Research is now attempting to identify the characteristics of different groups, the variety of drugs being abused and the relationship between time and transition to more severe forms of drug taking.[4] While it has been generally assumed that transition from, for example inhalation of drugs to injection of drugs is inevitable, it seems that this is not necessarily so, especially where knowledge of HIV among drug users is high. The route of first use drugs seems to bear some relationship to the year of first use. This may indicate the importance of the prevailing fashion at the time of first use of drugs on subsequent behaviour.

The importance of an analytical approach to drug taking in general practice is exemplified by the paper by Leaver and colleagues in this issue of the *Journal*,[5] which examines the relationship between a group of drug takers in inner London and their general practitioners. This paper has avoided the usual pitfalls of other studies trying to assess outcome of treatment provided over a short time period but instead has looked at other areas of importance. The high consultation rate, including emergency consultations, the high percentage of drug users being prescribed at least two items and the implications for the emerging new style of general practice are all identified and discussed constructively.

How drug users and patients with HIV infection will be managed in the new style general practice, where practices need to attract patients to their varied services in order to maximize income, is of importance in inner city areas. The suggestion by the House of Commons social services committee in 1985 that drug users may best be supported by the allocation of an item of service fee[6] may re-emerge for those with long term problems as well as for patients with HIV infection who require an intensity of work and responsibility perhaps commensurate with a special allocation of financial support.

The relationship between research and clinical practice in areas of behavioural problems such as smoking, alcohol abuse and drug dependency has always been tenuous and the rapidly expanding research agendas of academic institutions in relation to drug misuse, the acquired immune deficiency syndrome (AIDS) and HIV infection have yet to affect general practice significantly. Problems of accessing suitable samples of people involved with drug dependency should certainly be an area of interest for inner city general practitioners. Academic units and clinicians need to work together interpreting research data in the light of clinical practice. The limited connection between theory and practice is not a new problem but has undoubtedly held up the development of suitable rehabilitation programmes.

Not surprisingly, the initiatives tackling drug problems in the United States of America are more impressive than those in the United Kingdom, at least in terms of allocation of funds. The National Institute for Drug Abuse estimates that there are between 1.1 and 1.3 million individuals in the USA injecting mainly heroin and/or cocaine.[7] The 1991 budget of $416 million testifies to the anxiety that this creates. Again this is largely because of the concern over HIV infection which, because of its long incubation period and length of time in the USA population, has revealed a greater penetration into the non-drug using population. It is of interest that this budget and the associated AIDS budget for research have increased rapidly over recent years as the crisis is seen to threaten the heterosexual population. It may be that a similar pattern of events will increase the budget for tackling drug problems in the UK.

General practitioners should be aware of the possibilities emerging, not just in academic pursuits but in the practical issues on managing patients, which the research has revealed. They should also be aware of the importance of observation and recording data over time, tasks to which primary care lends itself.

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Chronic non-malignant pain

CHRONIC pain is a major health problem and it has been estimated that between 25% and 30% of populations in industrialized countries have chronic pain.[1] It seems likely that every general practitioner will see patients with chronic non-malignant pain. There may be an obvious cause of the pain, such as arthritis, or the cause may be uncertain. What is certain is that chronic non-malignant pain is a complex phenomenon. It is caused by many different factors, can be modulated by a variety of influences and affects those who suffer from it in many different ways. Chronic pain is not exclusively neurophysiological or psychological — it is multidimensional.[1] There is no straight line relationship between the extent of an injury and the amount of pain experienced.[2]

Chronic pain has no biological function and is destructive not only physically but psychosocially and economically.[1] It affects not only the person in pain, but their family and friends and society as a whole. It would seem that the relief of chronic pain must be a priority. However, this was not recognized by the recent white paper, *Health of the nation,* although relief of back pain was identified as a possible key area for future action.[3]

Acknowledging the complexity of pain means that dealing with chronic pain becomes a challenge both for sufferers and for those who try to alleviate this suffering. Some people cope well with chronic pain.[4] For others, perhaps the ones who tend to be remembered, pain presents much more of a problem.

Chronic pain has often been treated as if it were acute pain, both by the doctor and by the sufferer. An acute model dictates that the pain has an identifiable cause which, once treated, will get better. Unfortunately, chronic pain is not like that. It can be difficult (and understandably so) for people to accept that their pain cannot be cured. The following quotes come from the author's Department of Health funded research into teaching

relaxation to people with chronic non-malignant pain. One patient said:

> 'I will not accept that I have to learn to live with it. There must be someone who is willing to try and find out why I'm in this pain. Every pain has a foundation. If it is not in my bones, it must be somewhere else. I get angry if they say they don't know. Have they tried everything?'

The patient's stage of acceptance is thus important to consider.

It may also be difficult for doctors to accept that they cannot provide pain relief, as these patients' comments show:

> 'I had something [chronic pain] that was medically unacceptable.'

> 'I never go to the GP — he has labelled me a neurotic because they couldn't find anything wrong. His dismissive unlistening attitude to my mysterious pain almost amounts, in my opinion, to mental cruelty.'

The sense of abandonment felt by these patients is clear.

Some patients recognize the difficulties chronic pain creates for their general practitioner. One patient said she did not visit her general practitioner as:

> 'There is nothing the GP can do about the pain, so why make her feel awful?'

This recognition that the general practitioner may feel some sense of failure was reinforced by another patient who said:

> 'It is upsetting for the doctor not to succeed.'

It is therefore difficult if the general practitioner and/or the person with pain see success in terms of curing the pain. Once general practitioners and specialists are satisfied nothing more can be done to cure the pain and no further tests are useful, then the search for a cure becomes inappropriate. Any such efforts to treat chronic pain as if it were acute are likely to be frustrated and the patient will be continually disappointed. Acute pain should get better and if it does not, it may seem that the patient is not trying or not responding to the doctor's best efforts to help. Patients may feel that their general practitioners have failed them and the doctor–patient relationship may well deteriorate. The patient may change general practitioner.

What can the general practitioner do? Being told only that 'You'll have to learn to live with it' is likely to be overwhelming for many patients. Being told nothing more can be done medically is not and should not be the end, but rather the beginning of a process of adaptation for the person in pain, and to some extent, for his or her general practitioner too. It is not easy to learn to live despite the pain, as exemplified by a quote from one patient:

> 'Coming to terms with this pain is like being given an indefinite [prison] sentence.'

Although general practitioners may not be able to cure a patient's pain, they can help the patient come to terms with it and enjoy life despite the pain. Some patients may learn how to do this on their own over time; most will need help to adapt as their lives may be very different from their previous pain-free life.

From talking to sufferers, the most important factor in coming to terms with their chronic non-malignant pain is that the pain should be believed in. It must be devastating if chronic pain disrupts a person's life and is then dismissed as imaginary. It is crucial to have a shared perspective of the problem, keep communication channels open and work together towards common, realistic goals.

Since chronic pain is so difficult to treat, prevention is an area which seems attractive. The paper by Potter and Jones in this issue of the *Journal*[5] represents an interesting pilot study in this area and provides pointers for further research.

Controversy exists over the use of strong analgesics for chronic non-malignant pain. It has been argued that there is 'no place for opiates' in the treatment of such pain.[6] It may therefore be appropriate to refer patients to a multidisciplinary pain clinic for assessment since a 'multidisciplinary approach to diagnosis and treatment is the preferred method of delivery of health care to patients with chronic pain of any aetiology'.[7]

The International Association for the Study of Pain and the Pain Society both provide a forum for the exchange ideas and for keeping up to date with latest developments in the area. The international association has also produced a core curriculum for professional education about pain,[8] and there are standard texts useful for reference,[1,9] and self help guides for patients.[10-12] Twelve steps for mastering chronic pain have been proposed in one such self help guide[10] and might provide a useful initial framework for the general practitioner in helping the patient:

- Accept the fact of having chronic pain.
- Set specific goals for work, hobbies and social activities.
- Let yourself be angry at your pain if it seems to be getting the best of you.
- Take analgesics on a strict time schedule, and then taper them off..
- Get in the best physical shape possible, then keep fit.
- Learn how to relax, and practise regularly.
- Keep yourself busy.
- Pace your activities.
- Get your family/friends to support only healthy behaviour, not invalidism.
- Be open and reasonable with your doctor.
- Be empathetic with others having pain problems.
- Remain hopeful.

Offering a miracle cure should be avoided. It may take time to achieve appropriate pain management. Coping with chronic non-malignant pain is not easy for sufferers or for those trying to help alleviate their suffering, but there is hope.

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