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Commentary

It's complicated: Pain, priorities and primary care

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In this issue of the Journal, Tai-Seale and colleagues explore time spent and prioritization of pain management in US primary care consultations between doctors and older people. Data were obtained by analysis of 385 videotaped consultations in a range of medical practices in two US geographical regions. This is part of a broader study of doctor-elderly patient transactions, and so data are not available on important aspects of pain: for example, pain characteristics, pain psychosocial factors, and patient expectations or pain beliefs are not captured.

The main findings of the study were that pain was a common topic raised (in 48% of consultations) and often prioritized by older patients on the list of health topics discussed; however, the amount of time spent discussing pain during the consultation was very limited. Prior publications from this study suggest that other aspects of health suffer similarly from 'time poverty' – notably depression (Tai-Seale et al., 2007). The sampling methods used in this study are not population-based and therefore the generalizability of findings is unclear. However, there is salience between these results and the wider literature on primary care management of chronic conditions.

This study highlights the tension between the time constraints typical of primary care settings and the complexity of care needs of older people with troublesome pain. This is not a uniquely American problem. A study of primary care consultations in the US, Australia and New Zealand found that the age-standardized rates of consultation for musculoskeletal conditions were highly comparable (Bindman et al., 2007), and overall the type and number of conditions managed per visit were also similar.

Ageing populations, multi-morbidity and a high population burden of age-related musculoskeletal conditions are common to many countries. Higher levels of multi-morbidity and the clinical severity of individual health conditions are both associated with increasing age (Fortin et al., 2005). Yet randomized clinical trials, even of monotherapies never mind complex interventions, have typically and systematically excluded older people and people with complex multi-morbidity.

A recently published UK qualitative study involving interviews with general practitioners and practice nurses suggests that in busy primary care settings, managing patients with complex multi-morbidity remains a problem, and that treatment of each condition is still often compartmentalized in a sequential fashion (Bower et al., 2011). In our own experiences of working with older people in tertiary-level multi-disciplinary treatment programs, there is great willingness by patients to talk freely and at length about pain experiences and to learn new skills in settings where there are fewer time pressures, interested listeners, and a primary focus on pain management. How do we effectively translate this into more effective primary care management for older people with troublesome pain, where pain may not be the only problem?

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