A national survey of pain clinics within the United Kingdom and Ireland focusing on the multidisciplinary team and the incorporation of the extended nursing role

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Abstract

Inconsistencies in the availability and quality of pain service provision have been noted nationally, as have lengthy waiting times for appointments and lack of awareness of the Pain Clinic role. The 2013 NHS England report stated that specialist pain services must offer multispecialty and multidisciplinary pain clinics. This national survey of multidisciplinary pain service provision in the United Kingdom and Ireland provides a snapshot of pain service provision in order to review and highlight what variations exist in multidisciplinary team (MDT) provision and working patterns. A common perception among clinicians is that financial pressures have led to alternate ways of staff utilisation with variable degrees of success. The survey included 143 pain clinics, focusing principally on MDT working patterns, MDT composition and adoption of the extended role. The results identified that the majority of Pain Clinics utilise the MDT approach. However, provision of critical components such as regular MDT meetings is highly variable as is the composition of the MDT itself and also working patterns of the individual clinicians. The survey reports the successful use of the extended roles for specialist nurses in follow up clinics. In contrast, the survey highlights that a large proportion of clinicians surveyed have reservations about both the effectiveness and the safety of utilising specialist nurses in the extended role to see new referrals of complex pain patients to pain clinics. This survey underlines the essential requirement for incorporation of greater MDT working locally and nationally and allocation of appropriate resources to facilitate this.

Keywords

Pain, Multidisciplinary team (MDT), Nursing Extended role, National survey

Introduction

Chronic pain places a substantial socioeconomic and health burden on society across the globe.^{1–4} Indeed, the prevalence of chronic pain in Europe is reported to be 19%,⁵ which equates to approximately 12 million people in the United Kingdom alone. The scale of the problem is set to increase in-line with the ageing population; nearly a quarter of the UK population are now over 65 years of age and the incidence of chronic pain is greater in the elderly demographic.^{6–8} This is compounded by a trend towards increasingly complex pain disorders,^{9–11} making the need for a multidisciplinary team (MDT) approach more critical than ever. Patients

attending secondary or tertiary pain services often represent the most severely affected individuals, and their presentation may be complex and associated with additional problems such as anxiety, depression and

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fatigue, in addition to reductions in physical, social and cognitive functioning.^{12,13} This has been acknowledged by national standards that highlight the imperative for MDT working.¹⁴ However, it is a challenge for many Pain Services to meet these standards as demand outstrips supply and not all clinics are able to offer fully multidisciplinary care for their patients with complex biopsychosocial needs.¹⁴

Access to effective pain management techniques may be considered to be a fundamental human right¹⁵ but up to 68% of chronic pain sufferers describe their pain as not adequately controlled.^{5,16} Hence, the provision of effective multidisciplinary pain clinics is of paramount importance in order to address the impact of chronic pain conditions in terms of ethical and socioeconomic considerations.⁵ Specifically, recent reports have highlighted a need to improve the identification, assessment and diagnosis of chronic pain, to enable it to be managed in a cost-effective and timely manner.¹⁷ Inconsistencies in the availability and quality of services have been noted, as have lengthy waiting times for appointments and lack of awareness of the pain clinic role by both patients and healthcare professionals alike.¹⁸ Sadly, the profound misperception that there are no immediate health consequences from deficiencies in chronic pain service delivery has led to chronic pain funding provision falling behind other long-term conditions.¹⁹

Multidisciplinary pain clinics help to manage the long-term pain and aim to improve the quality of life and reduce the burden of care elsewhere that is associated with this patient group.^{14,20} This raises the question as to whether appropriate resources and personnel are allocated to pain services in order to deal with the burgeoning pain epidemic. This survey was performed in order to gain a pragmatic snapshot of current service provision in all known adult chronic pain clinics in the United Kingdom and Ireland and to gauge what variations in multidisciplinary staffing provision and frameworks existing in this age of austerity. The National Pain Audit¹⁴ suggested that future audits should seek to understand the available skills mix and competencies of each profession in more detail with a focus on cost-effectiveness, diagnosis, treatment and risk management to ensure safe working practice. Of particular relevance to this is the development of the extended roles for clinicians of different backgrounds.

Methods

The questionnaire (Figure 1) was developed by the authors to assess and compare the pain service provision across the United Kingdom and Ireland. The focus of the survey is on multidisciplinary working as well as the presence and roles of different healthcare professionals. The questionnaire utilised the www.surveymonkey.com

website and is detailed below (Figure 1). The questionnaire did not incorporate any patient information and ethical approval was not required. Data were processed and figures produced using Microsoft Office software (Microsoft Word 2008 for MACTM). Statistical analysis was not indicated.

Using the National Pain Audit.org search tool, we identified 188 clinics in England, Scotland, Wales and Northern Ireland and 15 clinics in the Republic of Ireland. In addition, we maximised data capture and clinic inclusion by emailing the Pain Consultants Google Group, which has approximately 500 members, the vast majority being based in the United Kingdom. Two of the authors also contacted the clinics directly by telephone and email to facilitate completion of the survey. Each clinic was given up to four opportunities to engage with the survey. Clinics were given the opportunity to complete the survey via telephone or a weblink. Data were collected over a three-month period from June 2015 to August 2015. The authors spoke directly with Pain Medicine Consultants or Pain Nurse Specialists via the telephone in order to complete the survey. A standardised approach was used by the authors with each interaction in order to avoid bias or leading of the participant.

Limitations of this study

For practical reasons, we were unable to use the International Association for the Study of Pain (IASP) description/definition for multidisciplinary pain clinics and multidisciplinary pain centres in our survey due to the length and level of detail inherent in these descriptions and the time constraints of undertaking the survey itself.

There is no single specific National Health Service (NHS) definition for Pain Nurse Practitioner and therefore our survey was not able to base its methodology on such a definition.

It was difficult to compare the results of our survey directly with other surveys in this field as the terms of reference for each study were different. However, all these surveys have highlighted the need for more comprehensive pain service provision and also the need for greater uniformity regarding staff training, working patterns and multidisciplinary cohesion.

The survey did not explore the proportion of pain consultants who responded to the survey versus the number of pain nurses who responded. For this reason, it is unclear what percentage of consultants/nurses were in favour/not in favour of nurse-led clinics accepting unselected new referrals.

Relatively minimal qualitative data were collected partly due to time limitations but also due to the fact that many responders were (perhaps surprisingly) not especially forthcoming with opinions. The authors

<p>1. Name of hospital/ Pain clinic (this will be confidential)</p> <p>2. Do you? (please pick as many answers as appropriate)</p> <ul style="list-style-type: none"> •Have a Multidisciplinary Pain clinic? •Find MDT meetings helpful? •Have a consultant led service with every new patient being seen by a consultant? •Have availability of in-patient beds for chronic pain and 24 hour medical cover? <p>3. How many from each discipline do you have?</p> <ul style="list-style-type: none"> •Consultants/ Locum consultants •Advanced Pain trainees (APT) •Nurses •Physiotherapists •Psychiatrists •Psychologists •Other (please specify) <p>4. How often do you have formal structured MDT meetings?</p> <ul style="list-style-type: none"> •Daily •Weekly •Monthly •No structured MDT meetings <p>5. What percentage of patients you see, do you refer for interventions?</p> <ul style="list-style-type: none"> •0-25% •25-50% •50-75% •75-100% <p>6. Do you have any of the following non-Pain Consultant led clinics? (please pick as many answers as appropriate)</p> <ul style="list-style-type: none"> •Nurse •Physiotherapist •Psychologist •Other 	<p>7. If you have non-Pain Consultant led clinics, do they see?</p> <ul style="list-style-type: none"> •New referrals to the service, or follow-up patients who have had an initial review by a Pain Consultant? •Do they review patients – in person / by phone / either? •What access do they have to supervision for these clinics? <p>8. Thinking particularly about the nursing role in the Chronic Pain Clinic:</p> <ul style="list-style-type: none"> •Do you think it is appropriate / safe for senior nurses to see patients newly referred to the service instead of a Pain Consultant? Yes/No (please say why in a few words) •Do you think this it is a cost effective way of working? Yes/No •Do you think it is appropriate / safe for senior or junior nurses (e.g. band 6 or above) to follow up patients already seen by a Pain Consultant? Yes/No (Please say why in a few words) •Do you think this is a cost effective way of working? (Yes/No) <p>9. Do you have a pain management program? If yes, which staff are involved? (please pick as many answers as appropriate)</p> <ul style="list-style-type: none"> •No Pain management program •Consultants •Physiotherapists •Nurses •Psychologists •APT trainees/Registrars •Other <p>10. Does your clinic run at a...?</p> <ul style="list-style-type: none"> •Surplus •Neutral •At a loss
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Figure 1. The pain service provision questionnaire.

have speculated that this may be due to individuals being worried that they may be ‘quoted’ directly and their comments coming back to haunt them. Indeed, anecdotally, a proportion of clinicians appeared to be mildly suspicious of the questionnaire itself.

Results

Of the 188 pain clinics currently in existence within the United Kingdom and Republic of Ireland, 143 clinics responded to the survey, giving a response rate of 76%. This included surveys completed via SurveyMonkey®, via the UK-based Pain Consultants

Google Group and also via telephone and email. This was a pragmatic approach that maximised data capture. An identical, standardised format was used for all methods, and there is no indication that the different approaches had an influence on the nature of the responses themselves.

Multidisciplinary pain clinics

Of the clinics that completed the survey, 84% reported to use the multidisciplinary approach, while 16% did not (Figure 2(a)); 84 clinics (59%) had at least one whole time equivalent (WTE) doctor, physiotherapist

Figure 2. (a) Percentage of clinics that had regular MDT meetings, (b) percentage of clinicians who found the MDT meetings helpful and (c) frequency of formal structured MDT meetings.

and psychologist and could therefore be considered IASP levels 1–2, with 41% being level 3 (level 4 is not a pain clinic in the United Kingdom). Of the total number, 79 clinics (or 55%) had at least one WTE doctor, nurse, physiotherapist and psychologist. Multidisciplinary clinics often include team meetings involving members from different specialities to discuss complex cases in order to utilise the expertise of all the different specialities in treating patients with complex pain conditions. Of the survey responders, 3% stated that they have daily MDT meetings, 43% had meetings on a weekly basis, 21% had them monthly and 4% had them sporadically, occurring less frequently than monthly and 29% did not have structured MDT meetings (Figure 2(c)). Of the responders, 78% found their MDT meetings to be helpful to their practice, while 17% did not and 5% were undecided as to their usefulness (Figure 2(b)).

The survey focused on the multidisciplinary composition of pain clinics, recording the number of clinicians from each of the relevant professions. With regard to consultant pain medicine specialists, the mode was four physicians per clinic. Interestingly, 2% of the clinics surveyed had no consultant pain physicians and 63% of clinics employed between three and five consultants (Figure 3(a)). With regards to specialist pain nurses, the mode was two per clinic; however, there was a relatively wide spread in the frequency of specialist pain nurses employed from zero to more than five per clinic. Of the

clinics, 10% had no specialist nurses, 35% employed one to two nurses, while 39% employed four or more specialist nurses (Figure 3(b)).

With regard to physiotherapists, 70% of clinics employed between one and three physiotherapists; 20% of pain clinics had no physiotherapist, while 10% had four or more per clinic (Figure 3(c)). With regard to psychologists, 52% of clinics employed one to two per clinic; 32% of pain clinics did not have psychologists, while 17% had three or more per clinic (Figure 3(d)). In contrast, only 15% of the pain clinics employed a psychiatrist within the clinic and only 28% of clinics had an advanced pain trainee (APT; Figure 3(e) and (f)).

Extended role clinics

Of the clinics that responded, 80% defined themselves as a consultant-led service. However, 36% of pain clinics had non-consultant-led clinics that saw new patients, while 79% had non-consultant-led clinics that saw follow-up patients. And 71% of clinics had nurse-led clinics, 49% had physiotherapist-led clinics and 45% had psychologist-led clinics. Physiotherapists and psychologists have long established roles as independent practitioners. In contrast, the extended role for specialist nurses within pain clinics is a relatively recent phenomenon for which the scope of practice and optimal degree of autonomy not yet firmly established. For that reason,

Figure 3. (a) Number of consultants per clinic, (b) number of nurses per clinic, (c) number of physiotherapists per clinic, (d) number of psychologists per clinic, (e) number of psychiatrists per clinic, and (f) number of APTs per clinic.

the survey asked for the impression of the responders regarding the safety and cost-effectiveness of the nurse-led clinics. With specific regard to the assessment of new referrals to the pain clinic, 47.5% of respondents stated that nurse-led clinics were safe, while 45% stated that they were unsafe and 7.5% were uncertain (Figure 4(a)); 58% of respondents stated that nurse-led clinics assessing new referrals were cost-effective, while 34% stated that they were not cost-effective and 8% were uncertain (Figure 4(b)). In contrast, with regard to nurse-led follow-up clinics, 93% of respondents stated that they were safe and 91.5% stated they were cost-effective (Figure 4(c) and (d)). Of the non-consultant-led clinics, 28% only saw patients in clinic, while 69% used telephone clinics as well as face-to-face clinics and 3% only used telephone clinics.

Injection-based therapies

Injection-based therapies are offered by many pain clinics. The survey enquired as to the percentage of patients the pain clinics referred for injection-based therapy. The mode was 26–50% with 37% of clinics referring a quarter to half their patients for injection-based treatment;

31% of clinics stated that they referred less than a quarter of their patients. Of the responders, 21% referred half to three quarters of their patients, and 3% of clinics referred a large proportion of their patients (75–100%; Figure 5). At the time of the data collection, 8% of responders did not have this information available.

Pain management programme

Of the responders, 75% had a pain management programme (PMP) within their pain service to help people learn key skills and techniques (Figure 6(a)). PMPs were run by a combination of the respective health professionals: physiotherapists in 97%, psychologists in 89%, nurses in 75%, pain consultants in 46% and occupational therapists in 8% (Figure 6(b)). Separately, only 13% of pain clinics had access to inpatient beds.

Finances

With ever-greater financial pressure on services, including pain clinics, it may be considered desirable for clinics to either run at a financial surplus or at least to balance expenditures against nominal income. With

Figure 4. (a) Are nurse-led new referral clinics safe? (b) Are nurse-led new referral clinics cost-effective? (c) Are nurse-led follow-up clinics safe? (d) Are nurse-led follow-up clinics cost-effective?

Figure 5. What percentage of patients are referred for interventions?

specific reference to that, 11% of clinics reported running at a loss, while 37% ran a surplus, 29.5% neither loss nor surplus and 22.5% of respondents did not have knowledge of their clinic's finances.

Discussion

The complex biopsychosocial factors associated with the development of Chronic Pain necessitated the creation of the MDT involving clinicians from different professions pooling their knowledge, skills and experience. This approach was, of course, pioneered in Seattle in the 1970s by the formidable Dr John Bonica, himself a sufferer of chronic pain as a result of a successful wrestling

career that enabled him to fund himself through medical school fees.²¹ Much time has passed since then and a great deal of progress has been made, with new medications and therapeutic interventions, as well as international acknowledgement of Chronic Pain as a discrete medical condition in its own right rather than merely a symptom. However, the ability to access appropriate therapeutic options can be highly variable depending on geographic location.¹⁴ Part of the reason for this disparity is the way services have evolved independently over time, led by individuals with widely differing approaches working in a relatively young speciality. As the field of pain management has developed into a firmly established and distinct field, it is an appropriate time to reflect upon the status quo.

The British Pain Society Guidelines²² stipulate that pain clinics must have a psychologist and a physiotherapist and that all PMPs should be led by an appropriately trained psychologist. However, as De Meij et al.²³ have reported in the Netherlands, pain management facilities differ widely and in a significant proportion of cases may not meet the full standards recommended by appropriate organisations such as the IASP. Indeed, the National Pain Audit for England and Wales¹⁴ also reported high variation in both access to multidisciplinary care and also the composition of the MDT. Specifically, they found that many services fell well below minimum requirements expected of a standard pain management clinic.¹⁴ Our national survey sought to evaluate what progress had been made since then

Figure 6. (a) Do you have a pain management programme and (b) composition of the pain management programme.

and also sought to take a snapshot of the prevailing attitude towards the implementation of the extended role, which has been adopted in a relatively arbitrary manner and not necessarily fully integrated within an MDT.

Although our survey found that the majority of clinics have a multidisciplinary pain clinic, it is still unacceptable that 15% do not use the MDT approach and 41% do not meet the IASP criteria for a level-2 pain clinic. Indeed, the proportion using the MDT approach is only marginally better than reported previously.¹⁴ In addition, among those that do have a multidisciplinary service, the frequency of MDT meetings varies substantially, with less than half of clinics having weekly MDT meetings and a third had either none or sporadic MDT meetings. It may therefore be argued that a significant proportion of clinics may 'tick the managerial box' for MDT, without actualising the true benefit of MDT working, which is consistent with the literature.^{23,24} Considering that MDT meetings have been endorsed by the Department of Health as the core model for managing chronic disease,²⁵ there appears to be a disconnect between endorsement and practice. This is an important issue to highlight given that communication between the different team members is vital for the delivery of optimally coordinated care for chronic pain patients presenting with increasingly

complex conditions. As anticipated and as in keeping with national and international guidelines, the vast majority of clinics found MDT meetings to be useful.

The skill mix employed in the pain services varied substantially, with the greatest deficit being apparent in psychology and physiotherapy, which were absent from 32% and 20.5% of clinics, respectively. This is a significant finding given that the British Pain Society guidelines specify that pain clinics must have a psychologist and a physiotherapist and all PMPs should be led by an appropriately trained psychologist.²² These numbers are almost unchanged in two decades.^{14,18} Specialist physiotherapists identify reasons for lack of progress in rehabilitation, such as fear avoidance of movement or unhelpful patterns of over- and under-activity. Functional exercise programmes are highly effective therapeutic options^{26–29} and it is therefore of crucial importance that pain clinics employ a dedicated specialist pain physiotherapist. Psychologists are integral members of every pain clinic and therefore it should be considered extremely surprising that contrary to recommendations, they are absent from one-third of clinics and that even when PMPs were present, they did not always incorporate a psychologist.

It is perhaps less surprising that psychiatric provision in the survey is low, with 85% having no attached

service despite the fact that it is widely recognised that many pain patients have co-morbid mental health issues. These include depression, anxiety, post-traumatic stress disorder and substance misuse. The lack of psychiatrists within pain clinics almost certainly reflects the scarcity of psychiatric provision and funding nationally,³⁰ rather than being a problem unique to pain clinics. Wallace and Panch³⁰ suggested that increased psychiatric involvement within pain clinics is highly desirable as it would likely lead to enhanced patient care through the utilisation of a more realistic and comprehensive approach.

Non-consultant-led clinics emerged as part of the strategy to meet increasing demands being placed on the health service in the face of reduced working hours for doctors with the advent of the New Deal and the European Working Time Directive.³¹ Extended Scope Physiotherapists (ESPs) emerged to help with the growing demands on hospital orthopaedic services and proved to be a vital resource. Byles and Ling³² reported that a physiotherapist practising independently could treat 40–60% of all orthopaedic outpatient referrals safely. ESPs are regarded as a cost-effective means of reducing hospital outpatient waiting times.³³ Further government policy documents such as 'Meeting the challenge: a strategy for the allied health professions', 'Ten key roles for allied health professionals' and 'Creating a patient-led NHS: delivering the NHS Improvement Plan' all set out the direction for more flexible working and workforce reconfigurations.^{34–36} The extended role was also introduced to other allied health professionals and to nursing. It is therefore unsurprising that a high proportion of clinics have incorporated the extended role, albeit primarily for follow-up patients rather than new referrals, and a significant proportion of consultations were telephone based.

Just over a third of respondents reported having non-consultant-led clinics in which nurses or other healthcare professionals saw new referrals. Of note, 90% of clinics had specialist nurses compared to 51% almost two decades ago.¹⁸ There was overwhelming support for nurse-led follow-up clinics being considered safe and cost-effective by 93% and 91.5% of respondents, respectively. However, opinion was almost equally divided about the safety of nurse-led clinics for review of new patients (47.5% in favour vs 45% against), and perceptions regarding the cost-effectiveness of this type of clinic were also polarised with 58% in favour versus 34% against. Some commented that senior nurse review of new patients was safe, cost-effective and consistent with extended role nursing practice, contrasting with others who felt new patients should always be seen by a consultant. Others commented that certain nurses could see certain types

of less complex new referrals under the umbrella of consultant supervision. These differences in opinion were evident among those who identified themselves as pain consultant and nurse respondents for the survey. However, a specific thematic analysis of the inter-professional differences of opinion is beyond the scope of this article. There is no consensus or established national competencies regarding the details for the specialist pain nurse role, and thus, it remains relatively nebulous. Concerns were raised about medical complexity and the risk of missing sinister or co-morbid pathology. This contributed to the popular perception that new patients should always see a medical consultant, as did a feeling that patients would have more confidence in a doctor. In addition, there has also been work published focusing on the negative impact of diagnostic uncertainty in chronic pain.^{37–39} Specifically, outcomes are typically better if the patients are given a diagnosis and nurses are not considered primarily to be diagnosticians.

With regard to nurse-led follow-up clinics, some suggested that nurses might have more time to spend with patients compared to a consultant and that nurse-led follow-up clinics freed up consultant time for new referrals. Some felt that nurses were more likely to adopt a biopsychosocial approach, which would be beneficial for patients. The comments reflect a wider debate about the nature, safety and cost-effectiveness of extended roles in nursing that occurs across a variety of clinical settings and specialities.⁴⁰ Extended role nursing exists under a variety of job titles, with post-holders having differing types of training, qualification and role remit.⁴¹

A previous unrelated survey found a wide range of job titles, experience and qualifications among chronic pain nurses.⁴² These included 'clinical nurse specialists' (60%), 'pain nurses' (10%) and 'nurse consultant' (4%). The majority had gained most of their experience in acute pain (70%), with only a third having prior experience of chronic health conditions. Most had gained additional training in pain, but there was no standardisation of qualification or competency level. Formal qualifications ranged from short course certificates to Master's degrees, and many had evolved their practice through informal training in the clinical setting mostly from medical colleagues (80%), but also from nursing peers (64%), and psychologists and physiotherapists (48%).⁴² The nurses generally perceived themselves to be adequately trained and safe to perform their roles within their particular clinics, although role variation between the clinics was beyond the scope of this survey, making it difficult to compare practices and required competencies.

Several authors have argued for greater regulation of extended role nursing practice, to enable it to be judged

against agreed competencies.⁴² Government bodies have also called for this,^{43,44} noting that the term 'advanced level practice' is inconsistently applied in nursing, leading to confusion for patients, clinicians and ultimately for nurses themselves with regard to what is expected from these roles. The Royal College of Nursing (RCN) outlines that specialist nurses require only a registered nurse qualification and sufficient experience of clinical practice that may vary across different specialities,⁴⁵ although there is consensus that a master's degree is desirable. Morgan points out that in the United Kingdom, nurses in extended roles are usually experienced in their speciality and then access further training and qualification in that speciality, in contrast to the US model where a broader 'advanced nursing practice' qualification must be obtained in order to practice under the title of 'Clinical Nurse Specialist' or 'Advanced Nurse Practitioner'. It would seem unlikely that nurses already performing extended role practice within more narrowly defined clinical specialities in the United Kingdom would then wish to pursue a broader qualification of this type or indeed find it useful within a narrower specialist remit. In reality, roles and competencies are often developed according to the needs of the service provider, rather than by the nursing profession itself with the primary driving force being simply the provision services at reduced cost.⁴⁶

With regard to pain management nursing, the RCN has more recently produced a guideline document,⁴⁷ endorsed by the British Pain Society to promote consistency in the development and recognition of competency across various levels of the nursing team. It is hoped that this framework will aid provider services in outlining role responsibilities for their particular services and promote transferable skills across different services amid calls for regulation of extended role nursing practice. Its impact is yet to be seen both within the nursing component of pain management services and its relationship to the MDT. This is vital because of the invaluable contribution of the nursing profession to chronic pain clinics as part of an MDT.⁴⁸ However, our survey confirms that there is wide variation in the remit and perception of the extended nursing role in the chronic pain clinic. The wider issues surrounding extended role nursing practice contribute to the concerns raised by our respondents which seem likely to continue unless pain management services and nursing itself can formally agree a required set of competencies for the extended role. At present, there is a lack of consensus about how best to utilise the extended role, and individual localised arrangements vary widely, and as a result, there is almost certainly wide variations in clinical efficacy and cost-effectiveness, as well as potential implications for patient safety.

At present, there is also a lack of consensus regarding the optimal use of interventional procedures such as injection-based therapies. They are considered to be a standard treatment modality for a minority of chronic pain patients in order to facilitate engagement with a balanced biopsychosocial approach.⁴⁹ However, the proportion of patients offered this type of treatment varies between clinics depending on case mix as well as local expertise and viewpoint. Taking this into consideration, it is perhaps reassuring that approximately two-thirds of clinics referred less than half of their patients for injection-based therapy. Arguably, this finding goes some way to refute the contention that pain clinics are focused overtly on injections.

Only 75% of clinics had a PMP, despite national recommendations and the fact that the role of PMPs is well established in the literature due to their efficacy and cost-effectiveness.^{22,27,50,51} In addition, it is worth noting that by their nature, PMPs are not uniform and this is related to individual clinical preferences and experiences as well as the skill mix of health professionals running them.

Weiner and Nordin⁵² reported that the combined PMP approach demonstrated greater overall effectiveness than common pain interventions such as cognitive-behavioural therapy or medication. Two goals of 21st century management of health care are self-management and partnership, thereby asking the patients to take more responsibility for their own health by working together with the providers of health care to produce an outcome. PMPs aim to improve quality of life whilst being a long-term cost-effective therapy.⁵³ It may be unpalatable for many health professionals to contemplate, but financial factors play a significant role in the modern health service, and clinicians who ignore this do so at their peril. It was interesting to find that 10% of clinics were believed to be operating at 'a loss' while almost a quarter of respondents were unaware of their clinic's financial position. Perhaps reassuringly for the longevity of Pain Management as a speciality, the remaining two-thirds of clinics appeared to balance their budgets or run at a surplus.

Conclusion/summary

This survey attempts to take a snapshot of pain management clinics nationally with specific regards to the provision of multidisciplinary working practices as compared to national and international guidelines. The results are open to interpretation. Optimistically much progress has been made within this sphere in comparison to the 1980s; however, this may have stalled to a degree over the last decade or so and it is hard to see this improving given the precarious financial and political position of the NHS in general. One certainty is

that this is an uncertain time for health care and pain management is not exempted from this. It is of significant concern that multidisciplinary working patterns and PMPs have not been adopted universally, despite national guidelines. Of specific relevance to this is the relative lack of physiotherapists and psychologists. Indeed, the best way for pain management in general to cope with present and future challenges must be to make best use of the MDT. Inherent in this is determining how best to use the extended role. Arguably, the extended role would be best utilised in the setting of follow-up clinics that have specific focus such as rehabilitation, the psychosocial approach, medication management or neuromodulation, rather than utilised to see complex unfiltered new referrals. Indeed, this pattern of working allows greater autonomy within the setting of an MDT and could potentially foster greater collaboration and respect between different professions as well as enhancing overall effectiveness. This survey has highlighted key issues and action is now required to tackle these nationally.

Conflict of interest

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