

Getting the best out of general practice — an open letter to the Minister of Health

Dear Mr Milburn,

CONGRATULATIONS on your reappointment as Secretary of State for Health. With the emotions expressed just before the election, perhaps you wondered if this was really what you wanted. The BMA's ballot and the day of protest in May suggested real unhappiness among general practitioners (GPs). However, as Richard Smith pointed out in the *BMJ*, it's not clear why. Paperwork is considerable, but it cannot be the only explanation.

Many of us (and I think this applies to hospital doctors as well as GPs) feel that the Department of Health now considers us to be part of the problem of delivering high quality health care, rather than part of the solution. We feel as if we are regarded as the enemy. Far from being hostile, most of us remain committed to the principles embodied by the NHS of a universal, high quality service, free at the point of delivery. Many of us voted for your party last time (and probably on 7 June as well), partly because of its commitment to adequate funding of public services.

That the NHS continues to work at all is the result of the commitment and hard work of doctors, nurses, and other health professionals. The NHS's most valuable resource is these professionals, and no commercial organisation would treat its staff with the high-handedness and contempt that we have experienced. Whatever systems are put in place over the next few years to check on doctors' competence, high standards will continue to depend overwhelmingly on professionals' own pride and desire to practice to a high standard.

As far as your approach to GPs is concerned, do try to understand what we do, and neither undervalue nor undermine it. The core is to provide personal and continuing care to patients and their families. We know that we are responsible for only one-fifth of the NHS's total budget and that we only register occasionally (and very briefly) as one of your department's concerns. You need to understand, not the often quoted and true mantra that more than 90% of all patient contacts take place in primary care, but that it is the high quality with which these 90% are handled, with so few referred to secondary care, that enables the system as a whole to function with an efficiency that is, even now, applauded by foreign observers of the NHS.

Here, of course, we are our own worst enemies. It is difficult for other doctors, let alone anyone else, to understand how anything can be done well in 8–10 minute episodes, so we look slapdash. We have even further weakened our position by conducting trials showing that well trained nurses working within primary care teams can handle some of this illness to a similar standard (although they take longer over it). What this research certainly didn't show is that large areas of our work can be passed on to unsupported nurses without thought, training, proper evaluation, or indeed adequate resourcing. The twin implications in the NHS Plan for England, that much of what we do is so simple that it can be

done by nurses, and that we would be better employed turning ourselves into intermediate level specialists, fail to acknowledge the value of our core work and are profoundly dispiriting.

As for undermining general practice, the preoccupation of your department in the previous administration with the flashy innovation of 'walk-in centres' may look like a success story. However, its willingness to create a separate structure, rather than work within its own existing systems, demonstrates contempt for those systems. Access to doctors remains a problem, but concentrating on it to the exclusion of other aspects of high quality care reveals a very narrow vision. Our main preoccupation is with the needs of the sick, especially those with multiple and long-term illness, and less with the desire of the younger group with predominantly self-limiting illness to see a professional within 48 hours.

Do try to be consistent when you deal with us. While we go about our daily business with costs always one of our concerns, ministerial criticisms of profligacy on our part, such as the Prime Minister's ineffably patronising comment in a speech some time ago to the College of Surgeons about helping GPs not to refer emergencies to hospital needlessly, are a routine insult. More damaging is the Department's willingness to throw huge sums of money at particular problems. Walk-in centres may be a huge success or an abject failure — we don't know yet. However, we do know that they have been very expensive, not only in terms of real money and the opportunity cost that represents, but also in taking substantial numbers of highly trained nurses away from nursing jobs in hospital, so that we have the unedifying spectacle of the Department of Health touring the rest of the world to Hoover up what is likely to be a scarce resource from their country of origin. The same applies to the pre-election pledge to make wider use of private health services.

Behind this inconsistency there is a more fundamental one that we have been making ever since Kenneth Clarke's reforms just over 10 years ago. The medical community is gradually becoming wedded to the principle that we move cautiously, only introducing innovations on a large scale when there is a reasonable body of evidence to support the move. The Department of Health supports this, both in terms of public statements and in funding some of the bodies to underpin the approach, such as the Cochrane Collaboration, and NICE. It is then hypocritical for some innovations to be instituted at considerable expense, without evaluation or consultation with the professions, on the whim of government ministers.

Do try to be realistic about what can be achieved in a short time. The NHS gave general practice a generous contract in 1966 and then left the GPs to get on with it for nearly 25 years. It took a long while for the implications of this contract to be fully understood and exploited. We are seen as a conservative lot, unwilling ever to change anything. However, both the content and the style of our work has changed enormously in the past 10 years, and will go on changing in

response to new drugs, new medical techniques, continued shifting of work from hospitals to primary care, and changing attitudes between doctors and patients. Please remember that while you and your officials are dreaming up exciting new wheezes we are fully occupied seeing patients. Considering and adopting major changes on top of that takes time. The government has at last, by implication, accepted that the real problem is a shortage of money, and that we do need more doctors and nurses. The creation of four new medical schools is welcome, but students entering one of these new schools in 2001 (and some of them won't be accepting new entrants until 2002 or 2003), won't be available for principal posts until 2010 at the very earliest.

One of the tensions is that we work to different time scales. We want gradual change that we can control and absorb without major disruption to our professional lives. Both you and the government want something dramatic to happen

within four years, to help you get re-elected. It's a reasonable ambition in the rough world of politics, and you can argue (and I might agree) that there is an element of high-mindedness in it. But you should beware of putting intolerable pressure on the NHS to achieve it. Recent ministers of health have been skilful in portraying themselves as protectors of the patients' interests against the self-interest of the doctors. The reality is quite the opposite: long after you have been rewarded by promotion to one of the great offices of state, and long after the next election, we shall still be here working with the patients to get the best of the system for them. If anything, we have a much stronger desire than any passing Secretary of State to ensure that the system is still providing high quality health care in the next 20 years.

DAVID JEWELL
Editor

Chronic pain: a challenge for primary care

AS general practitioners (GPs), we are intuitively aware of the magnitude of the daily challenge presented by chronic pain, from any of a multitude of causes. We are also aware of our profession's limited ability to meet the challenge successfully, and that many patients leave our care without having achieved therapeutic relief. It is therefore important that we research chronic pain epidemiologically, to inform health service planning and the identification, targeting, and evaluation of prevention and interventions, to relieve this important cause of suffering.¹ This research should be based in the community, where most of the problem exists and impacts. In this month's issue, Zondervan *et al* describe a community-based epidemiological study of chronic pelvic pain, with salutary confirmation of the high prevalence, co-morbidity and associated sociodemographic factors.² In these respects chronic pelvic pain is very similar to other chronic pain conditions, and we need to consider their useful results in a wider context.

Chronic pain is defined by the International Study for the Association of Pain (IASP) as 'pain which has persisted beyond normal tissue healing time', usually taken to be three months.³ While acute pain is usually appropriate and adaptive (for example, after an injury), the IASP definition understands chronic pain as a maladaptive or dysfunctional response. A large proportion of this response is subjective⁴ and it includes physical, psychological, social, and emotional domains. From the clinical perspective, this important difference between acute and chronic pain is reflected in the approach to management: while treatment of acute pain focuses on the cause, treatment of chronic pain must also focus on the effects.⁵

Specific diagnosis of the cause of chronic pain is often difficult or impractical and many classifications are based on site rather than underlying pathology. There may be more similarities than differences between causes of chronic pain, and some apparently formal diagnoses include a wide range of conditions. Chronic pelvic pain, for example, includes disparate conditions, such as endometriosis, adhesions, irrita-

ble bowel syndrome, and 'non-specific causes',² whose aetiologies may overlap and whose individual impact maybe similar. A 'chronic pain syndrome' has therefore been proposed to consider all these conditions as a global entity.⁵ This 'functional somatic syndrome'⁶ describes a pattern of experience and behaviour common to sufferers of chronic pain, irrespective of diagnosis, site or intensity. Such an approach is logical, as it allows us to group together many similar conditions, with a view to common prevention and intervention strategies.

The prevalence of chronic pain

There are relatively few studies of chronic pain in the community. Many studies of chronic pain prevalence have been based in secondary care, including pain clinic populations. These result in a huge underestimate of the prevalence in the community and tend to be biased towards particular subgroups of individuals and types of chronic pain.⁷ A recent systematic review, however, identified 15 studies of the prevalence of chronic pain in the community, with most data collection between 1980 and 1990.⁸ The authors calculated a median prevalence of 15% with a range of 2% to 40%, commenting that this wide range reflects differences in case definition (including indicators of severity) and research methods. Presumably it also reflects differences in populations studied as many different nationalities were represented in the review. They found chronic pain to be more common among women, in older age groups, and in lower income groups.

Two large studies, published subsequently, have confirmed a high prevalence and supported this demographic distribution.^{9,10} Gureje *et al*⁹ surveyed 5438 primary care attenders in 15 countries. They found that 22% reported chronic pain, though this ranged from 5% (Nigeria) to 33% (Chile), indicating the need to extrapolate figures from one population to another only with caution. The prevalence among primary care attenders in Manchester, England was 21%. There was a higher overall prevalence among women, but again this var-

ied considerably between centres. In Manchester, for example, there was no significant sex difference. Elliott *et al*¹⁰ reported a postal survey of a community sample of 5036 individuals in Scotland. They estimated a population prevalence of 46% and found chronic pain to be associated with female sex, increasing age, inability to work, and living in council rented accommodation. They found that the reported cause of chronic pain was much less important than these socio-economic factors in determining its impact. Although this high prevalence undoubtedly includes many with mild symptoms of limited clinical significance, 16% of cases reported severe, highly disabling pain, and 28% had sought treatment and professional advice recently and frequently.

Impact of chronic pain

Chronic pain is not simply a physical problem; it is associated with severe and extensive psychological, social and economic factors, with consequential high demand on the health services, particularly primary care. These include poor general physical health, disability, depression, unemployment, and family stress.⁸⁻¹² Many of these factors interact with each other and should be considered together when managing individual patients. Distinguishing the factors that cause chronic pain from the effects of chronic pain is difficult and requires detailed epidemiological study. Von Korff¹³ describes 'bi-directional' causal mechanisms in chronic pain. For example, a patient's altered behaviour as a result of activity limitation may alter others' views of the patient, with a consequent effect on the patient's experience of pain and the perception of its severity. In practical terms, for the GP, the distinction between cause and effect may therefore be irrelevant or unhelpful. Indeed, there is likely to be a significant interaction between aetiology and effect and in treating depression, for example, the GP may also improve chronic pain.

It is important also to consider the economic impact of chronic pain, both at the individual level resulting from treatment costs and reduced earnings, and at the national level, resulting from provision of medical services, lost productivity, and invalidity and sickness benefits.

Implications for primary care

Zondervan and her colleagues² imply that chronic pelvic pain is a problem of major importance to GPs, in view of its high prevalence, effects, and impact on the health services. By understanding its epidemiology in the community we can begin to address the problem, both at the individual and the community level. This is true of all chronic pain.

As chronic (not just pelvic) pain is multi-dimensional both in its aetiology and its impact, the GP is well placed to recognise its development and its severity. Individuals with chronic pain have been shown to use the primary care services up to five times more frequently than the rest of the population, with frequency of attendance related to persistence and severity of pain, and the male sex.¹¹ Chronic pain and its associated problems are therefore familiar to all GPs, whose approach to affected patients will, as usual, be most successful if holistic. Recent research in arthritis has suggested disparate treatment goals between doctors (who focus on pain intensity) and patients (who are more concerned with mobility and function).¹⁴ The management of chronic pain

must therefore be multi-dimensional, addressing all aspects of the patient's life, with consideration of family and employment. There are many different management strategies available in primary care,¹² of which only one is the prescription of analgesics. The optimum approach is likely to involve other members of the primary care team, including nurses, pharmacists, physiotherapists, and occupational therapists. It may also include liaison with social services, employers, and benefits agencies.

Much of the assessment and management of chronic pain can be undertaken efficiently and effectively in primary care, with referral to secondary care as appropriate. It is important to determine the cause where possible, so that specific interventions may be appropriately targeted. Gynaecologists, orthopaedic surgeons, rheumatologists, and others therefore have a crucial role to play. In many cases, though, their involvement is most relevant only at certain stages in considering, for example, surgical intervention, or excluding treatable pathology.

An evidence-based approach to managing chronic pain in the community is in its infancy so, although there are few published clinical trials in primary care, some research is current and more is planned. These necessarily employ complex outcome measures and require a detailed epidemiological background. Encouraging approaches include educational packages, brief cognitive behavioural therapy, and nurse-led clinics with some use the framework of Primary Care Groups or Local Healthcare Cooperatives. There is also considerable interest in the application of complementary therapies, such as homeopathy, though no conclusive evidence of benefit.

Conclusions

Further research into the treatment and prevention of chronic pain in primary care is required. Chronic pain describes a complex interaction between cause and effect, both of which are multi-dimensional. GPs therefore have an important therapeutic role, in which they can exercise their specialist skills. This role may be specific to the GP but the multi-dimensional nature of chronic illness is not specific to pain. Indeed, there are many chronic conditions in primary care that exhibit more similarities than differences in aetiology, impact, and the need for management,⁶ and the specialist role of general practice is therefore emphasised.^{15,16}

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