Author's response to reviews

Title: Recognition and use of the bio-psychosocial model of pain management in British pain clinics - results of a qualitative study of staff from a range of disciplines.

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Author's response to reviews: see over
The BioMed Central Editorial Team

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Dear Team

**MS: 2142216222285601**
Recognition and use of the bio-psychosocial model of pain management in British pain clinics - results of a qualitative study of staff from a range of disciplines.
Geoffrey Harding, John Campbell, Suzanne Parsons, Anisur Rahman and Martin Underwood

Please find below our considered responses to the three referees’ reports. We have addressed all the points raised and our responses are annotated below.

**Referee One: William Shaw**
1. Introduction. Comparing the design of chronic pain “centres” in the UK with those in other developed countries is extraordinarily complex as there are variations in configuration and ethos within UK pain clinics alone. Notwithstanding their claim to multidisciplinary approaches there are different emphases on the nature of services offered, depending on the pain clinic teams’ composition. We have no reason to assume this would not be the case in other developed countries.

2. Introduction/Discussion. We are have not included any suitable studies describing the practices and perspectives of rehabilitation professionals as we are not aware of any suitable published qualitative research that would serve as illuminating comparators.

3. Abstract/Conclusion. A more balanced conclusion is now expressed in the abstract.

**Referee Two: Julia Hush**
1. We have amended the footnote to state that pain management units are typically led by clinical psychologists.

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2. We have added the caveat in the conclusion that our findings may not reflect the experiences of pain clinics and professionals in other countries.

3. We have addressed the typographical errors identified.

Referee Three: Michael Nickolas
1. The clinic from which we drew our sample of patients for our previous study was included in the sample of clinics for this study. We have now made this explicit. We agree that comparing patients’ perspectives with perspectives of the pain clinic team would be particularly interesting, but with only one patient/pain clinic team data to compare building a robust analysis would be difficult and was out with the aim of this project.

2. Pain clinics in Britain are led either by physicians with a background in anaesthetics or rheumatology, or a combination of the two. Our sample of clinics was representative of each of these and the paper has been amended to clearly reflect this. No clinic approached declined to participate and is now duly noted.

3. We have now made clearer that the core staff composition of all pain clinics we sampled comprised of at least a physician, physiotherapist, and clinical psychologist. Some also included other health disciplines but often on an occasional basis. Moreover, there was considerable variability in the capacity of pain clinics we sampled – ranging from one session per week to full time clinics. Notwithstanding the often heterogeneous character of British pain clinics our specific concern was with how practitioners managed patients with chronic musculoskeletal pain for whom interventionist treatments such as injections alone were not applicable.

4. We accept the reviewer’s point that our argument that occupational therapists might best be skilled at managing patients social aspects of chronic pain is without substantiation and that such aspects require a specific designated staff member. We have therefore removed all reference to this assertion. We have added further text to clarify our point that practitioners purportedly subscribing to the bio-psychosocial model of pain management couched their approach as predominately a cognitive based one, whilst we have also acknowledged this may not preclude consideration of a social dimension. Equally it does not mean this is necessarily the case.

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5. We are curious at the reviewer’s impression that we hold a particular point of view about the bio-psychosocial model of pain management. The analysis was undertaken and validated by social scientists with no a prior assumptions about the bio-psychosocial model, other than that is would reflect in equal measure considerations of the model’s biological, psychological and social character. That we did not include a heading covering the biological interventions reflected the fact this was not an emergent theme from our analysis of the transcripts. Whilst we agree entirely that “drug management and physical modalities like TENS and exercise” are common features of pain clinic work, our concern was with how pain clinics and pain management programmes manage patients for whom interventions such as these are either inappropriate or have been proven ineffective.