SUMMARY: Interview with Dr. Eric Wilson, one of the most eminent pain interventionists in South Africa and resident of Capetown. The conversation took place during the V Singular Pain Medicine Course, at Singular Pain Center, Campinas-SP, Brazil, on Dr. Wilson's second visit to Brazil as a visiting professor.

Interviewee: Dr. Eric Wilson
Interviewer: Dr. Charles Amaral de Oliveira
Venue: Campinas-SP, Brazil
Date: June, 2015

Main points:

- Challenges in common with South Africa
- Doctors and training in both countries
- Continued education – specialize or not?
- Challenges in pain field in 10 years' time
- Personal experience with chronic pain

INTERVIEW

Dr. Charles Oliveira: Thank you very much for coming again to Brazil. Eric, the first question: what are the challenges that we have in Brazil and in South Africa... the challenges we have in these two countries?

Common ground with South Africa

Dr. Eric Wilson: my impression is...that we have technology and we have treatments that we can use, but often they are... the PRICE of delivery of those is out of reach of the population, so we can do much more than we're able to do but it's constrained by funding primarily.

Second of all, the tech... the kind of technology that we can use like stimulators and pumps, the sophisticated technology require a population that is able to deal with it in their home environment, so it's pointless putting in a first-world technology when somebody goes back to the third-world living environment and they can't maintain or sustain it. And then also that population of patients who would benefit from those technologies don't have the educational understanding of what you're trying to tell them and so it takes much more effort, in a multicultural, multilingual environment, to try and get an even distribution of knowledge to the patients that you're seeing. Not everybody has the same ability, both financially or educationally, to understand what we need, what we CAN do for them, what we need to do for them. So I think that's a very common ground between the two countries.

Dr. Charles Oliveira: How are the medical doctors in these two countries? Are they prepped to give the best to the patients?

Dr. Eric Wilson: I think so. You know, my impression of the [doctors] I've seen in the Singular program just speak with a different language, to the same level of training and personalities and abilities of the ones in South Africa. The advantage we have in Brazil and South Africa is we've got a big population, a large patient load, so your experience as a doctor is way in excess of somebody who's living in Europe who has a small clinic, and there're lots of doctors so you don't get the volume. We see a very big spectrum of pathology which requires you to have the skills, you have to learn skills to deal with that spectrum.

I think I just want to come back to one of the issues we have in common with you which is: Brazil is a huge country. And so people travel very long distances to see you. We look after patients from all over Africa into... up into W Africa and we have the same kind of problem: they have travelled large distances and often they come with expectations that they can get treatment on the day they arrive. Ahm... and one of our challenges is trying to get those patients to be adequately worked up and examined where they live, before they arrive, so that we can deliver effective treatment. It's almost impossible to deal with somebody from... who hasn't been investigated properly, on the day, at the clinic, and so we have the same kind of

problem. They arrive with a suitcase and think that somehow you can deliver a service which is comprehensive and effective in one day which is not...that is not practical.

Continuing education: specialize or not?

Dr. Charles Oliveira: Do you think we need to prepare medical doctors not so specialized in one... in head or in spine, but a medical doctor who could see the patient of pain from head to foot?

Dr. Eric Wilson: We discussed that earlier today I think. You and I. And the dilemma is to have somebody like a pain specialist. They have an integrated knowledge of how the pain pathways work as an integrated condition. I think there is a role for a more selective sampling of problems... the larger problems. So let's take oncology, for example: in the environment I come from, hospices regularly use morphine, non-steroidal anti-inflammatories and paracetamol. That's the total of the experience of pharmacology. There's no experience in interventional treatment, no experience in any other of the modalities, of pain pumps, of stimulators, any others. And so, patients who are in the hospice could be treated better if we taught simple blocks, other pharmacology regimes to those doctors. So that's it at hospice level.

For the MS pains, your clinic is like our clinic. We see a lot of shoulders, hips, knees that could be dealt with at the periphery quite effectively. So I think that there is definitely a role for a view of the common procedures which could be done by any competent, trained doctor at the periphery, and when those are ineffective you refer them to a referral center like our centers.

Dr. Charles Oliveira: What are the challenges for the next ten years in the pain field?

Dr. Eric Wilson: I think our challenges are in the emerging treatments of... As opposed to restorative medicine, you're looking at regenerative medicine, looking at how we fundamentally change the way we treat patients. If we can get regeneration of joint spaces, if we can get regeneration of discs as opposed to replacements, I think that's where some of the exciting changes are going to be. I think improved diagnostics of some of the conditions. So if you look at the change in the understanding of treatment of rheumatoid arthritis, osteochondritis, psoriatic arthritis; with the biological treatment of those, I think we have still to see that level of biochemical treatment of the pathway of pain. It is still very much five or six therapeutic classes of growth, of those we tend to use four or five because we don't quite know which one is going to work the best, instead of much more targeted therapy. So if somebody with rheumatoid arthritis or ankylosing spondylitis now… If you get them onto biologicals early, they don't end up with the joint diseases that we see in the pain clinics 25 years later. So earlier diagnosis, improved diagnosis, earlier treatment or more effective treatments, I think will make a difference to patients.

Then I think, one of the key issues is communication. As you've experienced in your own practice here, social networks have an ability to expand the message that we have, but at the same time, it makes patients seek out care that they don't necessarily need or [in some cases] they should be... seeing their primary doctors first. They've bypassed the primary care chain. Although we do take patients off the street, we don't do it as willingly as we would from another doctor. A patient who comes from another competent professional who has done the essential workup, has excluded the diseases that can be treated not by a pain clinic, makes the delivery of our service far better. We have a problem where patients arrive... undiagnosed ankylosing spondylitis or undiagnosed rheumatoid arthritis. That's not what a pain clinic is for. We're not a diagnostic service. We really are a treatment service, but it's getting those patients diagnosed correctly that will improve their quality of life, improve what we do.

Dr. Charles Oliveira: And last...how do you see ultrasound in the pain clinic?

Dr. Eric Wilson: Ultrasound is no doubt... is far more beneficial for the patient in terms of potential iatrogenic disease from radiation. And I think that it changes your perception. You see a real-time image of real tissue that is living. You see the vascular, neurovascular planes and you're, I think, far more accurate in the placement of instruments, of needles, and of drugs, actually at the place where they really are needed, as opposed to an implied [position], which is what you see on an x-ray. You have an implication of where you are, you don't have a real-time picture of where you are. So I think ultrasound is definitely the future. I think that ultrasound will be improved; I think the signal processing will improve the images that we see -- they are really improving. But I think, with integration, if you have a look at integration of CT and

ultrasound, integration of ultrasound with other modalities of investigation. So thermography with ultrasound would change the picture that we get. At the moment it's still very much an isolated: it's either ultrasound, or thermography, or X-rays, or MRI, so only when we integrate that image will we get a real change in what we do.

Personal experience with chronic pain – lesson learned and how it improved clinical practice

Dr. Charles Oliveira: And a personal question. We know that you had a plexopathy many years ago, that you stopped practising medicine and went to study economy and other things at a very important school, the London Business School, if I remember well. How did this make you a better person and how did it help you better how you treat your patients who feel pain 24 hours a day?

Dr. Eric Wilson: Well I think it certainly opened my eyes to the deficiencies in pain treatment… that the doctors who treated me were surgeons primarily and weren't really interested in the pain, they were interested in the treatment of the underlying pathology, not the result of the pathology. And the understanding of what it is to live every day with pain. I've lived with pain for 30 years of my life and you learn to cope with it. And it makes you realize that there's a component of personality in the way you express pain. If I hadn't had an injury to my shoulder, if I hadn't injured my brachial plexus, I would never have seen and done the things that I've done. So, I wouldn't choose to have the injury again but it certainly has broadened my perspective of life, and you have to look at the positive aspects of it. It's very easy to dwell on the negative aspects and to be a victim.

I think you can choose to find the value in what lessons you've learned or you can choose to be a victim. Our challenges as doctors is getting people to change their perception: instead of being victims...of being part of a process, and learning how to deal with these things better: whether it's end of life, and understanding what's the relationship you have with your family and the perception people have of death and dying, through you, or people around you who have adversity, teaching them capitalize on what they've learnt and to move on with their lives. Many people we see in pain clinics are stuck in a sick role, in a role of pain that doesn't... that they can't get past. And that's the challenge of the psychological component of getting people past that, and living with pain as opposed to trying to live WITHOUT it and never getting any further in their lives.

Dr. Charles Oliveira: Do you agree that oncologists try to take care of the sick, the pathology, and forget to take care of the pain of these patients?

Dr. Eric Wilson: I think to a certain extent that may be true. They have a very challenging job. They deal with very complex pharmacology regimes, with patients who are terrified of their emotional component… of families. I think they have a challenge. I think also, it is fair to say, they have been underwhelmed by the way other doctors manage pain; so, they are reluctant to refer those patients out because they see how poorly other doctors treat pain. Pain clinics are relatively new and few in number. And so if it is the oncologists' view that sending a patient back to the community, the patients' pain treatment really falls away and is not as effective, it's partly our fault as non-oncologists for not showing we can deliver that service. And also partly our fault for not educating the oncologists to know that we are educated. So I think that there're two sides to it. When oncologists trust a pain clinic will deal with the pain adequately, they are willing to refer. For pain clinics that don't offer a service which changes people's lives, then the oncologists are less willing to refer. I think it's a balance: it's finding how a partnership in looking after patients really works. And that is a challenge. It is a big challenge.

Dr. Charles Oliveira: Thank you very much for the interview and do come back to Brazil.

Dr. Eric Wilson: It's always a pleasure and nice to be in Brazil. Wonderful country.

Dr. Charles Oliveira: Hope to see you again next year.

Dr. Eric Wilson: Good, fantastic. Nice to be here.

Dr. Charles Oliveira: THIS year. (laughs) Thank you.

Dr. Eric Wilson: It is...these are big challenges...big challenges. (voice fades)