Life & Times

A new hope:

social prescribing in Cornwall

Last November I attended a 1-day event at the King's Fund entitled 'Social Prescribing: Coming of Age'. Why did I go? Gut feeling I suppose. I'm a GP in Cornwall with little understanding of social prescribing. But I do have history with the overdiagnosis group and I follow the mantra: winding back the harms of too much medicine. Local pain specialists and I have been on a mission to reduce Cornwall's (high) levels of opioid prescribing. We've done handouts, contracts, sample letters, and videos (all open access if you're interested),[1] for patients and clinicians. Everyone knows the risks of opioids for chronic pain and the lower the prescribing graph gets the more smug we become.

ALTERNATIVES TO MEDICINE

But I have a sense of unease. *'Jim, if I don't prescribe, what do I do?'* GPs often ask me. Good question.

We've got some great resources like https://livewellwithpain.co.uk/ to help GPs guide patients in self-management of chronic pain, but reducing opioid doses can be a terrifying and harrowing experience. It is unnatural for doctors to embark on a treatment plan that will cause distress (even if it is temporary and for the longer-term good), which is probably why we avoid it. Surely we must offer alternatives — though not in tablet form.

That's why the conference caught my eye. To me, social prescribing means the judicious use of non-medical interventions for non-medical (and sometimes medical) problems delivered by community solutions. There are a lot of people out there suffering but there's also a lot of people, groups, and organisations that can provide help too. The question is how to matchmake effectively, safely, economically, equitably, measurably, and at scale. Digital solutions will help but we need a local link worker familiar with what's available to perform a holistic assessment and skilfully nudge the patient's life in a better direction(s).

NHS England promises all primary care networks will have a link worker by 2023.[2] We might need two! One study found that a fifth of GP time is spent on non-medical issues.[3]

EVERYONE AGREES

At the conference we heard a heart-warming patient narrative from Arabella who, with the guidance of her link worker, turned her life completely around largely by gaining the confidence to sing in a choir. We heard not only from academics, policymakers, and clinicians as you'd expect, but also from the voluntary sector, community campaigners, and digital solutions, plus artists, dancers, and athletes; even the role of magicians for hemiplegia! Bogdan Chiva Giurca, a medical student, told us how he heard a talk on social prescribing (a topic never mentioned in his medical school curriculum), and liked the idea so much that he coolly set up a national database of medical student social prescribing champions that is publishing research papers[4] and responding to the 'it'll take a generation to change this' type of nihilism.

Then ... on comes the Secretary of State for Health and Social Care, the Rt Hon Matt Hancock. Now, I'm rubbish at politics but I know enough to know I should dislike this guy ... except ... he was great! He spoke about the evidence for the arts and social activity as therapy, people coming together for their health and for society, and a strong commitment to the future:

'Now, drug companies may not like that. And you can bet this multibillion pound industry will use every tool at their disposal to lobby for the status quo and convince us drugs are better than free social cures. That's why we need a National Academy for Social Prescribing to be a champion for non-drug treatments. And it's the role of the state to sponsor the treatments that are often cheaper, better for patients, and better for society.'[5]

Music to my overdiagnostic ears. Though it wasn't all smiles. There are uncertainties about funding streams and concerns that the voluntary sector is already creaking under the strain, but surely this has to be some long-awaited good news?

THE BIOMEDICAL MODEL NEEDS URGENT HELP

What does the evidence show? In summary: social prescribing? Yes. Why? Because it benefits patients and clinicians, saves primary and secondary care workload, is safe, and cost-effective. When? Yesterday: the clinico-political context is ripe and the tech is ready. How? Lots of people are doing lots of things in lots of different ways. We don't know what's best but don't miss the boat. Give it a go. There's an International Social Prescribing Network Conference at the University of Westminster from 11–12 July 2019.

More than anything, it makes sense. As doctors we're trained to find the pathology that explains the presenting complaint and exclude those pathologies that don't. If I used that model in my GP surgery I'd create more problems than I solved.

The vast majority of patients I see aren't suffering from symptoms of a disease; they're experiencing physical or emotional sensations that are unpleasant or unexpected or frightening but not explained biomedically. If I go searching for pathology that isn't there, the overdiagnosis chaos ensues but it takes skill to get the right balance for that patient. The lack of training both generalists and specialists get at spotting, understanding, and helping those suffering from non-disease is jaw dropping.

We're programmed wrong and the biomedical model needs urgent help.

As Bogdan (the medical student) reminded us:

'it's not what's the matter with the patient ... it's what matters to the patient that counts.'

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