MY PROFESSIONAL PHILOSOPHICAL STATEMENT

"It's our job to tell them that imperfect health is and always has been perfect health and that most of the things that go wrong with their bodies we can't do much about. So maybe we do make diagnoses; big deal. We hardly ever cure."- Samuel Shem(1)

My career and vocation in Medicine were patterned for me by several family members. While eventually achieving the aspirations of others in completing my undergraduate medical training, there was a craving for work that would provide me fulfilment and challenges for growth. The insight from my role in the healthcare system as a patient and carer has led me to understand that the patients are ultimately managers of their health. Patients consult a physician with an expectation from them that may not be fully recognised or realistic. Therefore, I espouse trust, knowledge, regard and loyalty, as I believe this underpins the "healing" (2).

I believe that in practising Medicine, my job is to empower patients to manage their health by bridging my expertise and their strengths/vulnerabilities. To borrow from Hippocrates, "Cure sometimes, treat often, comfort always" (3)is fundament to the practice of any branch of Medicine- much more so than in Pain and Palliative Medicine.

Both pain medicine and palliative medicine share a thread in that it often or explicitly seeks to assist those with no curative means to their illness. I believe that four factors separate these relatively young fields of medicine and characterise practitioners like myself:

1. **Dedication to non-technical skills** – Both in our training and beyond, there is a recognition that our relationship with parents has either a positive or negative effect on a patient's health
2. **Educating our colleagues-** with the opioid crisis converging with the increase in chronic diseases and the aging population with painful conditions, we need to avoid the past mistakes of offering simple solutions to complex problems
3. **Rethinking suffering as a chronic illness-** using the chronic disease model, we expect relapses but teach patients to be their own health care managers
4. **Investment in humanity –** pain is a symptom of not just disease, but something we fear and share a resolve to console in our survivors

Dedication to non-technical skills

During rigorous physician training that scrutinises trainees' technical skills, the lack of devotion to the art of medicine was apparent. As a result, I have received special training and emphasis on communication skills, motivation, observational skills, empathy, application of science, and navigating ethics, among other non-technical skills. I still do courses such as VitalTalk to enable to be a student and facilitator in communication styles.

"The House of God" rang true", The main source of illness in this world is the doctor's own illness: his compulsion to try to cure and his fraudulent belief that he can." Even when trained to recognise its oversimplification, the 'biomedical model' that we often default toward postulates a predictable causal-effect relationship between damage to a body part and pain (see Figure 1). The duality of body (somatic) and mind (psychogenic) mechanisms is simplistic and ignores the role of both in the pathogenesis of chronic pain. With life experience and insights from further education, my approach to consultations in building a history through the power of hermeneutics(4), communicating a formulation (rather than diagnosis) and forming management plans have become an exercise primarily of establishing rapport(5). I use the power of diagrams (such as the one by Prof Nicholas; see figure 2) to relate to my patients the complexity of their pain experience, and where my skills or others are needed to assist.

FIGURE 1 PATH OF BURNING PAIN- DESCARTES SHOWS THE PAIN PROCESS FROM RECEPTORS AT BURNING TISSUE TO THE BRAIN.

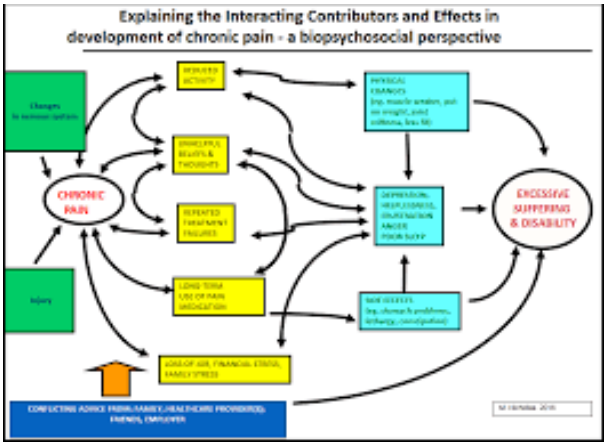

FIGURE 2 TAKEN FROM AGENCY OF CLINICAL INNOVATION. DIAGRAM BY PROF NICHOLAS SHOWING THE COMPLEXITY OF THE PAIN PROBLEM CONCERNING SUFFERING AND DISABILITY.

I believe that an accurate diagnosis through the iterative process of fulfilling criteria and an evidence-based treatment plan is not enough. The patient's insight, understanding, goals and aspirations, and participation in management need just as much attention. While the physical issues contributing to the pain are chiefly important to establish, it is rarely the only thing that should be managed. I thoroughly ensure to rule out serious signs ("red flags") of the pathology of disease, as opposed to injury, while reassuring this process should not be used to dismiss the threat of pain on its effect on function, relationships and identity(6). I avoid the real stigmatisation among patients who often do not believe why their pain experience is worse than others with the same diagnostic label.

With patients' permission, I consider family members and employers critical to be involved in the treatment plan to reduce the impact of isolation and guilt chronic pain sufferers feel from a perceived lack of competence. I assist them in navigating a very fragmented medical system, especially when weighing up multiple approaches

to their pain problem of variable invasiveness. I consciously ensure I am aware of patient advocacy groups and recommend those that provide sound resources.

I excel and strive to improve on ensuring that the *content* I express to patients is straightforward, the *process* of speaking allows engagement and rapport, and my *perceptual* skills utilise emotional intelligence to adjust and align the values of treatment with the patient(2).

Educating our colleagues

The flawed conclusions of the seminal paper by Portenoy and Foley(7) that once justified opioids for any non-cancer pain, and the precarious culture of palliative care in using opioids where pain just means having not found the correct dose of opioid(8), were not immediately apparent in my early training. Once a patient with steroid-dependent chronic emphysema consulted by Palliative Care had multiple rib fractures from steroid-induced osteoporosis that was poorly healing. Despite evidence that it was compromising rather than improving his ventilation, my boss kept increasing the dose. Instead of the opioid allowing him to get a full breath, it made it shallower and less able to clear carbon dioxide. My disagreement with my consultant was the week I looked up the University course in pain management.

I feel a shared responsibility in my profession's legacy of harm from failed chronic opioid therapy, including unintentional deaths, has left an indelible intergenerational aftermath of destruction throughout society.

I also believe the opioid deprescribing program can be just as harmful if not done in a way that promotes dignity, safety, and access to support. This has made me join the SafeScript Access Line as a consultant to assist general practitioners and pharmacists in appropriately responding to patients identified with possible problematic use of opioids. Only when witnessing opioid withdrawal close-up did I realise how traumatising it could be and how understandable it is that it can fracture the trust in the physician-patient relationship. Thus, I have also acquired skills in opioid treatment programs, learned harm minimisation/mitigation, and used trauma-informed motivation interviewing to assist patients.

Many issues can occur or be exposed to chronic pain, and thus it is imperative to assist patients to move from the idea of using single modal treatments that often have their own side effects. I consider the rehabilitation model with a functional restoration program that reconceptualises the problem to achievable targets. Many patients would benefit from psychological strategies, and though this may be focused upon by others in my team, as the physician, I lead and ensure consistency in approach. The treatment effectiveness using standard pain scores is inefficient, and I focus on medication use and other measures of function, mood and quality of life.

Rethinking suffering as a chronic illness

While the Declaration of Montreal that heralded the right for pain management (9) laments the restrictions on the availability of opioids globally, I found it more compelling when it argues that chronic pain to be managed like diabetes- i.e. a chronic disease model(10). I view it also as a public health issue given its severe economic and social costs(11) Like all chronic diseases, the ability to foster active self-management skill acquisition in my patients is a cornerstone to which other recommended/available interventions are added to it for defined treatment outcomes.

I advocate for more robust recognition and better research into feasible ways to address chronic pain, which has meant looking at more treatments that give the patient a sense of control. Work by Finnerup and others that grapple with the different mechanisms involved in neuropathic pain or post-surgical pain, and try to define provide better algorithms show the importance of scrutinising claims by pharmaceutical companies and the wide gaps of our knowledge.

I will never be able to have the skills to Holistic address the complex interplay of biological, psychological, functional, and social factors, and thus, I would only practice in a multidisciplinary manner, using direct contact with other clinicians, case conferencing and joint consultations. Even patients who prefer only medical intervention, it is often important to keep in mind the other factors when considering treatments such as neuromodulation.

The effect of stigma on "chronic pain" patients, whether overt, imperceptible or systematic, is especially acute among interactions with healthcare professionals. The more educated I have become, the more I have realised my own negative biases. The guilty sense of being incompetent as a physician in meeting their expectation of cure is sometimes displaced unjustly on the help-seeking patient. Being invalidated or unheard erodes a person's identity and leads to disability. Thus I use opportunities in symposiums, teaching undergraduates or peers, or writing clinical notes, to avoid pillorying language while still managing to challenge unhelpful beliefs they may hold.

Investment in humanity

In addition to the sequelae of modern cancer treatments, cancer survivors had to learn to cope with chronic symptoms in a very different paradigm that was inculcated during their battle with cancer. One where they should not fear pain or symptoms was not a sign of treatment toxicity requiring dose adjustments or disease progression requiring re-staging(12). The lack of focus on preventing the chronification of symptoms, such as pain post-chest surgery and mastectomies or chemotherapy-induced peripheral neuropathy, is a gap where the literature often has a very short-term view. Having mentors such as Prof Paul Glare and Prof Richard Chye, dual specialists, I see myself rising to the challenge in this population of unmet needs. The fear of pain while dying is the main reason patients desire physician-assisted dying, and I believe that the health system fails when the best it can do is kill its patient.

Following my work among refugees in Liverpool pain clinic and patients from other vulnerable groups, the impact of trauma in pain medicine is so profound. The idea that the patients that I see are those that *survived* the trauma rather than met their demise has revolutionised the way I see these patients' strengths and vulnerabilities. I have been reluctant to explore possible torture among my patients, and now I feel a responsibility to do so, using my multilingual skills and have a better understanding of the healthcare interpreter.

Conclusion:

Pain medicine will eventually change- from within and from without- and thus, considering my future career is like building on shifting sand. During my master's degree in Pain Medicine, the apparent fact is that there is much to discover about pain, stemming from the foundations of Melzack and Wall in 1965(13) that pain competes with other senses to the present time, such as the role of our digestive system with pain (14) and environmental factors that can affect the expression of our genes(15). I expect that changes in the workforce, society, healthcare organisations, and health technology will also influence my future practice. I see my future career to continue to be influenced by my patients, my colleagues, my involvement in academia, my critical appraisal of journal articles, my mentors and by reflective practice. I aspire to tap into the cross areas between the management of pain with a life-limiting condition and those of a less certain prognosis. These are often cancer survivors, those faced with the possibility of having organ transplants, or sufferers of neurodegenerative disease. I hope to be a physician who can adapt and change treatment goals for such patients and be there throughout the journey- for better and worse- but always for healing.

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