



**Opinion**

## Taking painkillers away from those in desperate need is a cruel health policy

*Rajesh Munglani*



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Perhaps it was inevitable that I would develop chronic pain. Both my parents were plagued for the last 20 years of their lives with severely painful knee joints. I was determined not to end up like them. I kept fit, and as a junior doctor conducted research into the molecular neurobiology of pain. But after a walking trip in the Lake District, I noticed an ominous burning sensation in my knees.

I carried on with these walking trips, but the pain continued to flare up. Thankfully, it would disappear overnight. But in my early 50s - while directing the pain clinic at Addenbrooke's hospital in Cambridge, and then at the West Suffolk - this knee pain became steadily worse. I wore spongy trainers all the time, but the pain increased, leading to swollen knees, an inability to deal with stairs, inactivity and eventual weight gain - and yet more pain. Like many, I avoided seeing my GP.

The National Institute for Health and Care Excellence (Nice) released [new guidelines](#) on chronic pain on Wednesday, recommending sufferers of chronic primary pain - pain for which there is no clear explanation, such as arthritis or nerve damage - [take exercise](#) instead of painkillers.

The logic here seems clear. We know that some pain-relieving drugs such as opioids and gabapentinoids don't work that well for chronic pain, but are perversely associated with higher rates of addiction and the chance of overdosing and dying. This risk seems to be highest in those who are anxious or depressed, the same individuals who are least resilient to pain. Instead, for such central pain processes, Nice suggests treatment with antidepressants, talking therapies, exercise and acupuncture.

Yet despite Nice's good intentions, I fear a foreseeable consequence of this new guidance will be the increased suffering of chronic pain patients with the indiscriminate withdrawal of powerful analgesics from many chronic pain patients by NHS commissioners.

Pain is not one thing but a complex phenomenon of many causes and processes. There are those that we can "see" - such as arthritis, soft tissue and nerve damage. We also know that the invisible processes of the mind profoundly determine our pain experience. Yet pain is not a diagnosis, rather a symptom that may represent many different pathologies. I find it difficult to

accept the Nice guidelines, which categorically state, “Do not offer this or that treatment.” None of us as doctors or scientists can say that. Each patient is unique and their pain is unique.

Our bodies are, from an evolutionary perspective, perversely attuned to experience pain: it’s part of our survival mechanism. In particular this applies to acute pain because it prevents further harm, prompting you, say, to remove a finger from a fire. Unfortunately, chronic pain, defined as any pain that lasts more than three months, has a profoundly life-diminishing quality.

In my pain clinic I accept that chronic pain can strike any of us at any time - **85% of us will suffer** a major episode of back pain in our lifetime and chronic pain is almost invariable in older life. So how then do we approach pain? First, there is no judgment: most of us have done nothing to cause us to suffer chronic pain, and certainly none *deserve* to suffer it. Pain is simply part of the human condition.

Unfortunately, all the conventional medical drugs we use for pain can cause side-effects. Opioids such as morphine, as well as causing constipation and cognitive problems, have been shown to cause a long-term decrease in quality of life in those who take the drugs regularly, with onset of cravings and addiction.

But many chronic pain patients rely on such drugs to achieve any quality of life. I know chronic pain is torture, dominating every moment of the day. People like me will at times need powerful drugs, sometimes morphine and gabapentin, to control arthritic joint pain, nerve pain, or more widespread pain and associated anxiety and depression.

In my own case, painkillers have at times proved vital but at others created more problems. Anti-inflammatory drugs such as diclofenac and ibuprofen gave me a sore stomach and chronic diarrhoea, and the consumption of too many opioids such as tramadol and codeine meant I would forget days at a time and became constipated. The pain was intense but I was only 55, too young for knee-replacement surgery.

An orthopaedic surgeon colleague and friend looked at my knees and said my cartilage had “worn away” and firmly blamed my genetics. He performed

**bilateral intra-articular stem cell injections**, taking special cells out of my body and reinjecting them into the joints to try to regenerate the cartilage. He also performed knee arthroscopies, a telescopic surgery to clean up the knee joint and encourage the cartilage to regrow. Unfortunately, they only provided temporary relief. I soon developed ankle pain that left me more disconsolate. I realised, despite my best efforts, that my lot was to suffer painful joints just like so many of the UK adult population.

In the end, after much trial and error, I had to lose a lot of weight to take the pressure off my knees. I now regularly take natural food supplements, such as **curcumin and boswellia**, which act as gentle versions of anti-inflammatories with many fewer side-effects. I occasionally take more powerful painkillers when necessary. I walk and garden but don't run. Through counselling, I learned acceptance: that none of us have the right to good health, but that we should do all we can to promote it.

Patients in pain are not one thing. We doctors need to be compassionate and carefully talk to our patients and assess the various complexities of their pain, as it is unpredictable what will work. We need to remember our shared humanity and suffering with our patients, for it could be any one of us sitting opposite the pain doctor in the clinic room.

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## comments (233)



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