



Barriers to Self-Management of Chronic Pain in Primary Care

The first phase of a two year project aiming to advance the primary care management of chronic pain

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Contents:

Section	Title	Page No.
1.0	Abstract	1
2.0	Participant Comments	2-3
3.0	Report	4-13

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

Background: The SIGN guideline (2013) recommends ‘supported self-management’ as an intervention for chronic pain. Effective self-management¹ should enable an individual to minimise the impact chronic pain has on their everyday life. Furthermore, evidence suggests self-management can reduce the impact of long term conditions on NHS services (LTCAS 2008). Some people may need the help of primary care¹ healthcare providers to manage their pain (HIS 2014). Primary care can therefore play a key role in supporting self-management of chronic pain.

Aims: The project aimed to gather evidence of possible barriers to the facilitation and adoption of self-management of chronic pain from both healthcare providers working in primary care and users of the primary care service.

Method: Eighteen focus groups were held with people with chronic pain and carers (‘patients’²) and primary care healthcare providers (HCPs) throughout Scotland. Fifty-four patients, nine carers and thirty-eight HCPs attended the groups. Focus group recordings were analysed by two researchers.

Results: Four categories of barriers emerged from the data:

Patient/HCP Consultation: Some patients felt a discussion about self-management came too late or not at all whilst there were consistent examples of both parties misinterpreting messages. Patients often felt misunderstood and disbelieved. **Patient Experience:** The emotional impact of chronic pain was difficult and the search for diagnosis and cure long and often fruitless. Patients often felt they got little HCP support with self-management. HCPs questioned some patients’ readiness or ability to self-manage. **Limited Treatment Options:** Some participants felt there was a tendency towards ‘over-medicalisation’. Whilst third sector support services were valued, some HCPs had concern regarding content and longevity. Patients sometimes felt HCPs did not understand or know about their self-management; more training was considered desirable. **Organisational Constraints:** Short appointments, long waiting lists and a compartmentalised NHS frustrated patients and HCPs and challenged the consistency and feasibility of discussing self-management.

Conclusion: The project found qualitative evidence of potential barriers to self-management of chronic pain in primary care from both the patient and HCP perspective. Barriers include those formed during one-to-one interactions between patient and HCP and those imposed by the constraints of the wider organisation. The often lengthy and inconclusive patient journey towards diagnosis and treatment, the emotional impact of pain, the need for ongoing support and a purely medical approach all provide opportunities for barriers to form. Knowledge of the current barriers in primary care can be used to inform possible interventions to help more people better self-manage their chronic pain.

¹ Definitions of self-management and primary care are provided on page 4 of this report

²For ease, data gathered from the focus groups with people with chronic pain and carers will be referred to as being from ‘patients’ throughout this document.

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

During the study we spoke to 101 people at 18 focus groups held throughout Scotland. This comprised 54 people with chronic pain, 9 carers, 16 GPs, 15 physiotherapists, 4 occupational therapists, 2 practice nurses and 1 pharmacist. The following quotes provide a snapshot of the four categories of barriers to pain self-management that were found and which will be discussed in this report:



Patient/ HCP
Consultation

“... I often find that self-management is used as a last resort rather than something that we use from the beginning.” [GP]

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

“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]

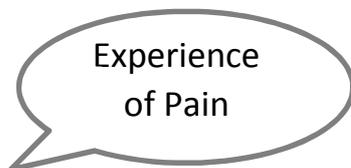
“But sometimes you know that there’s a much more obvious psychological/psychiatric issue but that’s a real difficulty if the patient just does not accept that or does not want to hear that at all.” [GP]

“I need to come in here, because I was at physiotherapy... they said, ‘describe your pain’. And I says, ‘ten’. ‘Och’, they laughed at me! ‘Och, don’t be silly! Describe your pain, what number is it?’” [Patient]

“It is true that I think unless you are in chronic pain you don’t know what they feel. And it is very difficult to relate to them. I think that’s what I find quite difficult to understand...” [GP]

“... it really does come down to that health professional’s attitude and general outlook.” [Patient]

“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]



Experience
of Pain

“When pain’s really bad it’s a very lonely thing, because you just can’t be bothered with anyone else.”[HCP - Other]

“It changes your character and it changes your confidence and it really can ruin your life...” [Patient]

“I think that that is probably the challenge, when they are stuck at the point of looking for a diagnosis and you are spending all your time and energy on that.” [GP]

“I think one of the hard things is if you don’t have a diagnosis and you go from A to B and ‘it’s not this, so OK we’ll try this’. And you understand that in a way it’s about elimination, by trying out different things, but it can be very frustrating.” [Patient]

“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. This is a significant psychological shift we are looking for them to go through.” [GP]

“I think what self-management means to me is you’ll always have pain, if you don’t accept it then it’s your fault that you’re not managing it properly. I should go away and learn how to self-manage.”



Limited
Treatment
Options

“And I need to be comfortable with promoting self-management. And I think we are less good at that because at medical school it’s all to do with medicalising everything and giving you ‘here is a problem, there is a solution.’ And the solutions most times are to do with giving patients prescriptions.” [GP]

“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 – other]

“I mean I know if I’m in pain and I get distracted, it helps the pain. 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]

“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].

“You walk into the GP... and within minutes you can see him looking at the clock”. [Patient]

“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 ten minutes – ‘let’s give you a prescription’. [GP]



Organisational
Constraints

“...so I think the continuity here is key... you can see how people lose confidence – people have been told ten different things before and they still don’t know what it is and ‘how can I then go on and manage it?’” [GP]

“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]

“And that is effectively how general practice is delivered at the moment in terms of the government set targets and we attempt to meet them.” [GP]

“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]



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

3.1 Introduction

Pain Concern received funding for a two year project aimed at advancing the primary care management of chronic pain. The first phase comprised a country-wide qualitative study researching possible barriers to self-management of chronic pain in primary care.

3.2 Background

Chronic pain has been estimated to affect around one in five of the Scottish population, six per cent of whom have severe pain (Smith et al 2001). The SIGN guideline (2013) recommends 'supported self-management' as an intervention for chronic pain. Most people affected by chronic pain primarily manage their day-to-day lives themselves whilst some may need the help of community and/or primary care healthcare professionals (HIS 2014). Primary care can therefore play a key role in supporting self-management of chronic pain. Effective self-management should enable an individual to reduce the impact their chronic pain has on their everyday life. Furthermore, evidence suggests that self-management can reduce the impact of long term conditions on NHS services (LTCAS 2008). Knowledge of the possible barriers could be used to inform future decisions and interventions to help more people better manage their pain.

3.3 Definitions of key terms

Self-Management - 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 (Boyers et al 2013 pg. 367).

Primary Care - Primary care is healthcare provided in the community by GP's and/or other health professionals whom can be accessed directly and usually through self-referral.

3.4 Method

Focus groups were used as the method of data collection, designed to generate group discussion and elicit rich data. Groups were held with two separate study populations: health care professionals (HCPs) and people with chronic pain and their carers ('patients'³). Recruitment of HCPs was undertaken by sharing details of the project with contacts of Pain Concern working in the NHS, who disseminated this information amongst colleagues. Patients were targeted in a similar manner: through contacts at various third sector organisations which provide support for people in chronic pain; by writing to members of Pain Concern and by advertising on various social media and voluntary organisation websites. All focus groups were fully transcribed and loaded onto NVivo 10, a qualitative data analysis package which facilitates the sorting and categorisation of data.

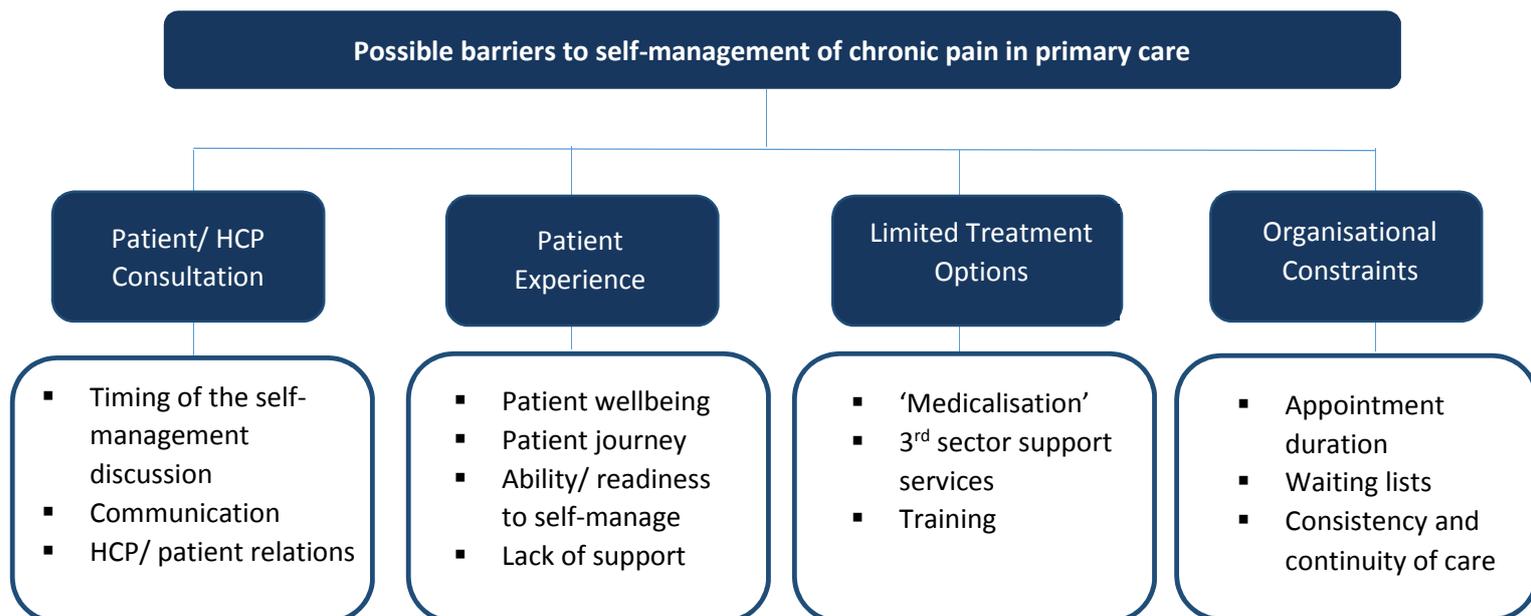
³ For ease, people with chronic pain and carers will be referred to as 'patients' throughout this document. Inclusion criteria were 'having a chronic pain condition' or 'caring for somebody with a chronic pain condition'.

3.5 Research Sample

Eighteen focus groups were held throughout Scotland with a total of 101 participants. Participants included 54 people with chronic pain, 9 carers, 16 GPs, 15 Physiotherapists, 4 Occupational Therapists, 2 Practice Nurses and 1 Pharmacist. Groups were held in Annan, Dunfermline, Dundee, Edinburgh, Falkirk, Glasgow, Inverness, Paisley, Rosyth and Rothesay.

3.6 Results

Barriers to self-management in primary care were grouped into four broad categories with sub themes under each.



Patient/ HCP Consultation

Timing of the self-management discussion

Some patients who were successfully managing their condition reflected on their discussions with HCPs with regard to self-management and felt that it came too late, if at all. There was a feeling that patients were left to teach themselves self-management, making it harder and more time consuming than if they had been supported by HCPs. This self-teaching was done by 'picking up this bit or this bit and trying to join them together'.

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

Patient/ HCP Consultation

Communication

There was some evidence of poor communication between patients and HCPs which led to frustration and negative emotions. Patients often felt that HCPs did not believe them with regard to the degree and the impact of the pain. HCPs suggested some reasons as to why patients did not feel believed, an impression that was difficult to subsequently reverse:

“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]

Patients sometimes found it difficult to describe their pain and, in one case, the description was met with instant disbelief:

“I need to come in here, because I was at physiotherapy... they said, ‘describe your pain’. And I says, ‘ten’. They laughed at me! ‘Och, don’t be silly! Describe your pain, what number is it?’ 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 TEN!’” [Patient]

Another area of discrepancy, which may be attributable to the difficulties in communicating and describing pain, was the GPs’ perception that they saw patients when their pain was at its worst. Patients, on the other hand, said they were unable to go out when their pain was at its worst and waited for it to subside before visiting the doctor.

When patients were asked if there was anything they wished HCPs would do differently, ‘listening’ was by far the most common response. Patients also wished that HCPs treated them as an individual and gave more than a ‘text book response’.

Patient/ HCP Consultation

HCP/ Patient Relations

It was widely accepted that a good relationship between patient and HCP was beneficial for the promotion and uptake of self-management. Patients’ positive experiences centred on listening, caring, patience, supporting and accessibility. Negative experiences included not listening, rushing, giving generic advice, not acknowledging the impact of pain, invoking feelings of inferiority, judging and insinuating that pain “is in the head”. Negative experiences with HCPs were thought to lead to worsening pain, poorer mental health and increased stress.

The feeling that HCPs did not understand chronic pain came through strongly from a number of patients. HCPs recognised this understanding was hard to come by:

“It is true that I think unless you are in chronic pain you don’t know what they feel. And it is very difficult to relate to them... when people say, ‘I’m in agony.’ And they’re always in agony, but they don’t look in agony. If I was in agony, I don’t think I’d be able to move. So there is part of that – it’s not that we don’t believe them, we don’t understand it.” [GP]

Most HCP groups made reference to chronic pain patients potentially being a difficult group. A number of reasons were cited including: disappointment that they could not fix the patient's problem; frustration at a lack of compliance; and the tiring and draining nature of connecting and empathising with a distressed patient. Such characterisation of patients as difficult was often discussed as being a cause of 'heartsink', highlighting the impact that a chronic pain patient may have on the HCP's emotions. Avoiding such associated emotions was not always possible:

"...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]

Patient Experience

Patient Wellbeing

The emotional impact of chronic pain was widely discussed. Some people with chronic pain spoke of finding pain depressing or of it making them 'very low' whereas others spoke of actually 'having depression' and a few spoke of being 'suicidal'. Some patients spoke of a feeling of grief and mourning for their former selves and one patient specifically linked this to a struggle with self-management:

"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 and wanting to be your former self. And that being too stubborn to accept [that you're not that person anymore]". [Patient]

A link between pain and poor mental health was recognised by HCPs and some patients, while other patients were sceptical of the relationship between depression and chronic pain.

Patients and HCPs spoke of the frustration at the limitations caused by pain, feelings of loneliness and changes in personality:

"When pain's really bad it's a very lonely thing because you just can't be bothered with anyone else." [HCP - Other]

"It changes your character and it changes your confidence and it really can ruin your life..." [Patient]

Other emotions mentioned by people with chronic pain centred around feelings of guilt or inadequacy at not being able to function in the way that they used to, feeling embarrassed about no longer working or using disabled 'privileges' such as designated parking spaces.

Patient Experience

Patient Journey

Whilst reaching a point of acceptance was considered beneficial for self-management, patients found it a difficult, emotional and sometimes unachievable point to reach. Reaching, or not reaching, acceptance was often preceded by a search for diagnosis and cure which was not always conducive to self-management. One GP summarised how ceasing the search for a diagnosis was a difficult discussion to have.

“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 and that is often when you get stuck with difficult patients.” [GP]

The realisation that the outcome of treatment would most likely be a reduction in pain as opposed to a complete cure left patients disappointed and HCPs sometimes felt they had ‘let the patient down’ as a result. Both groups thought these feelings were due to the traditional, implicit assumption that ‘doctor fixes patient’. The expectation of a cure was sometimes perpetuated by family, other HCPs, the media and pharmaceutical companies.

Both patients and HCPs felt the frustrations of seeking a diagnosis and cure evoked negative emotions and potentially compounded the problem due to the lengthy periods of time involved. Focusing on self-management during this time could be challenging:

“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 OK we’ll try this’. And 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.” [Patient]

Patient Experience

Ability/ Readiness to Self-Manage

There was some discussion amongst HCPs of a population of people with chronic pain who are self-managing successfully and therefore do not regularly utilise primary care services. This raised the question as to why some people are more successful with self-management than others. HCPs suggested this may be due to ability or capacity to learn or willingness to self-manage. Difficulties with self-management cited by patients focused on having to get things done, the unpredictability of pain flare ups and lack of access to self-management resources. The discrepancies in beliefs about ability and willingness may be due to a biased patient sample who already had an interest in self-management.

Patients and HCPs recognised that medication could be a challenging aspect of self-management due to complex prescriptions and patients not wanting to take the medications prescribed. Medication side effects on memory and functioning added to the challenge.

The concept of 'readiness to change' was discussed by HCPs, noting that although patients may not always be changing behaviours there and then, it was hoped and expected that this would come with time. HCPs sometimes found appointments with patients who they perceived were not ready to change to be frustrating and draining with self-management suggestions continually rejected.

Patient Experience **Lack of Support**

Some patients and most HCPs felt that self-management was about patients taking control and HCPs empowering them to do so, therefore implying a degree of joint working. However, patients felt that they were often left on their own to self-manage with little 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 amongst HCPs that use of the term 'self-management' may have led to negative patient associations of abandonment.

Although many patients expressed a willingness to undertake their own research, this was still accompanied with a desire for more support. Patients also felt resistance from the HCPs to take on board the research and suggestions they had found for themselves, with some feeling that their own knowledge brought about conflict with the GP. One GP spoke of the 'sobering effect' of realising a patient knew more about their fibromyalgia and self-management than he did himself.

Clinics, including physiotherapy, were described as being organised around short courses of appointments, after which patients would be 'signed off'. However, this was often done without any long term strategy for managing their condition in the community. Some HCPs acknowledged that being able to offer something longer term would require resources but it was argued that this would be more effective than having the same patients repeat further short-courses of physiotherapy. HCPs felt that the patients who were successfully self-managing could still require ongoing support at times of flare up or during other life events which could disrupt self-management plans. Without access to such brief interventions to get them back on track, HCPs felt that some patients had to go back to the start of the system.

Limited treatment options **"Medicalisation"**

Some HCPs felt that there was a tendency towards "over-medicalisation" in the treatment of chronic pain and cited a need for a switch towards a more psychosocial model of healthcare:

"... at medical school it's all to do with medicalising everything and giving you 'here is a problem, there is a solution.' And the solutions most times are to do with giving patients prescriptions." [GP]

Patients also felt they were often offered a prescription as the only treatment option. The side effects of ever increasing medication were widely acknowledged.

However, the switch towards self-management as an effective means of treatment was generally seen by HCPs to be a significant cultural shift that is not yet embedded in society or patients' ways of thinking. Such a shift was recognised as requiring time and effort.

Limited treatment options

Third Sector Support Services

Third sector support groups were widely discussed, with a broad range of thoughts and experiences expressed. Generally patients had a far more positive view of such services compared to HCPs. The method of patient recruitment may have led to the differences in opinions with the majority of participants recruited from a support group, therefore leading to a sample biased in the favour of such groups. Patients were extremely positive about the support groups and spoke of the difference which they made to them and the management of their pain:

“And it’s just like banging your head and there’s nowhere to turn. This is the only place where I get somewhere where I can come and there’s somebody who understands us. I don’t have anything other than this group. I don’t know what I’d be without it. And that’s only once a month...” [Patient]

Other positive comments included: being amongst people with similar experiences; being able to talk to other people and therefore not burdening family; and sharing ideas. HCPs also recognised the benefits of groups including: learning from peers; being amongst peers who will be perceived to have better understanding; and reducing feelings of isolation.

However, HCPs sometimes expressed a sense of reservation about signposting patients to such groups. Reasons included: concern with regard to the content; previous bad reports from patients who had attended a group; messages and language inconsistent with that which HCPs used; and a concern that groups may reinforce an attitude of ‘I can’t do that’.

Other practical issues were raised as a barrier to signposting including the transient nature of third sector organisations, whose existence is dictated by the availability of funding. This led to concern about referring patients to something that no longer existed, disappointing the patient and possibly making the HCP look foolish in front of the patient. One GP felt that the less easily measured benefits of support groups meant they might be de-prioritised as a treatment method:

“I mean I know if I’m in pain and I get distracted, it helps the pain. 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]

Limited treatment options

Training

A perceived lack of HCP knowledge was highlighted by many patients. They felt it was important that HCPs kept up to date with current research, although generally they felt that

this did not happen. Training on chronic pain and self-management was raised in the majority of HCP groups, specifically, undergraduate level training and continuing professional development. Generally it was felt there was not enough training provided, a view expressed across the different professional groups, and some felt they would benefit from additional training on the self-management techniques which could be advised to patients. Some of the Edinburgh-based physiotherapists had undertaken additional pain training which they felt was extremely beneficial in their subsequent treatment of and confidence in dealing with patients in chronic pain.

Although training was raised as a means of improving the management of chronic pain, one GP felt that the nature of their role and the massive variety of conditions and patients that they see meant there had to be a limit to how many had specialist pain 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]

Organisational Constraints **Appointment Duration**

It was rare for HCPs not to mention problems associated with highly limited appointment duration at some point during their discussion. For GPs the key issue was the problem of dealing effectively with chronic pain patients in a ‘ten minute’ appointment. The problems associated with short appointment time included: not being able to find out what was really happening with the patient; not having time to discuss chronic pain because the patient had several other problems/symptoms; not having time to be empathetic with the patient; not having time to introduce the concept of self-management or discuss self-management techniques. The pressure of the short appointments was not unapparent to patients.

GPs emphasised that educating patients about chronic pain was time-consuming and potentially energy-sapping, adding to the challenge of the short appointment. Some linked this directly to a tendency to reach for the prescription pad:

“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]

“We need half hour appointments”. “We really do. I mean I think we could transform things like pain with a half hour appointment, absolutely”. [GPs]

Organisational Constraints **Waiting Lists**

Both HCP and patients referred to long waiting times for referrals to other services as a key barrier in achieving good treatment and by extension good self-management. Two services were mentioned in particular in this context: psychology/psychiatric referral and referral to

physiotherapy. The problems caused by long waiting lists included: worsening pain; the impact of worsening pain such as job loss while waiting for treatment; anger with the 'system'; and a loss of motivation and interest in self-management. Some HCPs and patients recognised that waiting lists may lead to the pain becoming more entrenched and the associated impacts on mental health worsening. Physiotherapists spoke of the pressure to move patients on in order to reduce the waiting list, sometimes leading them to signing a patient off earlier than they would like due to the need to attend to the next person in line. On a similar note, GPs voiced the frustration that their patients were being discharged too quickly from outpatient clinics and subsequently returning to the GP surgery.

Organisational Constraints **Consistency and Continuity of Care**

Both HCPs and patients recognised that self-management messages were not always consistent throughout the health service, often depending on an individual's views on the subject and leading to mixed messages.

A frustration for both patients and HCPs was a feeling of the compartmentalised structure of the NHS. A common experience was of multiple investigations where specialists ruled out factors specific to their expertise, but nobody thought of the patient as a whole person:

“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 and the whole person's in there not getting looked at as a core human being”. [Patient]

Both patients and HCPs talked of the lack of prioritisation of chronic pain within the NHS. Government target setting was discussed in a number of HCP groups, with the impact being a struggle between meeting targets and treating conditions falling outside such targets, including chronic pain. One patient group discussed the impact and unjustness of a lack of prioritisation:

“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] “But it does make your life really sometimes not worthwhile and you do think, why bother?... Is that not a life threatening attitude?” [Patient]

3.7 Conclusion

Through data collection across a broad sample population of HCPs and people with chronic pain some of the barriers to facilitating and adopting self-management of chronic pain in primary care were highlighted. Communication about chronic pain was found to be challenging for both patients and HCPs, sometimes leading to difficult relations. The complexity of the condition, difficulties in describing pain, differing perceptions of pain and of the right time to introduce self-management added to the challenge of forming a partnership between patient and HCP. The emotional impact of pain and the long and possibly inconclusive patient journey which often accompanied pain can leave patients



feeling unsupported and HCPs drained. Broader factors, such as the cultural acceptability of self-management, patient capacity and challenging life events, can hinder the uptake and continuation of self-management.

A stretched health service, set up on a medical model, better suited to the treatment of acute rather than long term conditions, imposed constraints on the use of self-management approaches. It was highlighted, by HCPs that very little training is available on chronic pain management or on self-management specifically. It was felt that short appointments discouraged discussion and HCPs would prescribe medication as it was “the only thing we can do in 10 minutes”. A cultural shift towards a preference for self-management as opposed to passive care and utilisation of other, less medicalised, treatment options may help overcome some of these limitations. Knowledge of the current barriers in primary care could be used to inform future decisions and possible interventions to help more people better self-manage their chronic pain.

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Next Steps:

In the second phase of the project, which will run through 2015, Pain Concern will aim to develop and pilot resources that may help to reduce some of the barriers found. At present we are proposing to focus on: increasing the level of knowledge of self-management of chronic pain; increasing patient awareness of the emotional impact of pain; and improving communication between patient and HCPs with regard to self-management. We will also aim to share the findings of the research done to date as widely as possible.

For further information or questions please contact Katy Gordon at research@painconcern.org.uk, 0131 669 5951 or Pain Concern, Unit 1-3, 62-66 Newcraighall Road, Edinburgh, EH15 3HS.