

Editorials

NICE guideline NG193 for chronic pain:

reasons to be cheerful

INTRODUCTION

Publication of the National Institute for Health and Care Excellence (NICE) guideline for assessment of chronic pain and management of chronic primary pain (NG193) was a watershed moment.¹ The guideline received a polarised response from both people with chronic pain and clinicians. Many reports focused on, and often misinterpreted, the pharmacological recommendations in the guideline. However, we suggest that the guideline sends a hopeful message, initiating a step change in how we conceptualise and manage persistent pain while reducing harms from medical treatments.

PATIENTS' AND CLINICIANS' EXPERIENCES

Pain is a common presentation in primary care. Between a third and a half of the adult population in the UK experience chronic pain and 14% of the population have disabling symptoms.² Chronic pain is something that remarkable scientific advances have failed to crack. Patients and clinicians report that clinical consultations for pain are unsatisfactory. Patients describe a need for empathy and an awareness by the clinician of what life is like for them, as an individual, living with pain. They also want to be well informed, and empowered to manage their symptoms and to be partners in their care.³ They want honesty from clinicians when there is uncertainty about what to do. In parallel, primary care clinicians describe dissatisfaction with such consultations, lack of consensus regarding treatment, a feeling of pressure to prescribe, and they find such consultations emotionally exhausting.⁴ When medical treatments are poorly effective, this can lead to feelings of failure for the clinician and can precipitate a lengthy journey of futile medical opinions and interventions.

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exception of antidepressants, the balance of benefits and harms is unfavourable for all medicines currently used to treat chronic primary pain. However, if clinicians do not prescribe, they are accused of 'just leaving people in pain'. This cuts very deep and we need to remind ourselves that, faced with people who are struggling, the best and most compassionate response is to first do no harm.

COMPLEXITY OF CHRONIC PAIN

Chronic pain is described as lasting for >3 months, but the phenomenon is more complex. The experience of chronic pain is less associated with injury signals and is more shaped by mood, anxiety, deprivation, social circumstances, early experiences, particularly childhood trauma, culture and beliefs, and expectations. The aetiology of pain is often elusive and compounded by the coexistence of underlying (secondary) causes alongside chronic primary pain (CPP). The presence of CPP may be suspected when the pain or its impact is out of proportion to any observable injury or disease, particularly when the pain is causing significant distress and disability. Our skill is recognising the complexity of a person's pain experience.

ASSESSMENT AND COMMUNICATION

The central pillar of the guideline is about building supportive and collaborative relationships. Being there 'for the journey' is how one GP trainee described their role to a patient (Sharma S, personal communication, 2013). The guideline emphasises the importance of empathy and validation of the person's pain experience.

Discussing how life events and experiences play a central role in chronic pain allows the clinician to demonstrate that they recognise how difficult, distressing, and disabling the symptoms are, and leads to an empathic and shared discussion about the patient's strengths and what is most likely to help.

MEDICINES

History tells us that we cannot ignore that people use medicines to attenuate the unpleasantnesses of life. Deprescribing is currently a hot topic, and prominently so, in the sphere of medicines for pain.⁵ Recognising the challenges people with pain are living with helps us to have a more nuanced understanding of their relationships with medicines. This prepares us to support people in the slow and sometimes unsuccessful journey to reduce harmful or unhelpful use of drugs.

OTHER APPROACHES

Non-pharmacological options are, in evidence terms, the best bet. Notably, exercise, delivered by qualified professionals in a group setting, can be helpful for CPP in improving pain, quality of life, and physical and psychological function. A recent community-based exercise initiative has reported positive outcomes for people with chronic pain.⁶ Cognitive behavioural therapy and acceptance and commitment therapy also have evidence for benefit.¹ Active rather than passive treatments make sense when supporting people to self-manage their condition; nonetheless, the clinical and economic evidence for acupuncture for CPP suggests that this might be offered in some circumstances. Social prescribing is embedded in the *NHS Long Term Plan*⁷ but robust evaluation is still lacking. However, although no recommendation was made in NG193, the pivotal importance of social influences on pain suggest that this population should be offered referral to social prescribing link workers in primary care.

Chronic pain is a population health

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problem with significant health inequalities, as highlighted in a recent report.⁸ Many of the challenges patients bring to us would be best dealt with by societal responses that address these inequalities. Much of this is out of our control as clinicians, but we must not fall into the trap of providing unhelpful medical treatments as an alternative.

CONCLUSION

NG193 signals an important paradigm shift in the assessment and management of pain. Patients should now be assessed meaningfully to develop a more constructive shared understanding of how their experience is shaped. Patients will have time to tell their stories and be partners in their care, and they should be less harmed by their treatments. The recommendations play to the strengths of primary care practice. Clinicians in primary care can be empowered by better knowledge of what is not helpful and can move towards aligning expectations about what can and cannot be done.

The challenge is that these recommendations come at a time of unprecedented workload in primary care.⁹ There may be some interim ‘hacks’ to create the time to offer better care (longer

appointments, multiple appointments, and sharing assessment and provision of support with other team members) but ultimately good care costs time and money, and we must identify what we can stop doing for people with pain to fund the things we need to do and co-design services with patients to make this happen.

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Provenance

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Competing interests

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