Pain Management

LEARNING TO LIVE WITH PAIN

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For my son Philip Alexander

A Rockpool book

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Prologue

Renée's Story, Part I

Late winter, 1962, Berkshire, England. It was a freak accident. According to the police report, a soft-top Morris Minor 1000 had jumped a country hedgerow, thrown all the passengers out into a field, rolled three times, leaving deep indentations in the grass, then had come to a stop on top of the body of a young woman.

The wreckage was out of sight. Two hours later a couple in a passing car heard the sound of a baby crying. The woman insisted they search for the baby. What they found about a hundred metres away was a field strewn with three bodies — a woman in her late fifties, a young man in his early twenties, both of whom were unconscious, and a baby in a carrycot crying and hungry but miraculously unhurt — and an overturned car with an arm protruding from beneath it. The woman ran to a nearby house to call an ambulance. The man remained at the scene of the accident clutching the outstretched hand.

The two adults who had been flung into the field regained

consciousness as the first ambulance arrived. The man crouching beside the car kept holding the hand poking out from beneath the wreck. An army colonel, from his knowledge of first aid he knew that the young woman required a doctor and probably an immediate transfusion of intravenous fluids. He stretched beneath the car and measured the weakening pulse of the bloodless arm. The woman was unconscious and barely breathing, but she kept a tight grip on the colonel's hand. He hoped that if he could keep hold of her till the moment she was taken into the operating theatre somehow this link might keep her alive.

The ambulance driver radioed for back-up medical staff and arranged for a crane driver to move the car's weight from the young woman. It was a skilful task: the slightest incorrect movement could cause her death. The team arrived almost an hour later.

The three passengers in the first ambulance were checked out as fit at the hospital. The woman's crushed ribs were strapped, as was the usual practice then. The young man was concussed, stunned and fearful about his wife — picturing her in the field beneath the car. The seven-month-old baby had settled well in the arms of a nurse, who gave him a warmed bottle of milk. He was sleeping soundly by the time the second ambulance arrived with the young woman, identified as his mother.

The headline in the *Oxford Times* of 20 February 1962 read: 'Mother Killed Baby Lives in Freak Accident'.

The newspaper was wrong. I was that young woman.

My pelvis was fractured in nine places and the fractured bones had caused internal organ damage. My liver had burst and, as the surgeon noted, 'it was as if a bomb had exploded' within

my body. My bowel, spleen, bladder and womb were also damaged: repairs were sutured where possible, the liver reconstructed as best could be, the spleen removed, and blood transfusions of twelve litres administered over the following three days. I was unconscious for three and a half weeks. But at one point, I distinctly heard a doctor say, 'This one won't last twenty-four hours.' A voice within me wanted to scream in language I seldom use, 'I'll bloody fight and live, you'll see.' I had a young baby to care for and a husband who loved me.

When I regained consciousness, I spoke only in French (which I knew well, but it was not my first language). The doctors thought I was rambling nonsense until a physiotherapist who came in to assist my breathing said, 'That's not nonsense, it's French. She's asking where she is.'

True, I did believe I was on another planet. Just before the crash, we had been listening to the radio broadcast about John Glenn going into space.

It took eighteen months to get out of the Radcliffe Infirmary. My first operation had taken over nine hours. I had been lucky. I was alive. But all agreed that I would never walk again. I was twenty-one, and this was very hard to cope with. Terrified that my baby might be taken from me forever — he was with my husband's parents during my hospital stay — I was determined to prove everyone wrong. When I left hospital I was still in a wheelchair, yet more certain than ever to disprove what I regarded as their 'curse'.

At times like this it seems we either fight harder — if there is something we can fight for — or we give in. One of the reasons

I am writing this book is to demonstrate there is always something worth fighting for.

Probably most of us have an opportunity in our lifetime to learn something very important and, if we don't take that lesson, we keep receiving it again, until finally we get the point. I learned to fight to live, to recover, to keep going — come what may. The period in hospital was one in which I became virtually institutionalised mentally yet my brain kept working out what I would do when I came out. I never doubted that I would be discharged, and I planned ahead. Music was my secret weapon against loneliness and against people saying cruel or negative things about my lack of progress.

It had taken ten months for me to lift my right foot one inch above the bed sheet. The physiotherapists had given up on me. No rehabilitation program was considered worthwhile. I would spend my life in a wheelchair. Why waste time on me?

In the forty-bed geriatric ward — the lot of long-term patients — we had a four-hourly bedpan round, and bad luck if you wet the bed (or worse) in the meantime. Many of us did, and it was time-consuming for the nurses but humiliating for us.

Because I was regarded as a waste of time, in that the staff were busy and others were easier to rehabilitate, I had all the more reason to do something for myself. In a way this was better, because self-motivation is often more powerful than being forced to do things in some pre-planned program. It made me proud of what I was going to achieve. I was going to bring up my baby, make my husband happy, learn to walk and make a contribution to society in some way.

I had the same idea about returning home. Keep on fighting, I told myself. Little did I know how hard that would be. Due to hospital regulations my baby had not been allowed to visit at all. Being separated from my adored boy until he was nearly two was unbearable, but his beautiful picture by my bedside urged me on. I wanted so much to hold him in my arms, to walk with him. No one else believed in me, only I did.

How lucky I was to have someone, something, to live for, and that aim — getting well for my husband and baby — was my mantra. I was not going to be a kind of doomed Madame Butterfly, committing suicide (not trying to walk) or giving up my baby. The parallel with the operatic story that I knew so well was to become a part of my life which I never could have foreseen.

On my first night home my husband announced he was in love with another woman and that she was pregnant by him, the baby due in three months' time. Horrified and stunned, I told him to leave right away, not to hang around out of pity. Yes, he could see our baby whenever he wanted to. He went. He had put Philip in his cot and waited for him to go to sleep before getting up his courage to give me the news he had withheld on his daily visits, visits lasting only thirty minutes, as permitted under the hospital regulations of the time.

Using the wheelchair carefully as a frame, I leaned into the cot, over my sleeping baby, embraced him and fell asleep thus, weeping. (That scene from *Madame Butterfly* flew into my mind:

at least, unlike Cio-Cio-San, I was keeping my baby and my husband's new love was not going to take him away from me.) Later, when I awoke, I put myself to bed, crawling to the bathroom, too exhausted by grief to make decisions about how I was to cope. I had no support network, no relatives I could call on. It was a 'challenging' time.

Pain was an immense and constant presence. When I was in hospital, how much I had hung out for yet another injection of what sounded like 'pethilorphan', which was administered four-hourly, as an addition to the morphine drip in my arm. Relief lasted a mere ninety minutes then my countdown in and out of hell would begin. (Nowadays, patients are given a self-controlled device in a drip, which gives them a dose of morphine when they need it. The dose is small and more constant so the awful see-saw of pain control I experienced is not such an issue.)

After the first six weeks, the pain lessened slightly and I was given only aspirin, a sudden withdrawal eased only by barbiturates for sleep. The doctors feared I might get addicted to stronger opiates (see pages 197–203). Desperately in pain, there was little relief other than the barbiturates, so I was dosed heavily and slept away much of the day. When I was discharged, I was given a bottle of barbiturates. I poured them down the toilet immediately after my husband left. They were no use to me. I had a baby who might wake and need my assistance. I had to learn independence and that was all that mattered.

Fortunately, and I have always found good fortune and inspiring people around me, neighbours rallied and new friends appeared. After six months I had learned to use Philip's pram as a

walking frame and extended my walking from around our flat in Abingdon to the outside — to the washing line, to the corner shop, and eventually to the village one whole English mile away.

My pain was controlled with paracetamol alone. Many tears were shed. But somehow, with beautiful young Philip beside me, crawling at first and then helping me learn to walk — playing opposite roles, with him as leader — I made it. My exercises were those I remembered from ballet lessons as an under-five. Who could ever have thought the importance of those lessons at the time? Gradually, I did my own program of physiotherapy.

Friends strengthened my resolve towards independence. I gained a scholarship to a teacher training college in nearby Oxford. A car was necessary because, although I had given the wheelchair back to the hospital as soon as I could, I still limped and could not walk far. I purchased the car on the never-never, as we called it then, and undertook my three years of professional training.

Through all this, the staff of the clinic and of the hospital where I had worked as a research assistant before the accident kept in touch, visited, helped and encouraged me. Now that I had to support my son, they gave me work in the academic vacations so I could earn extra money, because my scholarship, a mere ten pounds per week, was barely adequate. How lucky I was having work and a professional life to fall back on, not just for financial aid but as a social network — this was a way of dealing with pain by distraction. Hospital staff looked after Philip while I worked as a research assistant again after I qualified as a teacher, and then, six years after the accident, I was accepted as a migrant back to

Australia, a country I loved and where I had spent most of my pre-teenage years.

All this led me to Sydney and the field of teaching children with physical and emotional difficulties. For many years I worked with children suffering from varying degrees of disability. Then, after further years working in opera, coaching singers in foreign languages, and for television, it seemed only natural to go back to teaching, albeit in a part-time capacity.

Living with chronic pain is a great teacher, and I hope I have gained an understanding of the suffering of others. It's been forty-five tough years for me, with many setbacks, the kind that all people in chronic pain probably encounter.

There have been fifteen further attempts to correct my spinal and pelvic injuries. In 1992 I had a setback that made me accept a wheelchair once more. But I am one of the lucky ones. The doctors' prognosis was wrong. I can walk, at least a little. To someone who is unable to walk one step, walking 100 metres is like climbing Everest. So to all of you I say: have courage and confidence in yourself. To the French novelist Honoré de Balzac (1799–1850), it was important that one 'should write not of himself but about the pain of others, not that which one sees in the mirror.' My pain is your pain, we understand one another.

I offer this book as a grain of sand in your ocean of discovery and I hope it will be of some help to some of you some of the time.

1

Pain Explained

What does 'pain' mean? You can speak of emotional and psychological pain, or think of any type of suffering as a kind of pain, but I want to start with the plain and simple one, physical pain. 'It hurts, stupid!', as a sensible child told me. Of course, physical pain involves emotional and psychological suffering as well, and I have much to say about this too.

It helps to have some idea how physical pain is caused. There are two good reasons for looking at the 'how it works' of pain. One is so that you can better understand the language your doctor and other health professionals use when they are talking about pain — because they may have a very different understanding from you, based on their technical training. Good, free and fearless communication is very important in being able to cope with pain, and it certainly helps if you and your doctor/therapist are not talking at cross purposes.

And knowing how pain 'works' makes it easier to understand how treatments work. This may help you to have realistic

expectations and to use treatments effectively. Also it might make it easier for you to make informed choices about the treatments offered to you, including some less 'mainstream' treatments, which may not always offer good value for money or time.

Types of pain

Pain can be classified in various ways. It is like cutting up a cake in different ways: slices, wedges or chunks. Each way of dividing it is interesting and useful in its way, but it remains the same cake.

One such division is pricking, burning or aching pain. Each of us will recognise these from our own experiences. Different types of nerve fibres seem to be responsible for carrying the message of these different qualities of pain, and these qualities may help a doctor make a diagnosis about what kind of problem is going on.

Another way of dividing pain is into 'acute' and 'chronic'. Again, it is helpful to know what doctors and other health professionals mean when they use these words. A lot of us use 'acute' to mean *really* bad and chronic to mean really *bad*. But health professionals mean something quite specific when they use these words. Acute pain is of short duration — like the pain of a heart attack or appendicitis, a kidney stone or an attack of gout. Chronic pain is of longer, more continuous duration — like the pain of osteoarthritis.

Another important factor is the severity of pain. Nowadays it is common to use a simple scale to describe levels of pain. It generally goes from one to ten, with one being the least severe

and ten the most unbearable. A doctor might ask, 'How bad is your pain on a scale of one to ten, when one is quite bearable and ten is really extremely bad?' This is not very scientific, but it is surprisingly useful, especially for measuring changes in your pain level. It is less useful for comparing different people's pain, of course, since everyone is different.

Why do we have pain?

A biologist will answer this question pretty simply: pain is protective. It gives a warning of harm and tells the organism to beat a hasty retreat.

Let's imagine that a creature comes into contact with a very hot saucepan or something nastily sharp like a cat's claw. What happens is that the ends of certain nerves of the body, called pain fibres, detect the tissue damage and send a message back to the nerve centre of the body. Even in primitive creatures with no brains, this is instantly linked up with a signal to certain muscles to 'Get the hell out of there!' This is called a 'withdrawal reflex' and is what you experience when you accidentally touch something like the hot saucepan — your muscles have acted well, possibly before you have become aware of the pain, and certainly before you have time to think about it.

The withdrawal reflex is important because if the pain continues in a low-grade fashion it causes muscle spasm, which is itself painful and can make your pain a lot worse. The withdrawal reflex is important in understanding some sorts of pain and some things you can do about it.

Creatures with no brains have these sorts of reflexes. But can we say they experience pain if they never become aware of it? Most of us don't think twice about boiling up shellfish. But what about fish, which do have brains? Most people are happy enough to accept that catching a fish is OK, arguing that, although its body might be experiencing pain, the fish has no consciousness — something that others might dispute. However, most people would agree that sheep, rabbits, dogs, horses and other mammals do experience pain and accept that it is our responsibility to minimise that pain.

As for humans, we not only have awareness of pain but we think about our pain too. If that means our suffering is greater than that of the fish, it also means we can influence our pain with the ways we think and act.

Pain and the human nervous system

Obviously our nervous system is more complex than that of a mollusc's. It is not necessary to understand all its complexities, but a few concepts help.

Pain fibres from all parts of the body connect to the spinal cord, which is a thick bundle of nerve fibres (rather like telephone cables) known as the central nervous system. Don't get confused here. The spinal *cord* runs in a canal protected by the bones of the spine: the spine and spinal cord are not the same thing.

Pain fibres are nerve fibres and they have a direct connection with other nerve fibres running back to the muscles. When you experience pain, the circuit of nerve fibres connected to the

muscles in the part of the body where the pain came from produces the withdrawal reflex.

In the spinal cord, there are also connections with other types of nerve fibres: with 'touch' fibres, for instance, which tell you when something is touching or pressing on you, and with fibres that indicate the position of your joints or the length of your muscles.

Interestingly, if enough 'noise' is coming from these other sources, it can reduce the signals relayed from the pain fibres up the spinal cord. This is known as 'gating'. Think of a porter at the gate (or someone at the window) who closes it when there is a lot of noise outside, and you are getting close to the idea of gating. Gating is a useful model for understanding several of the treatments for chronic pain; for example, it may explain the benefits of TENS machines, acupuncture, 'deep heat' and even rubbing your arm when you hit your funny bone.

The spinal cord has to coordinate a whole lot of different messages — after all, it is not much use your arm muscles withdrawing from a hot saucepan if your hand muscles are doing the opposite. Pain from one part of the body also has effects on other parts of the body, with messages going up and down the spinal cord via 'relay' nerves. Don't be surprised when pain in one part of your body has effects on other parts, especially in adjacent parts: every osteopath knows that a problem in the neck can cause a pain in the jaw (although your doctor may be less likely to accept the idea).

At the very top of the spinal cord sits the brain, which has 'primitive' parts (like a fish brain has) and also the clever bits that

make us aware and give us the ability to think. Pain fibres have two important relay connections in the more primitive parts, and these are important in the 'fight or flight' response of the body: if something causes you pain, your body is programmed to fight it or run.

One important connection is in that part of the brain that regulates how awake or 'aroused' we are. This makes sense because getting away from a painful burn or cat scratch is a lot harder if you are still asleep. But there is a downside. If you are constantly aroused by chronic pain, causing sleep disturbance (insomnia), this can make your pain worse. It's important to be aware that this arousal may be going on at the subconscious level of the brain, especially when you have chronic pain.

Another primitive part of the brain coordinates the function of our internal organs. Responding to a painful cat scratch is easier if your heart is pumping thirteen to the dozen, your breathing is fast and if certain interesting things happen to your intestines. But this bodily experience of anxiety can make the pain worse, especially when it increases muscle tension in the body. Pain causes anxiety symptoms, and these can worsen pain. Such anxiety is not about being neurotic, it's physical. It is part and parcel of the experience of pain, and it is important for doctors and patients alike to recognise and accept it.

Finally, in the 'higher' parts of the brain, there are relay connections of pain fibres which give us our awareness of pain, help us to interpret it, decide on action and integrate the pain with our emotional responses.

The pain threshold

You might hear talk about the pain 'threshold', which is the point at which a person experiences pain — for example, how sharp a knife has to be before it causes you to feel pain. At first, you might think this is very different from one person to another — after all, some people and some cultures, such as the unflinching Native Americans, are known to be especially stoic about pain. In fact, pain thresholds don't vary all that much between different people, and they certainly don't vary systematically between cultures, yet the way people experience pain obviously does vary a great deal. The power of the brain to alter our experience of pain is shown by the way some people can endure pain in special circumstances, such as walking on hot coals.

Our experience of pain is influenced by our emotions, by our expectations and fears, and especially by what we have learned in our previous experiences of pain. So if your doctor talks about these things, don't be offended by the idea that it is all in your head, because in fact all pains are experienced through the mind.

The good news is that this gives us another avenue of modifying or controlling our pain.

Causes of pain

What sorts of things can set pain fibres firing off messages to the nerve centres of the body? The typical situation is when some thing or other irritates the nerve endings. This is usually a chemical released by injury, whether the injury be a burn, physical trauma or some kind of disease. Doctors generally use the word

'trauma' to mean a physical injury, whereas most of us think of trauma as anything particularly shocking — another example of how language can lead to misunderstandings.

Inflammation

When doctors talk about 'inflammation', patients may have only a vague idea of what they mean. Many types of pain happen through a process of inflammation. Inflammation is the body's response to any of a number of damaging 'insults', whether it be a poison (such as alcohol), an injury (like a sprained ankle) or a virus in the stomach.

Most of us know what sunburn feels and looks like. We know the skin gets red and hot and may get visibly swollen, especially if there are blisters. And it hurts.

Here are the four signs of inflammation: redness, swelling, heat and pain. '*Rubor, tumor, calor, dolor*' goes the chant in Latin (nowadays your doctor will not speak Latin to impress you and to keep you in the dark, like doctors used to do).

The body reacts to an injury with a rush of blood to the area (causing redness and heat) and the release of lots of fluids. The fluids, which cause swelling, contain white blood cells and all sorts of enzymes to fight off any foreign bodies and to promote healing. Healing often involves producing some 'scar tissue', which is a kind of generic all-purpose tissue — think of it as being like Polyfilla used for repairing cracks in buildings.

Now we come to the most important point of this section. Those enzymes and chemicals in the inflammatory fluid powerfully stimulate pain fibres, causing *acute* pain. If this process

persists it will cause *chronic* pain. Even old scar tissue can cause chronic pain if it presses on nerves or upsets the orderly function of muscles, joints and ligaments.

To make it easier to understand your doctor, it is good to know that any word with '-itis' on the end just means inflammation of that particular part of the body. Hepatitis is inflammation of the liver, sinusitis is inflammation of the sinus, gastroenteritis is inflammation of the stomach and intestines, dermatitis is inflammation of the skin, arthritis is inflammation of the joints. There are dozens of such examples.

Two important causes of inflammation are infections and autoimmune diseases, but other things, such as poisons, can also cause inflammation. Alcohol is a well-known poison which can cause hepatitis if taken in excess.

Although inflammation is a protective process, it may give us pain signals that we don't really want or need. There is a whole series of 'anti-inflammatory' medicines that are used to reduce pain and other symptoms of inflammation, ranging from aspirin through to the recently controversial Vioxx.

Infection and inflammation

The most common cause of inflammation is infection, whether it be the 'flu, food poisoning, a tooth abscess or a urinary tract infection. But not all inflammation is caused by an infection. For example, although arthritis can be caused by an infection (so-called 'septic arthritis'), it is more often the result of wear and tear ('osteoarthritis') or of autoimmune disease ('rheumatoid arthritis').

Autoimmune disease

A substantial number of people, including children, with chronic pain have some sort of autoimmune disease. 'Autoimmune' means that, instead of attacking foreign bodies like bacteria, the immune system gets muddled and attacks some part of the body itself. Rheumatoid arthritis is perhaps the best known case. When the immune system acts this way, it causes inflammation and may eventually cause scarring. Both of these can cause pain.

For autoimmune disease, medicines such as cortisone used particularly in joint injections or orally may be needed to damp down the unhelpful immune activity.

Oxygen, muscle spasm and pain

There are two other special related cases when chemicals in the body can make pain fibres go haywire, and both happen when a part of the body is starved of oxygen. All parts of the body need oxygen, carried by the blood, to keep functioning. The muscles of the body, especially, do not take kindly to being deprived of oxygen. In fact, when there is not enough oxygen, muscles begin to hurt like hell. This is probably because they switch over to an emergency energy supply that produces lactic acid, a chemical that fires off pain fibres.

There is a well-known dramatic example of this. The 'mother of all muscles' is the heart. When the heart runs short of oxygen, usually because of coronary artery disease, it causes the pain known as 'angina' and, if this persists, the pain of an actual heart attack. Doctors call this 'ischaemic' pain, which means pain from lack of blood supply. Angina is a type of acute ischaemic pain, but

it is usually recurrent — that is, it tends to occur again and again (but not continuously, so is not chronic pain).

Other muscles of the body can suffer from lack of oxygen. For instance, a muscle cramp occurs when a muscle that runs out of oxygen goes into spasm, produces lactic acid and causes acute pain. Runners and swimmers know the risk of cramps all too well, and they know not to exercise after eating because this is a time when the body moves its oxygen-rich blood supply to the intestines to help absorb food.

We can begin to put these ideas together. Imagine a chronic pain that causes a chronic withdrawal reflex in muscles — the muscles are in low-grade spasm — and the result is a spreading and worsening of the original pain.

For the person with chronic pain, from whatever source, this is a danger to be reckoned with. Have a look at a picture of the muscles of the human body and see just how many muscles there are, both great and small. Any single one of them can cause severe pain if it goes into spasm, and also more subtle pain and insidious pain that might even defy your doctor's diagnostic powers.

Muscle spasm is a protective reflex that may give us unhelpful pain. Many treatments, including medicines like diazepam (Valium), are used to reduce pain caused by muscle spasm.

Neuropathic pain

Neuropathic pain is another term doctors use. This type of pain does not start at the nerve ending that is detecting tissue damage, but in the nerve fibres that send messages to the spinal cord, up

the spinal cord and to various parts of the brain. When there is neuropathic pain, these nerve fibres are firing out of control. Think of it this way: the message is not coming from the telephone receiver, but from a malfunction somewhere in the telephone cables or telephone exchange.

This pain can happen in several different ways. One is when something presses on a nerve, as often happens in people who have problems of the spine: nerves are particularly vulnerable to pressure where they pass through narrow windows in the spine to enter and leave the spinal cord.

Another case is when the nerve is injured by a poison or disease: alcoholics and untreated diabetics can get nerve damage causing chronic neuropathic pain. Viruses can also injure nerves and cause neuropathic pain, like 'trigeminal neuralgia' (which is a neuropathic pain in the trigeminal nerve, in the face).

One of the most telling examples is 'phantom pain', when a person feels pain in a limb that has been amputated: clearly the nerves which used to represent that part of the body are sending wrong, and unhelpful, messages.

Neuropathic pain often does not respond well to the usual types of painkillers. It can be treated with medicines that damp down the firing of the nerves and are more commonly used to treat depression and epilepsy.

Referred pain

This just means that a pain is experienced not where you might expect it to be. Most of us, knowing the heart is usually on the

left side of the chest, would expect this to be where heart pain is felt, but actually there is a medical rule of thumb that pain over the heart is often not coming from the heart.

There is no need for us to go into the reasons for this — it is up to doctors to make accurate diagnoses. The important thing for us as patients is to remember that the source of a pain may not always be what we think it is. Common examples are when people have a pain under the right ribs, which they think is from their liver because that is where the liver is; and when people have a pain in the flanks which they are convinced is coming from their kidneys. In these cases the pain is very often coming from the muscles and ligaments of the spine.

2

Dealing with Health Professionals

The choice of a good doctor can mean the difference between you dreading and delaying each visit and a relaxed relationship conducive to your health. In Australia and New Zealand we are fortunate to have a choice of doctors, unless we live in an isolated country area — in which case we are lucky to have a doctor at all. In the metropolitan area of most cities there are sufficient doctors for the population, although it may happen that the best or most popular ones are heavily booked.

You should play your role in establishing this important relationship just as much as the doctor must. Let's imagine the situation when you are sick and are visiting a new doctor for the first time. If your condition is a complex one, it would be wise to book a long consultation, both to be practical and as a courtesy to the doctor and other patients in the waiting room. It is helpful to write down the reasons for your visit before you go, and make a copy of your notes for yourself as well as one for the doctor. When we are unwell we do not always think clearly, so it is a good idea

to have notes to refer to, particularly if you are nervous or find it difficult to explain your past medical history.

It works well to have a list noting symptoms such as:

- severe headache
- nausea
- difficulty sleeping
- pains in the abdomen.

Keep the list to a manageable size, with five points at most. Believe it or not, at one surgery I saw a notice stating: 'Due to pressure of the doctor's time, patients are urged to complain of only one symptom per visit.' Imagine a dangerously sick asthmatic who has broken his foot in a bike accident and is frightened to mention both ailments. I am happy to say the notice was not there long.

Doctors and nurses distinguish between 'symptoms' and 'signs'. It helps to know the difference so you can understand them. *Symptoms* are things a person complains of: for example, a pain or a cough, nausea or vomiting, dizziness or numbness. *Signs* are things the doctor finds when she examines you, like an irregular pulse, an enlarged liver, a high temperature.

Some things can be both a symptom and a sign. A person may complain of jaundice (yellow eyes and skin), for instance, and the doctor may observe it. But some things — including pain — are only ever symptoms and the doctor cannot see them (although a patient writhing about is a clear sign of pain). Pain is a symptom, but tenderness when the doctor presses your belly is a sign; likewise, an itch is a symptom, but scratch marks are signs.

It is useful to make a succinct summary of your complete medical history in chronological point form. This can save a doctor lots of time and leave time for talking about the important things. I always take one if I see a new doctor, and I produced one for my child years ago. Now he is grown up, it is a useful reference for him when he goes overseas. Include in it a list of any medications to which you are allergic or intolerant (and the type of reactions you experienced).

Below is an example of the sort of medical history that will be helpful to your doctor.

Medical history: Jennifer Dickson (b. 13/09/1939)

1945 Tonsillectomy
1952 Sinus operation to correct blockage
1956 Appendectomy
1973 Viral encephalitis
1983 Viral pericarditis [a viral infection of the pericardium, the membrane covering the outside of the heart]
1989 Cervical laminectomy
2004 Total left hip replacement

Allergies and drug sensitivities: Penicillin (swollen face), Maxolon & Stemetil (lockjaw).

Current medication: MSContin 40 mgs daily; diazepam 5–10 mgs at night; paracetamol as required.