allow some time into which opportunistic screening may be fitted, a process which could be facilitated if the patients' notes contained a form which could be filled in over the course of a number of consultations. This could go a fair way towards meeting the screening requirements of the new contract, though it would not of course solve the administrative problem of contacting non-attenders. Alternative approaches to screening involve other members of the primary care team, and Marsh[16] has described how substantial parts of the doctor's traditional work can be undertaken by an extended team.

How should surgeries be booked?

Running late is bad for patients. Long waiting time is another common complaint of patients[17,18] and a paper by Hill-Smith (p.492) demonstrates the exponential rise in patients' waiting time if consultations are booked at less than the mean consultation time. However, running late is also bad for doctors. In preliminary results from a study in Lothian, Porter and colleagues[19] suggest that running late is a major source of stress for general practitioners, particularly if they have other fixed commitments to attend to. Hill-Smith's solution to this problem is to book short frequent surgeries. In practice, this is most readily achieved by breaking up long surgeries with short periods of administrative time at intervals of one to one and a half hours. These act as a buffer against cumulative lateness and allow the doctor breathing space every 10 patients or so. Hill-Smith also investigates the effect of allowing patients to choose their own appointment times. This did not appear to be an efficient use of doctors' or patients' time in his study, although in other hands, appointment times chosen by patients have been associated with short waits by both doctors and patients.[20,21]

The conclusion is that consultations in the 1990s should probably be booked at 10 minute intervals if list size allows. This interval will allow some time for opportunistic screening. If long surgeries are broken up with short periods of administrative time, this will decrease patients' waiting time and probably reduce stress for general practitioners.

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Chronic non-malignant pain: time to take on the challenge

WHILE some patients with chronic pain are referred to hospital clinics and those with malignant disease are treated in hospices, the majority of patients with chronic pain are managed by general practitioners. Chronic pain has a poor prognosis and even in one of the best specialist centres 40% of patients with non-malignant pain experienced no relief and 38% only partial relief.[1] The challenge for primary care is to provide a coherent response to the needs of patients with chronic pain.

The prevalence of chronic pain in the community has been variously estimated at 9.4%,[2] 8.7%,[3] and 11%[4] in three very different studies but it is well known that general practitioners see only a small proportion of the illness in the community[5] with many factors influencing patients' decisions to consult.[6] This 'pyramid' of patients receiving various levels of care has been quantified for back pain.[7]

Aristotle defined pain as 'an agony of the mind',[8] but in 1986 the International Association for the Study of Pain agreed on 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage'.[9] This definition encourages a broad approach to evaluation, and may be therapeutic in giving patients the language to communicate their distress, thereby reducing feelings of isolation.[8]

Various dimensions of the experiences of patients with pain need to be assessed, including intensity[10,11] and quality of pain,[12,13] psychological state[14,15] and their attitude to pain[16] with the use of active and passive 'coping strategies'.[17] The last of

these may have a predictive value in the development of chronic pain.

In primary care we are concerned with the interactions between patients and their families and recently there has been interest in the relationships of patients with chronic pain. However, the evidence regarding aetiological factors within the family, the influence of relatives other than the spouse and the possible importance of operant conditioning, is inconclusive.[18,19] The spouse of a chronic pain sufferer may develop physical complaints, and marital satisfaction tends to diminish, but a positive correlation has been found between the solicitousness of the spouse and pain intensity perceived by the patient.[20] The adoption of the 'sick role' described by Parsons,[21] in which the patient has obligations such as seeking professional help but also privileges such as being excused the 'bread-winner' role, may be dependent on family factors.

A behavioural approach to family therapy has been advocated by Fordyce.[22] This aims to discourage the use of 'passive coping strategies' and encourage the conditioning of 'well behaviours'. However, even if a structured behavioural approach is not adopted, general practitioners can explore the meaning of the chronic pain to the patient and provide psychological support for the patient, the spouse[23] and other relatives.

A multidimensional approach to management is the hallmark of good general practice and this is particularly true for the patient with chronic pain. The primary health care team should be establishing the prevalence of the problem, describing the pathogenesis of chronic pain, developing practical methods of patient assessment, identifying prognostic indicators with a view to prevention, and testing the efficacy of therapeutic manoeuvres. General practitioners are uniquely placed to perform this long overdue research.

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