the rehabilitation of an amputee. One of Richard's local patients attended the meeting and demonstrated his prosthetic leg and how it's function could be assessed and altered with the use of a laptop.

RM also provided some interesting facts. 10% of amputees lost their limbs as a result of trauma. Most amputees have lost limbs as a result of vascular issues. 75% of amputees are men, a significant amount due to motorcycling and increased vocational risks.

RM outlined the importance of taking into account both psychological and physical factors when selecting an appropriate prosthetic for a particular person. If the correct product is not chosen for their particular needs then they wont, or won't be able to use it. Compensation can sometimes be double-edged. It is key to being able to obtain the appropriate specialist care and best products but it sometimes has a detrimental impact as some patients have been seen by RM to fear making too much progress, too quickly as it could affect claim values.

Rehabilitation is a phased process. A patient will begin by using crutches, then sticks and then a prosthesis. Once these phases are complete, emphasis turns to issues of cosmesis (aesthetics), serviceability of the prosthesis, durability and function. A balance has to be struck between cosmesis and functionality as, for example, silicone prosthetics look more life-like but they can reduce function.

RM gave some more interesting facts. Below the knee prosthetics require 12-15% more energy input to be able to walk but there are little or no limitations. Above the knee prosthetics take 49% more energy and problems are more frequent as they are harder to fit to the patient.

RM stressed the importance of ensuring that a surgeon specialising in amputation carries out the surgery, if amputation is a possible outcome, as a well executed amputation can lead to a much better outcome for a patient than a poorly executed amputation. The patient attending the meeting had had his amputation revised. Particular surgeons recommended by RM were Mr Mike Sarleh (Norfolk) and David Ward (S. London).

Usually a patient will require two sets of every day legs and when the legs are changed, the sockets and joints will also need to be changed.

Mick Upton (Solicitor), Taylor Vinters, Cambridge
East Anglian Regional Secretary
17 November 2009