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Barriers to self-management of chronic pain in primary care:

a qualitative focus group study

Abstract

Background

Supported self-management is a recommended intervention for chronic pain. Effective self-management should enable an individual to reduce the impact of pain on their everyday life. Clinical guidelines suggest primary care services have a role to play in supporting self-management of chronic pain.

Aim

To examine the opinions of primary care healthcare professionals (HCPs) and people with chronic pain and their carers, in order to identify possible barriers to the facilitation and adoption of self-management.

Design and setting

A qualitative study using focus groups in locations throughout Scotland.

Method

Eighteen focus groups were held with patients and HCPs. Fifty-four patients, nine carers, and 38 HCPs attended the groups.

Results

Four categories of barriers were found. 1) Patient-HCP consultation: some patients felt a discussion about self-management came too late or not at all. Communication and building positive relations were sometimes challenging. 2) Patient experience: the emotional impact of pain was difficult and patients often felt unsupported by HCPs. 3) Limited treatment options: some participants felt there was a tendency for overmedicalisation. 4) Organisational constraints: short appointment times, long waiting lists, and a compartmentalised NHS created challenges.

Conclusion

This study illustrates some of the barriers faced by HCPs and patients in the facilitation and adoption of self-management of chronic pain. If self-management is to be an important approach to chronic pain, primary care services need to be designed to address the barriers identified.

Keywords

chronic pain; long-term conditions; primary care; qualitative research; self-management.

INTRODUCTION

The measured prevalence of chronic pain varies according to how it is defined and identified. Scottish studies have found chronic pain, including mild pain, to affect 46% of the adult population,¹ and severe chronic pain, resulting in high disability and severe limitation, to affect 5.6%.² An estimated 4.6 million GP appointments a year in the UK are for chronic pain, costing £69 million.³ A 1998 study found chronic back pain alone cost the UK £1.6 billion in direct healthcare costs and £10.7 billion in total that year.⁴ More recent health economic data are not available. Chronic pain can have a major impact on patients' quality of life, employment status, daily activities, relationships, mood, sleep, and all aspects of general health.⁵ Living with chronic pain can present daily challenges and those affected often have to learn how to manage their pain to allow them to continue with life as normally as possible, while accepting that there may never be a cure.⁶

The Scottish Intercollegiate Guidelines Network guidance includes self-management as one of five interventions in the treatment and management of chronic pain, recommended from the early stages of a pain condition.⁷ A variety of definitions of self-management exist in the literature. Similar to Boyers and colleagues,⁸ the current study adopted the definition '... a single approach or combination of approaches that can be

initially taught by any health professional or learned by an individual to enable them to minimise the impact their chronic pain can have on everyday life'.

This definition encompasses the broad range of ongoing, daily efforts that people in pain can make to improve their health and wellbeing. By adopting this definition this study differs from the growing body of literature that assesses the effectiveness of specific self-management education programmes (for example, that of Kroon and colleagues).⁹

Improved life expectancy and an ageing population will see more people developing long-term conditions,¹⁰ but the healthcare system is traditionally better aligned to treating acute disease.¹¹ Although supported self-management is integral to meeting the challenge of long-term conditions,¹² many people find optimal self-management difficult to achieve.¹³ People with chronic pain may need help from primary care services in supporting their self-management,¹⁴ and this help can come from a number of different professions.^{15–17} However, previous research has suggested that supporting self-management of chronic conditions is challenging.¹⁸ This study investigates the barriers to primary care supporting the effective self-management of people with chronic pain.

METHOD

The study used focus groups, which have

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How this fits in

Self-management of chronic pain can improve patients' quality of life and reduce the impact of long-term conditions on NHS services. Self-management is a recommended intervention for chronic pain, a long-term condition that is estimated to account for 4.6 million GP appointments a year in the UK. This study builds on the limited previous research into barriers to self-management of chronic pain. These challenges need to be addressed to achieve effective self-management support of pain in a UK primary care context.

become an important part of data gathering in primary care,¹⁹ to elicit a large amount of rich data from different perspectives.²⁰ Eighteen focus groups were held with two populations: primary care healthcare professionals (HCPs), and people with chronic pain and their carers. For ease, the second population will be referred to as 'patients', although they were not recruited through the NHS and were not necessarily receiving active treatment from the NHS at the time of the study.

The study used a convenience sampling approach, a common method of recruiting for focus groups,²¹ ensuring participants live in circumstances relevant to the phenomenon being studied.²² HCPs were recruited through NHS contacts who further disseminated the project details among colleagues. Patients were targeted in a

similar manner through contacts at third-sector organisations providing services for people in chronic pain. Project details were also e-mailed or posted to members of the charity leading the research and posted on social media. Additional information was sent to anyone who contacted the researcher expressing an interest in participating. This information sheet stated criteria for participation: either 'you are a healthcare professional working in a primary care setting with experience of treating people with chronic pain conditions' or 'you are either a person living with a chronic pain condition or you are a carer for someone with a chronic pain condition'. No further definition of 'chronic pain condition' was given, leaving it open to individual interpretation. Signed consent forms stated an understanding of the information sheet and it was assumed therefore that participants who subsequently agreed to participate were eligible. Nobody elected not to participate in a group.

Focus groups were held between March and September 2014, scheduled at times and locations to maximise attendance. Separate groups were held for HCPs and patients. Fifty-four patients, nine carers, and 38 HCPs attended the groups (Tables 1 and 2). Focus groups lasted no longer than 2 hours and were facilitated by the lead researcher. HCPs were paid a professional attendance fee and patients' travel expenses were reimbursed. All groups were audiorecorded with permission of the participants. Questions were designed to be open-ended and semi-structured, allowing the flexibility to explore

Table 1. Characteristics of healthcare professional study population

Focus group location	Number of participants	Occupation					Sex	
		GP	Physiotherapist	Practice nurse	OT ^a	Community pharmacist	Female	Male
Edinburgh	7	1	6	—	—	—	5	2
Edinburgh	8	1	7	—	—	—	6	2
Glasgow	4	4	—	—	—	—	3	1
Dundee	5	4	1	—	—	—	1	4
Dunfermline	4	2	1	—	—	1	1	3
Glasgow	2	—	—	2	—	—	2	—
Annan	2	2	—	—	—	—	1	1
Inverness	2	2	—	—	—	—	—	2
Glasgow	1	—	—	—	1	—	1	—
Dunfermline	1	—	—	—	1	—	1	—
Edinburgh	2	—	—	—	2	—	2	—
Total	38	16	15	2	4	1	23	15

^aTwo of the occupational therapists worked in secondary care as opposed to primary care but due to difficulties in recruiting this profession group they were invited to attend.
OT = occupational therapist.

Table 2. Characteristics of patient study population

Focus group location	Number of participants	Patients	Carers	Sex	
				Female	Male
Edinburgh ^a	10	6	4	7	3
Edinburgh	3	2	1	2	1
Glasgow	6	6	0	6	0
Rosyth ^b	21	17	4	12	9
Rothesay	7	7	0	6	1
Paisley	8	8	0	6	2
Falkirk ^c	8	8	0	4	4
Total	63	54	9	43	20

^aRan as the pilot group. ^bThis group ran as part of an ongoing monthly support group. Numbers attending were higher than expected based on previous months and outwith the control of the researcher on the day. ^cRan as a sense check of themes emerging to date.

themes as they arose. Questions were initially drafted by the researcher based on the project aims and existing literature, and were subsequently discussed with the wider research team, which included specialist HCPs, academics, and a patient with chronic pain. The summarised focus group protocol is shown in Box 1.

Focus groups ceased when data saturation (the point in data collection when no new or relevant information emerges²³) was reached. The population was reviewed at a mid-point in the study and purposive sampling was used to fill the gaps (occupational therapists, practice nurses, and rural HCPs). These subsequent groups were smaller, with one or two participants, and therefore were facilitated as semi-structured interviews using the same

Box 1. Focus group protocol

1. Introduction to the researcher and the project.
2. Discuss information sheet and get signed consent.
3. Provide project definitions of self-management and primary care.
4. Question guide: healthcare professionals (HCPs)
 - What does self-management mean to you?
 - What do you see your role being in providing self-management support?
 - Can we talk about your experiences of discussing self-management with patients?
 - What helps you to discuss self-management with your patients?
 - Do you face any issues when supporting people to self-manage?
 - Looking back, has there been anything relevant we have missed in our discussions?
4. Question guide: patients
 - What does self-management mean to you?
 - What helps you to manage your pain?
 - Can we talk about your experiences of receiving self-management support from HCPs?
 - Looking back, is there anything you wish your HCPs had done differently?
 - Are there any changes that could be made to primary care that would help provide self-management support?
 - Looking back, has there been anything relevant we have missed in our discussions?

questions as the focus group protocol.

Data analysis

Focus groups were transcribed and analysed by two members of the research team using NVivo (version 10). Data were analysed using thematic analysis: a method that identifies, analyses, and reports patterns, allowing a rich, detailed, and complex account of the data.²⁴ The steps followed in the data analysis and checking process are detailed in Box 2.

RESULTS

Four key themes emerged from the data: patient-HCP consultation; patient experience; limited treatment options; and organisational constraints. Each had a number of subthemes as detailed below.

Patient-healthcare professional consultation

Timing of the self-management discussion.

Some patients who were successfully managing their condition reflected on their discussions with HCPs about self-management and felt that these discussions came too late, if at all. They often felt they had been left to teach themselves:

'You end up picking up this bit or this bit or this bit or this bit and then trying to join them together. And that works but that might be over 10 years as opposed to over a couple of months.' [Patient 13]

There was discussion among HCPs as to the right time to introduce self-management, with some favouring early intervention. However, patients and HCPs both recognised that acceptance of pain made self-management more possible:

'Then once you have that acceptance you can get on to the process of self-management but before that, no. I think you will fail until the patient actually accepts what they have.' [GP 9]

Communication. There was some evidence of poor communication between patients and HCPs, which led to frustration and negative emotions. Patients commonly cited 'improved listening' as the key thing they desired from HCPs. They sometimes found it difficult to convince HCPs of the level of their pain:

'I was at physiotherapy ... they said, "Describe your pain". And I says, "10". "Och", they laughed at me! "Och, don't be silly! Describe your pain, what number

Box 2. Step-by-step approach to data analysis

Step 1: All transcripts were reviewed and initial coding framework with key themes and subthemes was drafted.

Step 2: The framework was discussed. Omissions and misunderstandings were identified. Initial coding framework was revised accordingly.

Step 3: Two members of the research team coded the same two transcripts. The coding comparison tool on NVivo was used to indicate consistency.

Step 4: Significant inconsistencies were discussed. Differences arose when the two researchers had different understanding of what the code was capturing. The differences were resolved and a written definition of each code was entered onto NVivo including examples of what would and would not be included in each.

Step 5: Two members of the research team recoded the same two transcripts. The coding comparison tool on NVivo indicated improved consistency (increase in κ coefficient from 0.20 to 0.47). κ coefficient between 0.40 and 0.75 demonstrates 'fair to good agreement'.

Step 6: Remaining transcripts were coded by one of two members of the research team. An 'other' node in NVivo allowed the capture of emerging themes that did not fit easily into the existing coding frame.

Step 7: All individual subthemes were reviewed. Subthemes that were not supported with a large amount of data were removed or merged with similar subthemes. Four key themes and 13 subthemes remained.

Step 8: A final patient focus group was held in August 2014. The group were invited to discuss the identified themes and asked to what extent these matched their own experiences. No major discrepancies were identified.

Step 9: All study participants were sent a copy of the summary report in early 2015. Comment was invited from all 101 participants and given by four.

is it?" ... You know, so this thing about numbers. I know how severe my pain was — it was like a red-hot poker in my back. But they're wanting you to say "Four or five or six." "No, it's 10!" [Patient 21]

HCPs talked of difficulties discussing the biopsychosocial approach to chronic pain:

'... we go down the road enquiring about "how they're feeling", "how life is", or "any connections between what's happening in their life". Then they assume that we think it is the main cause but in fact it is multifactorial. The skill we have to develop is reassuring that we're looking for lots of reasons why this is a problem for them and it's not just that we think they're mad.' [GP 1]

'But sometimes you know that there's a much more obvious psychological/psychiatric issue but that's a real difficulty if the patient just does not accept that or does not want to hear that at all. Because as soon as you sometimes go down that route, even suggest that, you can be accused of "Oh, are you saying it's all in my head and I'm making this up?" And that's a difficult road to try and get down sometimes I think.' [GP 12]

Healthcare professional–patient relationship.

Both groups felt that a good relationship between patient and HCP was beneficial for self-management. Patients' positive experiences centred on HCPs listening,

supporting, caring, being patient, and being accessible. Negative experiences included HCPs not listening, rushing, giving generic advice, not acknowledging the impact of pain, invoking feelings of inferiority, not understanding chronic pain, judging, and insinuating that pain 'is in the head'. The latter was a phrase commonly quoted by patients:

'I can't help but wonder whether if doctors don't see a tumour on the scan, then it's psychological. "Oh, it's in your head love, take your diazepam."' [Patient 52]

Most HCP groups made reference to patients with chronic pain potentially being a difficult group. A number of reasons were cited including disappointment that they could not fix the problem, frustration at a lack of compliance with physiotherapy recommendations, and the draining nature of empathising with a distressed patient. This highlighted the impact that a patient with chronic pain may have on the HCP's emotions:

'Because we aren't psychologists and sometimes you do feel overwhelmed and you think "This isn't what I signed up for! I don't know what I'm doing here." So there are times when you feel a bit overwhelmed.' [Physio 28]

'... it is really important about our perceptions and our prejudice. And of course we try to avoid that, but we're humans. So the way we have experienced pain and the way we have lived with pain and the previous experiences we have had in our family with people with pain, it may affect the way we deal with patients with chronic pain. So there are also barriers from our own person that impacts on the way we deal with patients with chronic pain.' [GP 14]

Patient experience

Patient wellbeing. The emotional impact of chronic pain was widely discussed by patients and HCPs. Negative emotions ranged from 'feeling very low' to 'having depression' to 'being suicidal'. Some patients spoke of a feeling of grief and mourning for their former selves:

'I think a lot of the time that's what can make the whole self-management thing so difficult to stick to, it's the thing of wanting to be your old self ...' [Patient 12]

A link between pain and poor mental health was recognised by HCPs and some

patients. Other emotions discussed included frustration at the limitations caused by pain, loneliness, feelings of guilt or inadequacy at not being able to function in the way that they used to, and embarrassment about no longer working or using disabled 'privileges' such as designated parking spaces.

Patient journey. Patients and HCPs felt chronic pain often meant a long and inconclusive journey dominated by the search for a diagnosis and cure:

'I think that that is probably the challenge when they're stuck at the point of looking for a diagnosis and you are spending all your time and energy on that. How do you help someone transition without an "I can guarantee you there is nothing wrong" conversation? That is often when you get stuck with difficult patients.' [GP 8]

'I think one of the hard things as well is if you don't have a diagnosis and you go from A to B and "it's not this so we'll try this". You understand that it's about elimination, by trying out different things, but it can be very frustrating. And by going through that you get quite disappointed because your expectations are building up. You know you're going to see somebody and you think "Oh, maybe we're going to find out what it is and then we can get on with it or we can resolve it."' [Patient 23]

The realisation that treatment would most likely reduce rather than cure pain left patients disappointed and HCPs feeling like they had 'let the patient down'. Participants felt the expectation of a cure was sometimes perpetuated by family, other HCPs, the media, pharmaceutical companies, and the traditional implicit assumption that 'the doctor fixes the patient':

'I accepted it a while ago but my husband's still not accepting it. He's like that, when I'm really bad, "For goodness sake, they must be able to give you something."' [Patient 53]

Ability or readiness to self-manage. HCPs suggested that not all patients had the ability, learning capacity, or willingness to self-manage:

'One of the problems is that we are often dealing with people who aren't empowered in any other aspect of their life, they have an external loci of control ... They're not looking to take over control of their own lives in many areas and to expect them to do it for pain, just because we have told them it's a

good idea, is ridiculous.' [GP 5]

Some felt that patients were not ready to change but hoped that this would come with time. Difficulties with self-management cited by patients focused on having to complete day-to-day tasks, the unpredictability of pain flare-ups, and the lack of access to self-management resources.

Lack of support. Many patients felt they had little self-management support from their HCP. In some cases they felt self-management was something they had to do to plug a gap in healthcare provision, when waiting for a referral, or to make up for the perceived failings of the GP. There was some discussion among HCPs that the term 'self-management' may have negative associations of abandonment for patients:

'I think it's a slightly off-putting term for some patients ... "Oh, the doctor's not interested." "On you go, I can't do anything about this, you deal with it."' [GP 13]

Physiotherapy clinics were described as being organised around short courses of appointments, after which patients would be signed off without any long-term strategy for managing their condition. Ongoing support, at times of flare-up or other disruptive life events, was considered desirable by both physiotherapists and patients:

'... the successfulness of the [self-management] strategies to work long term is for us to be long term ... I finish my course with my patients ... I give them information about masses of different things. But I don't follow that patient up and nobody else does.' [Physio 24]

Limited treatment options

'Medicalisation' Some HCPs felt that there was a tendency for 'overmedicalisation' in the treatment of chronic pain. Patients also felt they were often offered a prescription as the only treatment option. However, HCPs argued that achievement of widespread acceptance of self-management as an effective treatment of pain, compared with medication, would require a significant cultural shift in attitudes towards health care:

'I mean we are only getting used to it as healthcare professionals so obviously our client group are behind us ... we shouldn't be disheartened. If we introduce it now, maybe the next generation will be more accepting [of the idea of self-management].' [HCP — OT, 35]

Third-sector support services. Patients attending support groups were extremely positive about them. Some HCPs expressed a reservation about signposting patients to such groups. Reasons included concern with regard to the content, previous bad reports from patients, inconsistent messages and language, reinforcement of a negative attitude towards lifestyle changes, and the transient nature of third-sector organisations whose existence depends on unpredictable funding. One GP felt that the less easily measured benefits of support groups meant they might be de-prioritised as a treatment method:

'So those kind of softer things, like community activity groups, could be hugely helpful, but they're much less easy to tick boxes and to audit and all of those kinds of things now that everything has to be.' [GP 3]

Training. Many patients highlighted what they perceived as a lack of HCP knowledge of specific chronic pain conditions, such as fibromyalgia, or of the most recent developments in pain research. The participants in the HCP groups often highlighted the absence of undergraduate-level training in chronic pain and self-management. Some of the Edinburgh-based physiotherapists had undertaken additional pain training:

'And since doing that — it's a lot to take in — but it makes you feel a lot better trying to cope with these patients. Because when you've not got any training in it you're just like "What do I do? Where do I start?" — it's a massive area. So having that resource and then having a refresher is obviously really good.' [Physio 22]

However, some GPs questioned how realistic it is to have a wide roll-out of specialised training:

'They always talk about training for GPs, "train GPs more", and I think GPs who have an interest in chronic pain probably know a lot about it already ... But that is difficult, I don't know if primary care can expect to have GPs with time and expertise in every GP surgery, it would be nice.' [GP 5]

Organisational constraints

Appointment duration. It was rare for GPs not to mention problems associated with short appointments:

'I am very against that it is only about

medicine. I am convinced we are not doing the right thing with that but we are in a spiral at the minute that that is the only thing we can do in 10 minutes — "Let's give you a prescription."' [GP 9]

GP 1: *'We need half-hour appointments.'*

GP 3: *'We really do. I mean I think we could transform things like pain with a half-hour appointment.'*

The pressure of the short appointments was also apparent to patients:

'You walk into the GP, we've all done it, and you see the man and within minutes you can see him looking at the clock.' [Patient 38]

Waiting lists. Long waiting lists were commonly discussed by both patients and HCPs in relation to psychology, psychiatry, and physiotherapy. The problems caused included worsening pain and subsequent job loss, anger with the 'system', and a loss of motivation and interest in self-management. Physiotherapists spoke of the pressure to move patients on in order to reduce the waiting list.

Consistency and continuity of care. Both HCPs and patients recognised that self-management messages were not always consistent:

'I think the continuity here is key. If one person goes to see a different professional who says a different thing, with their own personal views on self-management, many of which would differ entirely (and that is just my own perception) you can see how people lose confidence. People have been told 10 different things before and they still don't know what it is and how can I then go on and manage it?' [GP 7]

Another frustration related to the compartmentalised structure of the NHS:

'Well, you're not treated holistically. You're hacked off into bits and separated out into separate parts of the NHS and one part deals with one part and another part deals with another part ...' [Patient 47]

Both patients and HCPs talked of the lack of prioritisation of chronic pain. HCP groups discussed how government target setting meant a struggle to balance meeting targets with treating conditions falling outside such targets. One patient group discussed the impact and injustice of a lack of prioritisation:

Patient 6: *'If it's a life-threatening thing then you get the care but when it's not regarded as life threatening, and chronic pain unfortunately isn't, then [you don't get the care].'*

Patient 3: *'But it does make your life really sometimes not worthwhile and you do think, "Why bother?" ... Is that not a life-threatening attitude?'*

DISCUSSION

Summary

A number of interconnecting barriers were found, presenting difficulties to both HCPs and patients in the facilitation and implementation of self-management. Chronic pain is a complex condition for which there is no cure and effective management favours a biopsychosocial approach, but the results of this study indicate that this is challenging for primary care HCPs. GPs struggled to treat chronic pain with the thoroughness they desired in the appointment times available and physiotherapists felt their treatment strategies were sometimes compromised by a lack of longer-term support. A partnership relationship between HCP and patient was thought to support self-management, but these relationships were sometimes difficult to build. Negative emotions arose when patients felt disbelieved and not listened to, whereas HCPs acknowledged that patients with chronic pain were sometimes perceived to be a difficult group.

Although most patients accepted self-management as something they had to do, it sometimes came with negative associations of 'failure' to find a cure. The movement away from 'doctor fixes patient' requires a cultural shift without which self-management may not always be accepted and welcomed. Some indications of this shift were present with patients voicing a desire for HCPs to provide more than just a prescription. Adding to the challenge of discussing self-management was the need to balance addressing it early, as recommended, while being sensitive to varying degrees of acceptance of pain and its impact.

Strengths and limitations

Focus groups allowed for rich energetic discussion on the topic with a wide range of participants. Although the HCP sample was initially dominated by GPs and physiotherapists, the later purposive sampling ensured that the views of a wider range of primary care professionals were included in the study from both urban and rural locations.

It is possible that the HCPs who

participated in the study were those who had a greater interest in chronic pain. Similarly, the patient recruitment strategy may have led to a study population who were active self-managers, using third-sector services more so than the overall chronic pain population. This experience and expertise facilitated deep and rich accounts of possible barriers. However, different barriers may exist among HCPs and patients who are less tuned into self-management and chronic pain.

Comparison with existing literature

Existing qualitative research has explored the lived experience of pain. Meta-ethnographies or meta-synthesis of such studies provide a useful comparator for the current study. The findings resonate with many of the themes discussed: the adversarial struggle to affirm self, explain pain, negotiate the healthcare system, and to be valued and believed;²⁵ the undermining and disempowering impact of pain, and unsatisfying relationships with healthcare providers;²⁶ difficulties with activities and stigma;²⁷ and the impact on self and relations with significant others.²⁸ The same studies find some evidence of moving forward with pain, accepting and adjusting, and changing outlook.

Fewer empirical studies include HCP experiences. Those that do highlight the emotional toll of treating patients with chronic pain;^{29–33} time constraints;^{29,34,35} long waiting lists;²⁹ difficulties of taking a biopsychosocial approach;^{31,32,34} a long search for diagnosis;^{32,34} and not knowing the appropriate information to give patients.²⁹ The current study finds that these factors experienced by many patients and HCPs can also create barriers to successful self-management.

Some previous studies have sought to identify barriers to self-management of chronic conditions with both patients^{36,37} and GPs,¹⁸ and more specifically chronic pain in older people,³⁸ and those with comorbid depression.³⁹ The findings of the current study concur with much of this earlier work. Taylor and colleagues⁴⁰ rapid synthesis of self-management support for all long-term conditions explored what works, for whom, and in what contexts. They identified a need for a culture of actively supporting self-management as a normal, expected aspect of the provision of care; the need for tailoring to the individual, their culture and beliefs, and the time point in the condition; the need for good communication between patient and HCP; information and education; support with psychological

impact of long-term conditions; and implementing a whole-systems approach to self-management support. The synthesis covered a wide range of 'exemplar' long-term conditions; however, the current study shows these findings to be applicable also to patients with chronic pain.

Implications for research and practice

Qualitative research can contribute to a collaborative patient-clinician partnership.⁴¹ The findings of this study have been presented in six online videos that raise awareness of the barriers, promote means of addressing some barriers, and share the experiences of people with chronic pain and HCPs. The videos are available online at: <http://painconcern.org.uk/self-management-videos/>. Signposting patients to the videos could provide a quick and timely introduction to self-management. Furthermore, previous research found presentation of qualitative findings of pain research through film had useful learning

potential for clinicians.⁴²

Qualitative research has the potential to incorporate the patient voice into the design of healthcare services.⁴³ The study was undertaken in the context of an increasing emphasis on self-management of long-term conditions from the Scottish Government.¹² Identification and evidencing of the barriers to self-management pave the way for future research that tests interventions to address them. A further research project is planned to test the effectiveness of an intervention that combines brief training for HCPs and a 'navigator tool' to be used during consultations. The intervention aims to focus the consultation on the concerns that are most pressing for the patient, encourage shared decision making, and promote a biopsychosocial approach to treatment. This research will determine if the proposed intervention would optimise the limited time available with HCPs and, by better facilitating self-management, reduce the number of repeat appointments.

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Ethical approval

Ethical approval was granted by NHS Research Ethics Committee (reference number 14/SC/0116) and the R&D department of individual health boards involved in the study.

Provenance

Fully submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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REFERENCES

- Elliott AM, Smith BH, Penny KI, *et al.* The epidemiology of chronic pain in the community. *Lancet* 1999; **354**(9186): 1248–1252.
- Smith BH, Elliott AM, Chambers WA, *et al.* The impact of chronic pain in the community. *Fam Pract* 2001; **18**(3): 292–299.
- Belsey J. Primary care workload in the management of chronic pain. A retrospective cohort study using a GP database to identify resource implications for UK primary care. *J Med Econ* 2002; **5**(1–4): 39–50.
- Maniadakis N, Gray A. The economic burden of back pain in the UK. *Pain* 2000; **84**(1): 95–103.
- Price C, Hoggart B, Olukoga O, *et al.* *National pain audit: final report. 2010–2012*. British Pain Society, Health Quality Improvement Partnership, Dr Foster Intelligence, 2012. <http://www.nationalpinaudit.org/media/files/NationalPainAudit-2012.pdf> [accessed 12 Dec 2016].
- Clarke KA, Iphofen R. Accepting pain management or seeking pain cure: an exploration of patients' attitudes to chronic pain. *Pain Manag Nurs* 2007; **8**(2): 102–110.
- Scottish Intercollegiate Guidelines Network. *Management of chronic pain. SIGN 136*. Edinburgh: SIGN, 2013. <http://www.sign.ac.uk/pdf/SIGN136.pdf> [accessed 12 Dec 2016].
- Boyers D, McNamee P, Clarke A, *et al.* Cost-effectiveness of self-management methods for the treatment of chronic pain in an aging adult population: a systematic review of the literature. *Clin J Pain* 2013; **29**(4): 366–375.
- Kroon FP, van der Burg LR, Buchbinder R, *et al.* Self-management education programmes for osteoarthritis. *Cochrane Database Syst Rev* 2014; **1**: CD008963. DOI: 10.1002/14651858.CD008963.pub2.
- Audit Scotland. *Managing long term conditions*. Edinburgh: Audit Scotland, 2007. http://www.audit-scotland.gov.uk/docs/health/2007/nr_070816_managing_long_term_km.pdf [accessed 12 Dec 2016].
- Holman H, Lorig K. Patient self-management: a key to effectiveness and efficiency in care of chronic disease. *Public Health Rep* 2004; **119**(3): 239–243.
- Long Term Conditions Alliance Scotland. *'Gau yersell': the self-management strategy for long term conditions in Scotland*. Glasgow: LTCAS, Scottish Government, 2008. <http://www.gov.scot/resource/0042/00422988.pdf> [accessed 12 Dec 2016].
- Newman S, Steed L, Mulligan K. Self-management interventions for chronic illness. *Lancet* 2004; **364**(9444): 1523–1537.
- Healthcare Improvement Scotland. *Chronic pain services in Scotland: where are we now?* Edinburgh: Healthcare Improvement Scotland, 2014.
- Royal College of General Practitioners. *Statement 2.01. The contextual statement on the GP consultation in practice*. London: RCGP, 2010.
- Chartered Society of Physiotherapy. *Physiotherapy works: chronic pain*. London: Chartered Society of Physiotherapy, 2014.
- Kemppainen V, Tossavainen K, Turunen H. Nurses' roles in health promotion practice: an integrative review. *Health Promot Int* 2013; **28**(4): 490–501.
- Blakeman T, Macdonald W, Bower P, *et al.* A qualitative study of GPs' attitudes to self-management of chronic disease. *Br J Gen Pract* 2006; **56**(527): 407–414.
- Twhigh PL, Putman W. Group interviews in primary care research: advancing the state of the art or ritualized research? *Fam Pract* 2002; **19**(3): 278–284.
- Gibbs A. Focus groups. *Social Research Update: Issue 19*. Guildford: University of Surrey, 1997. <http://sru.soc.surrey.ac.uk/SRU19.html> [accessed 12 Dec 2016].
- Stewart DW, Shamdasani PN. *Focus groups: theory and practice*. 3rd edn. London: Sage Publications, 2014.
- Mays N, Pope C. *Qualitative research in health care*. London: BMJ Publishing Group, 1996.
- Saunure K, Given L. Data saturation. In: Given LM, ed. *The SAGE encyclopaedia of qualitative research methods*. London: Sage Publications, 2008: 195.
- Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psych* 2006; **3**(2): 77–101.
- Toye F, Seers K, Allcock N, *et al.* *A meta-ethnography of patients' experience of chronic non-malignant musculoskeletal pain*. Southampton: NIHR Journals Library, 2013 (Health Services and Delivery Research, No. 1.12).
- MacNeela P, Doyle C, O'Gorman D, *et al.* Experiences of chronic low back pain: a meta-ethnography of qualitative research. *Health Psychol Rev* 2015; **9**(1): 63–82.
- Froud R, Patterson S, Eldridge S, *et al.* A systematic review and meta-synthesis of the impact of low back pain on people's lives. *BMC Musculoskel Dis* 2014; **15**: 50.
- Snelgrove S, Liossi C. Living with chronic low back pain: a metasynthesis of qualitative research. *Chronic Illn* 2013; **9**(4): 283–301.
- Breen A, Austin H, Campion-Smith C, *et al.* 'You feel so hopeless': a qualitative study of GP management of acute back pain. *Eur J Pain* 2007; **11**(1): 21–29.
- Matthias MS, Parpart AL, Nyland KA, *et al.* The patient-provider relationship in chronic pain care: providers' perspectives. *Pain Med* 2010; **11**(11): 1688–1697.
- Patel S, Peacock S, McKinley R, *et al.* GPs' experience of managing chronic pain in a South Asian community: a qualitative study of the consultation process. *Fam Pract* 2008; **25**(2): 71–77.
- Peters S, Goldthorpe J, McElroy C, *et al.* Managing chronic orofacial pain: a qualitative study of patients', doctors', and dentists' experiences. *Br J Health Psychol* 2015; **20**(4): 777–791.
- Crowe M, Whitehead L, Jo Gagan M, *et al.* Self-management and chronic low back pain: a qualitative study. *J Adv Nurs* 2010; **66**(7): 1478–1486.
- Allegretti A, Borkan J, Reis S, Griffiths F. Paired interviews of shared experiences around chronic low back pain: classic mismatch between patients and their doctors. *Fam Pract* 2010; **27**(6): 676–683.
- Bergman AA, Matthias MS, Coffing JM, Krebs EE. Contrasting tensions between patients and PCPs in chronic pain management: a qualitative study. *Pain Med* 2013; **14**(11): 1689–1697.
- Jerant AF, von Friederichs-Fitzwater MM, Moore M. Patients' perceived barriers to active self-management of chronic conditions. *Patient Educ Couns* 2005; **57**(3): 300–307.
- Bayliss EA, Ellis JL, Steiner JF. Barriers to self-management and quality-of-life outcomes in seniors with multimorbidities. *Ann Fam Med* 2007; **5**(5): 395–402.
- Austrian JS, Kerns RD, Reid MC. Perceived barriers to trying self-management approaches for chronic pain in older persons. *J Am Geriatr Soc* 2005; **53**(5): 856–861.
- Bair MJ, Matthias MS, Nyland KA, *et al.* Barriers and facilitators to chronic pain self-management: a qualitative study of primary care patients with comorbid musculoskeletal pain and depression. *Pain Med* 2009; **10**(7): 1280–1290.
- Taylor S, Pinnock H, Epiphanou E, *et al.* A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions. *Health Serv Deliv Res* 2014; **2**(53).
- Toye F. 'Not everything that can be counted counts and not everything that counts can be counted'. *Br J Pain* 2015; **9**(1): 7.
- Toye F, Jenkins S. 'It makes you think': exploring the impact of qualitative films on pain clinicians. *Br J Pain* 2015; **9**(1): 65–69.
- Barker KL. How can qualitative research be utilised in the NHS when re-designing and commissioning services? *Br J Pain* 2015; **9**(1): 70–72.